

**ROLE OF PERCEIVED FAMILY SUPPORT AND RESILIENCE IN  
THE RELATIONSHIP BETWEEN PRENATAL ANXIETY AND  
PSYCHOLOGICAL WELLBEING AMONG EXPECTING MOTHERS**



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By

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## DECLARATION

I, **Miss. Ayesha Ali**, Registration No. **453-FSS/MSCP/F21** student of **MS** in the subject of Psychology, session **2021-2023**, hereby declare that the matter printed in the thesis titled: **ROLE OF PERCIEVED FAMILY SUPPORT AND RESILIENCE IN THE RELATIONSHIP BETWEEN PRENATAL ANXIETY AND PSYCHOLOGICAL WELLBEING AMONG EXPECTING MOTHERS** is my own work and has not been printed, published and submitted as research work, thesis or publication in any form in any University, Research Institution etc in Pakistan or abroad.

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## RESEARCH COMPLETION CERTIFICATE

Certified that the research work contained in this thesis titled: Role of perceived family support and resilience in the relationship between prenatal anxiety and psychological wellbeing among expecting mothers has been carried out and completed by Miss. Ayesha Ali, Registration No. **453-FSS/MSCP/F21** under my supervision.

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## **Dedication**

*With deep gratitude, I dedicate my thesis to my pillars of support my cherished mother and devoted teacher, **Dr. Mamoonah Ismail Loona**. My mother's limitless love empowers my pursuit of knowledge, while Dr. Mamoonah's guidance and passion for education inspire my academic journey. This work stands as a tribute to their unwavering belief in my potential.*

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**List of abbreviations**

APA	American psychological association
DSM	Diagnostic and Statistical Manual of Mental Disorders
PRA	Pregnancy-related anxiety
PWB-S	Psychological Well-being Scale
BRS	Brief Resilience Scale
PASS	Prenatal Anxiety Screening Scale
SPSS	Statistical Package for Social Science
WHO	World Health Organization

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## Abstract

This study investigated the impact of perceived family support and the ability of expecting mothers to recover relationship between the prenatal anxiety and psychological wellbeing. Additionally, we aimed to examine the moderating effects of perceived family support and resilience on the relationship between prenatal anxiety and psychological wellbeing. By using the convenient sampling method we collected data of 200 pregnant women from various gynaecology departments of Islamabad/Rawalpindi hospitals. The participants aged between 18 to 40 having diverse education background and socio economic status. Perceived family support is measured by perceived family support scale (Abbas, 2019) which has 20 items. Resilience is measured by brief resilience scale Smith et al., (2008) which has 6 items. Prenatal anxiety is measured by Prenatal Anxiety Screening Scale (Somerville et al., 2014) which has 31 items. Psychological wellbeing is measured by psychological well-being scale (Ryff & Keyes, 1995) which has 18 items, 3 items each for its subscale. Reliability of all scales was found to be statistically significant. An independent sample t-test was used to assess the mean difference between two groups for parametric data. The ANOVA was used to analysis relationship between the variables. The result of this empirical study revealed that prenatal anxiety had a significant negative correlation to psychological well-being and resilience serves as a moderator with only subscale of prenatal anxiety between the variables under the study. However there was no moderating effect of perceived family support. It was found that the expected mothers who have high level of resilience embrace new experiences with courage. The expected mothers who have high level of perceived family support are less prone to prenatal anxiety. Prenatal anxiety significantly predicted a negative relationship with psychological well-being. Integrate mental health services within prenatal care settings to provide counselling and support for pregnant women experiencing anxiety.

*Keywords: prenatal anxiety, perceived family support, Resilience and psychological wellbeing.*



## Chapter 1

### Introduction

Pregnancy, while a significant and joyous milestone for women, is also recognized by psychologists as an emotionally challenging period, often referred to as an emotional crisis (Robertson et al., 2014). Failure to effectively manage and control this crisis could result in its prolongation, leading to numerous adverse outcomes for both the mother and her baby. In developed countries, the prevalence of anxiety disorder during pregnancy is approximately 10%, whereas in developing countries, the rate is higher, at around 25% (Glover, V. 2014).

Pregnancy is the condition during which a developing fetus grows within the womb or uterus of a woman. The typical duration of pregnancy is approximately 40 weeks, which equates to slightly over 9 months, starting from the last menstrual period up to the time of delivery (Smith, 2023). Medical professionals categorize pregnancy into three distinct phases known as trimesters.

**First trimester (week 1 to week 12).** The process of pregnancy initiates with conception, wherein a sperm successfully enters and fertilizes an egg. The fertilized egg, known as a zygote, proceeds through the woman's fallopian tube and attaches itself to the uterine wall after reaching the uterus. The zygote comprises a group of cells that eventually give rise to both the fetus and the placenta. The placenta serves as the link between the mother and the fetus, facilitating the supply of nourishment and oxygen to the developing baby (Ford et al., 2011).

**Second trimester (week 13 to week 28).** Between 18 and 20 weeks, which is the usual timeframe for conducting ultrasounds to detect birth defects, it's often possible to determine the gender of your baby. Around the 20-week mark, a woman might start to perceive fetal movements. By the 24th week, the fetus has developed footprints and fingerprints, and it follows a regular pattern of sleeping and waking. As per findings from the NICHD Neonatal



Research Network, infants born at 28 weeks have a survival rate of 92%. However, it's important to note that these premature births are often associated with significant health challenges such as respiratory and neurological issues (Stoll et al., 2010).

**Third trimester (week 29 to week 40).** At 32 weeks, the bones are pliable but nearly completely developed and the eyes have the ability to open and close. Infants born before reaching 37 weeks of gestation are categorized as preterm. These children have an increased susceptibility to confronting difficulties like developmental delays, impaired vision and hearing, and cerebral palsy. Babies born between the 34th and 36th weeks of pregnancy are categorized as late preterm (Spong, 2013). Babies born between the 37th and 38th weeks of pregnancy, previously categorized as full term, are now termed as early term. Infants born before 39 weeks, which is now considered full term, experience greater health Weaknesses compared to those born at 39 weeks or later. Infants delivered after completing 39 or 40 weeks of gestation are categorized as full term.

Infants born within the full-term range tend to exhibit better health results in comparison to those born before or, in some situations, later than this specific timeframe. Therefore, if there are no medical reasons to prompt an earlier delivery, the recommended course of action is to plan for delivery at or after 39 weeks. This timeframe ensures adequate time for the comprehensive maturation of the infant's lungs, brain, and liver (National Institute of Child Health and Human Development [NICHD], 2013). Babies born between 41 weeks and 0 days and 41 weeks and 6 days are categorized as late term. Infants born after 42 weeks are classified as post term.

**Prenatal Anxiety.** Pregnancy constitutes a distinct and complicated phase in a woman's life. The observed changes are evident not only in the biological and physiological aspects but also manifest in her psychological and social functioning. Changes in psychological functioning

can manifest from the earliest stages through the conclusion of pregnancy, including the postpartum duration as well. Pregnancy brings about notable transformations in both physical appearance and feminine characteristics, influencing emotional experiences and sexuality. Concurrently, the woman's role and position undergo a renewal, adopting new qualities (O'Hara et al., 1991).

To varying extents, nearly every pregnant mother undergoes psychological ambivalence, frequent shifts in mood ranging from fatigue to excitement, emotional disruptions and a blend of anxiety and depressive symptoms. Moreover, pregnancy gives rise to various distinct concerns about its progression and result, rendering the woman uniquely susceptible and necessitating appropriate intervention, depending upon her personality's adaptive capabilities (Ross et al., 2006).

Additionally, looking at it from a psychosocial viewpoint, pregnancy could be seen as a unique and profoundly emotional state that has the potential to impose considerable stress. Perinatal maternal stress can give rise to a range of complications that profoundly affect the newborn infant's physical and psychological health. This review investigates pregnancy as a multidimensional psychological phenomenon, delving into the diverse alterations in a woman's psychological state during both usual and psychologically complex pregnancy experiences (Gavin et al., 2010).

During pregnancy, a woman undergoes a phase of change that involves shifts in cognition, emotions, physical aspects, and social interactions. It's natural for expectant mothers to feel concerned about their upcoming future. It's completely normal to feel anxious during pregnancy. The process of childbirth marks a period of change and adaptation for women bringing it with a range of typical worries. During this period, it's common for expectant mothers to have concerns about the well-being of their unborn baby, the process of childbirth,

and the forthcoming duties of parenthood. Lack of support from a spouse or family, along with an unexpected pregnancy, can intensify these challenges for a pregnant woman. Researchers frequently label pregnancy-related concerns as pregnancy-specific anxiety, a designation that can contribute to a significant elevation in anxious feelings (Chandra & Nanjundaswamy, 2020).

**Transactional theory of Stress and Coping.** This theory proposed by Richard Lazarus and Susan Folkman (1984). This theory looks at stress as a kind of interaction between an individual and their environment. Your ability to handle it becomes crucial because the tactics you employ can impact both your psychological well-being and resilience. Prenatal anxiety can be viewed as a stress factor. Elevated anxiety levels throughout pregnancy might trigger coping mechanisms that can impact a woman's mental well-being. When a pregnant woman utilizes effective coping strategies like seeking social support, practicing relaxation techniques, or fostering a positive mindset; these actions can enhance her psychological well-being.

Conversely, employing maladaptive coping methods like avoidance or negative rumination could worsen the influence of prenatal anxiety on psychological well-being. In this context, resilience can be interpreted as the capacity to recover from stress and adversity, while preserving a relatively steady mental and emotional state. In current investigation, it is assessed that expectant women facing psychological challenges tend to exhibit elevated levels of prenatal anxiety. This is attributable to the common occurrence of heightened anxiety and concerns among pregnant women regarding the baby's health, the childbirth process, and the potential for emotional instability and mood swings. This may appear as enduring sentiments of sadness, diminished energy, alterations in sleep routines, and a waning interest in activities.

Anxiety manifests as a feeling of anticipation, fear, and unease. It could lead to perspiration, restlessness, tension, and an accelerated heartbeat. A typical response to stress is

common. As an example, one might experience anxious emotions when dealing with a demanding task at work, approaching an impending examination, or when making a significant decision (Lakhera, 2018). Pregnancy-associated anxiety represents a distinctive manifestation of anxious feelings experienced by pregnant women, notable for its focus on fears and worries directly related to the process of pregnancy. This type of anxiety has been linked to various adverse outcomes during pregnancy, childbirth, and in relation to the health of the new-born and the mother. Pregnancy constitutes a delicate phase for women, where approximately 15% of them undergo psychological challenges during both the pregnancy and postpartum periods. The prevailing mental health issues during this timeframe are anxiety and psychological well-being, which have been associated with negative consequences for both the mother and the infant, such as low birth weight and premature birth. Considering their origins anxiety has been identified as a potential contributing factor to the emergence of anxiety disorders (Mudra et al., 2020).

Pregnancy-related anxiety (PRA) encompasses feelings of anxiety related to various aspects of pregnancy, such as concerns about labor and delivery, the well-being of the fetus or infant, the mother's health, the availability and quality of healthcare services, and the individual's capacity for parenting. Pregnancy-related anxiety (PRA) stands apart as a unique phenomenon from the general anxiety experienced alongside pregnancy. It exhibits a more pronounced connection to preterm birth, defined as delivery before 37 weeks of gestation, and in comparison to the more commonly examined general anxiety or depression (Tarafa et al., 2022).

Pregnancy-related anxiety is linked to negative effects on both maternal well-being and infant health. Unfortunately, although depression during pregnancy has been thoroughly investigated, the level of comprehensive research on anxiety specifically in this context is not as substantial. While it's common to have anxiety during pregnancy, if it increases to a point

of distressing magnitude, it can negatively influence behaviour and possibly harm both the mother and her developing fetus or child at home. The extended duration typically required for clinical diagnoses of anxiety and related conditions may not be suitable for pregnant patients. As a result, terms like pregnancy-related anxiety have emerged to address this issue. Significantly, raising awareness about the heightened possible hazards to mothers who might experience anxiety while pregnant or during the post-partum phase could enhance the screening of maternal mental health and the availability of proper care (Schetter & Tanner 2012).

Research conducted in numerous high-income countries has established a significant connection between anxiety related to pregnancy (PRA) and adverse outcomes such as preterm births, complications during pregnancy, and unfavourable outcomes for infants. Pregnancy-related anxiety constitutes a unique syndrome separate from depression, stress, or general anxiety. (Blackmore et al., 2016). Pregnancy-related anxiety involves various aspects, including concerns about the well-being and viability of the unborn child, the possibility of having a baby with health issues, the process of giving birth, the potential emergence of medical complications during pregnancy, and the confidence in being able to effectively parent and nurture the baby once it's born. The presence and impact of pregnancy-related anxiety are expected to be heightened in low-income and middle-income countries (LMICs) due to the heightened rates of maternal and child mortality, widespread poverty, and constrained resource availability (Fisher et al., 2012)

Pregnancy is characterized by notable physical, emotional, and psychological transformations, frequently giving rise to feelings of anxiety and fear. These sentiments are linked with the various short- and long-term alterations in biological, psychological, and sociocultural aspects that impact both the mother and the child (Slade et al., 2009). Perinatal mental disorders manifest from pregnancy through the first year after delivery. They encompass both newly appearing and recurring disorders that originate either during pregnancy

or in the postpartum period (O'Hara & Wisner, 2014). During pregnancy, ethnic minority women are more prone to reporting reduced levels of mental well-being compared to White women (Robinson et al., 2016). These rates underscore the significance of mental health services throughout the duration of pregnancy (Smith et al., 2011). There is a prevalent emphasis on prioritizing physical well-being over mental well-being (Bowen & Muhajarine, 2006). Despite the emergence of new stressors, only a small number of women actively pursue professional assistance (Fonseca et al., 2015).

Prenatal anxiety is frequently identified by increased worry, profound fatigue, irritability, tense muscles, struggles with concentration, and disturbances in sleep (American psychological association [APA], 2013). Although there isn't a specific diagnosis exclusively dedicated to pregnancy-related anxiety, it's crucial to recognize that increased anxiety levels and various anxiety disorders such as generalized anxiety disorder and panic disorder can emerge during this stage.

In the study by Schetter (2011), pregnancy-related anxiety was characterized as an adverse emotional condition that initiates concerns regarding the health and welfare of the baby, the hospital experience, the impending childbirth, healthcare provisions encompassing maternal well-being and pregnancy outcomes, the delivery process, postnatal aspects, and the responsibilities of parenting. Therefore, the connection between pregnancy-related anxiety and a woman's overall vulnerability to stressful emotional conditions becomes evident in the context of her pregnancy circumstances. These factors involve medical vulnerabilities such as hypertension that might affect pregnancy outcomes, past pregnancy-associated risks, and psychosocial elements like unplanned pregnancies, absence of preventative care, restricted social support, financial constraints and insufficient resources. When a woman is pregnant and feels very anxious, she might become more sensitive and see things that aren't clear, like test results that aren't certain or feeling strange pains, as something scary.

**Prenatal anxiety and family support.** During the first trimester, pregnant women universally experienced a notable level of general anxiety ranging from moderate to severe, which differed significantly from their experience in the middle trimester of pregnancy. The results showed that anxiety levels were higher in the last three months of pregnancy compared to the first three months and the middle three months (Madhavan Prabhakaran et al., 2015). Research has shown that the things that can make a pregnant person or new parent feel worried and anxious are not getting enough care, having problems in their marriage, feeling let down by their family and not having enough help and support from friends and other people around them (Karacam & Ancel, 2009, Robertson et al., 2014). Younger pregnant women often experience a lot of worry and nervousness about being pregnant, and this matches what researchers have found in their studies (Arch, 2013, Henderson & Maggie, 2013). Pregnancy is a time when a woman's body, mind, and feelings go through big transformations. These changes can make women more likely to feel anxious (Wenzel, 2011). Guardino and Schetter (2014) suggest that certain situations, such as having a high-risk health condition or experiencing an unwanted pregnancy without sufficient support from the father of the infant, can induce anxiety even in women who typically do not experience anxiety.

**Psychological wellbeing.** Feeling good in your mind and emotions is called psychological well-being, and it's something that can be different for each person. Despite experiencing periods of mental and emotional challenges, individuals with a strong sense of positive psychological well-being are capable of effectively managing their difficulties. This situation can also impact a person's body health (Klein et al., 2009, Guardino & Schetter, 2014).

Psychological well-being is about understanding how you think, feel, and how happy you are with your life (Diener, 2000). Psychological well-being means feeling good when you're with other people and your needs are taken care of. It's when you can do things that matter to you and make you happy, and you have a good and satisfying life. Psychological

well-being means being able to experience life fully and deal with problems or challenges in a positive way, through our thoughts, feelings, and actions (Rueger et al., 2010). Psychological well-being means feeling good about yourself, having strong connections with others, being able to handle social pressures on your own terms, having an impact on the world around you, finding purpose in life, and constantly recognizing your own strengths. (Ryff, 2000).

Psychological well-being means feeling good about yourself and your relationships with others. It includes how you see yourself, how confident you feel, and how you're growing as a person. Subjective well-being is how happy and satisfied you feel with your life when you think about your emotions and how you judge your overall happiness. Psychological well-being is a way of feeling good inside your mind, and this experience varies from person to person. Although everyone encounters periods of psychological and emotional difficulties, individuals who achieve a state of positive psychological wellbeing demonstrate the ability to adeptly handle their challenges. This condition impacts an individual's physical well-being (Häusser et al., 2010).

**Psychological wellbeing of women with prenatal anxiety.** Pregnancy is an important time for women, and how they feel emotionally during this period is a very important part of their overall health. The way a woman's body changes when she's pregnant can affect how she feels in her mind. If these changes aren't taken care of, they could cause problems for her mental health. Psychosocial well-being means feeling good in your body and mind. It's about having enough money, friends, and a sense of belonging. It also involves being happy, handling your emotions, respecting your culture, and feeling connected to something bigger than yourself. Feeling good and doing well in life means being able to handle the challenges that come up each day and making the most of your abilities to contribute positively to the community (Howard et al., 2020).



Feeling a bit scared and worried about what's going to happen when you're going to have a pregnancy is completely normal. Lots of people are feeling really stressed at this time, especially when they have to deal with a big change that they can't completely get ready for or control. Also, being pregnant can sometimes make you feel worried and tense. Besides dealing with the changes in your body and hormones, you might also feel worried about things like tests during pregnancy. You might feel more worried if something bad happened to you before, like having a miscarriage. (Hanna-Leena Melander, 2002).

Diener (2000) stated that psychological well-being means thinking about and feeling how good your life is when it comes to your thoughts and emotions. How often people feel good or bad emotions, which can make them feel happy or unhappy. On the other hand, psychological wellbeing is about how a person feels when they think about their entire life. Feeling good in your mind mostly comes from the real situations in your life. (Janse et al., 2004) propose that the psychological well-being of an individual is equivalent to their quality of life. Psychological well-being is a multifaceted notion encompassing subjective, social, and psychological elements, along with behaviours linked to health (Ryff, 2005). Feeling good inside our minds can mean different things. Some key parts of this are being strong when facing challenges, staying positive, being happy and playful, and managing ourselves well. People from all around the world share these important aspects (Sinha & Verma, 2001).

Psychological welfare means having a positive state of mind and good feelings (Ryff, 1995, Ryan & Deci, 2001). This means that mental well-being can be thought of as having positive emotions and feeling good overall. However, there is a discussion about what is considered good about how things work and what makes life enjoyable. Researchers have utilized various methods to investigate psychological well-being.

In 1950, various theoretical frameworks were employed to address the concept of positive mental health. They focus on different important things, such as how people personally feel about their own happiness, how culture affects mental health, and how well someone can handle tough situations and bounce back from stress (World Wellbeing Organization [WWO], 2004). In the area of young people's health before they become adults, the idea of health has grown. It used to only focus on looking at problems and bad feelings. But now, it also includes thinking about how young people grow well, do well, and work well (Bernat & Resnick, 2006, White, 2009).

**Six Domains of Psychological Well-being.** According to discourse theorists, the concepts of wellbeing and happiness are complex and interconnected constructs. The relationship between happiness and our mental functioning is a popular subject among experts. Some people strongly believe in a theory by Ryff that suggests there are six important factors to think about when it comes to having a healthy mind. This theory helps us understand how our minds can work at their best. She designed her work in a way that resembles an evaluation, so she can help people understand and use her Six more effectively. This helps readers figure out where they're doing better than others in different areas (Ryff, 1989).

**Self-acceptance.** This is about how much someone likes themselves, feels good about things they have done before, and the choices they have made. People who are good at accepting themselves tend to feel comfortable around others who have different sides to them, including both their flaws and strengths. Actually, individuals who struggle with not accepting themselves tend to be quite hard on themselves. They often feel confused about who they are and really wish they could be different in many aspects (Ryff, 1989).

**Relation with others.** In a positive relationship, a person feels connected, valued, respected, and genuinely loved. It helps people feel stronger when they share their personal stories and

close moments. This makes them feel safe in their relationships. However, people who don't have good relationships often feel like they aren't noticed, valued, loved, included, connected, friendly, or properly understood by others. So, they start feeling unsure about themselves and might even distance themselves from others (Ryff, 1989).

**Sense of Autonomy.** People who are really good at doing things on their own and feel sure of themselves might seem a little bit proud. They like to do things in their own unique way and aren't too concerned about what others think about them. On the other hand, individuals with low autonomy see themselves as reliant on others and are consistently anxious about others' opinions. They frequently seek advice from others and feel significant pressure to comply with the wishes of others (Ryff, 1989).

**Sense of mastery over the environment.** Individuals who possess high social mastery feel confident in their ability to deal with challenges and stress. They trust that they can effectively handle tough situations without feeling overly burdened. People who feel like they don't have much control over their surroundings might believe they're not strong enough to improve the things they don't like around them. They might also think they don't have the tools to stand up for themselves, and they often feel really stressed or overwhelmed by the situation (Ryff, 1989).

**Personal growth.** People who experience a lot of personal growth feel like they are moving in the right direction. They feel like they are becoming better at things, getting more mature, learning more about themselves, and getting good at new things they haven't done before. People who don't experience much personal growth tend to feel like nothing important is changing in their lives. They often get bored and don't feel like they're getting better over time (Ryff, 1989).

**Life Purpose.** When individuals feel that they have a purpose they believe their lives are important. They work hard to create positive changes and usually feel a connection to important

concepts or trends in society. So, they have a clear way of looking at their own life. People who live without a clear sense of purpose sometimes wonder if there's a bigger reason for their existence. They don't see life as having any meaningful or important significance beyond just completing various tasks (Ryff, 1989).

Pregnancy is a natural part of life, but it brings many changes to different perspectives of a woman's life. Pregnancy usually lasts around 266 days (which is about 38 weeks) from when the egg is released. This is roughly equal to 9 months. Pregnancy is a natural occurrence that brings joy to many women. When a woman realizes she's going to have a baby, she usually feels really happy and excited. However, some women might experience a mental challenge that shows up as feelings of worry, sadness, and stress, along with other emotional difficulties. Extensive research has been dedicated to examining psychological factors in pregnancy, along with various other aspects. This happens because when someone is going through emotional problems, it can make pregnancy, giving birth, and the growth of the baby harder. It can also make the mother feel not so good mentally (Erickson, 1976). One important thing that can affect pregnant women psychological wellbeing, which hasn't been talked about much in research, is the different times or phases of being pregnant. In this pregnancy phase, if the signs and symptoms aren't managed properly, expecting mothers might experience a lot of stress, leading to them feeling emotionally unwell and reduce psychological wellbeing.

Throughout pregnancy, women experience a range of physiological, emotional, and societal changes. Dealing with changes during pregnancy is important, but if someone doesn't handle them well, it can lead to problems. While pregnancy is a natural process, certain situations can make it risky for the mother or the baby. These situations turn a normal pregnancy into a high-risk one, causing women to go through more stress (Medeiros et al., 2016). Roughly 22% of expectant mothers experience high-risk pregnancies. Positive and

dedicated spousal relationships enhance the psychological wellbeing of a pregnant women, whereas unfavourable marital relationship diminishes it (Fellmeth et al., 2018)

Feeling stressed during pregnancy might not only make expectant mothers feel unhappy and decrease psychological wellbeing, but it could also be bad for the growing baby and how it's born. For example, there is evidence linking maternal depressive symptoms with reduced newborn birth weight and an increased likelihood of preterm delivery, which refers to giving birth before completing 37 weeks of gestation (Grote et al., 2010). When a woman is pregnant, she might feel very worried about her baby's feelings and health. She might also be scared about going to the doctor while pregnant, giving birth, and becoming a mother. This kind of anxiety is called pregnancy-related anxiety. This form of anxiety is closely associated with reduced gestational duration and has been identified as a contributing factor to the risk of preterm birth (Dole et al., 2003, Mancuso et al., 2004, Kramer et al., 2009). Fluctuations in emotions, both highs and lows, are a natural and typical experience during pregnancy. The majority of women experience positive psychological well-being during pregnancy, although some may encounter greater challenges in managing it. Caring for your mental health and psychological well-being during pregnancy holds the same level of significance as attending to your physical health. If pregnant women feel happy and calm, they can handle the things that pregnancy and taking care of a new baby bring more easily.

**Perceived Family Support.** Perceived family support during pregnancy means how a pregnant woman feels about the help she gets from her family members. This help can be emotional, practical, or social and is based on what she thinks and feels about it. Different people in your family, like your partner, parents, brothers, sisters, their spouses and other relatives, can all provide you with help and care (Celik & Ayna, 2014).

Perceived family support in psychology means feeling that your family is there to help you, both with your emotions and practical things. This includes getting help and comfort from

your family members when you need it. Perceived family support means that when someone in the family needs help, the rest of the family gives them a helping hand. Parents or kids can give different kinds of help. This help can be information, like telling you things you need to know. It can also be emotional, like making you feel better when you're sad. And it can be practical, like doing things to help you out. Family support means helping families that have a member with a disability. This could be a child, an adult, or even a parent in the family (Russo et al., 2016).

Every pregnant woman is not the same, but they all need a strong and caring family to help them during these nine months, both emotionally and physically. When women who are going to be moms soon go through significant body changes like morning sickness, strong feelings due to hormones, and even some memory changes, having their family there to support them during pregnancy can really make these experiences easier to handle. Incorporating family participation during pregnancy can have advantageous effects on expectant mothers, such as diminishing maternal stress, promoting favourable maternal behaviors (Alio et al., 2013), and maintaining emotional stability throughout this significant life juncture and the transition into parenthood (Mosunmola et al., 2014).

When mutual support exists between partners, it enhances their connection and fosters a stronger sense of collaboration. Particularly during this hectic period, a partner's backing holds significant value for both the mother and the baby. When a woman receives support from her partner throughout and following pregnancy, it can contribute to increased happiness and reduced stress levels (Morris & Blanton, 1995). Having a strong circle of friends and supportive family members can contribute to reduced stress and improved psychological well-being in women. On the other hand, experiencing strained family connections and lacking social support may be linked to the presence of depressive symptoms (Prezza & Giuseppina, 2002).

According to Adamson's research (2012), pregnant women who undergo stress have reduced likelihood of delivering a healthy baby. Moreover, if any unfortunate event occurs, this probability diminishes even further. Persistent stress can stem from various sources such as financial limitations, a lack of emotional attachment with a partner, the absence of a reliable social support network, significant health challenges, or overwhelming feelings of stress and depression. Depression, a medical condition characterized by prolonged and intense feelings of sadness, can disrupt the ability to maintain a regular daily routine.

Pregnancy-associated anxiety can be profoundly experienced by certain women due to the occurrence of early miscarriages or multiple miscarriages (Quenby et al., 2021). It is still have not figured out all the different reasons that can make pregnant women feel stressed. In basic words, in the field of biology, they explain it as being connected to hormones. When someone is pregnant, feeling stressed can release certain chemicals in the body that might lead to problems with the pregnancy and even make the immune system weaker because of being stressed for a long time. The body's defence system, called the immune system, protects us from getting sick. But sometimes, when a mother is pregnant, both she and the baby can be affected by stress. Infections can lead to babies being born too early or having problems during birth. Stress can also change how a pregnant woman deals with everyday situations (Geller, 2004).

A strong support network, encompassing the pregnant woman's spouse, family, extended relatives, friends and others plays a significant role in alleviating stress during pregnancy. The family arrangement can either be a nuclear system consisting of a husband, wife, and any children, or a joint system involving both spouses and their respective parents, when talking about the community of people from Asia and especially the society in Pakistan, most people like to live with their extended family. This is because they really value this way of living together, which is an important tradition for them. It's clear to notice the advantages

and disadvantages of living in both systems (Hayat, 2002). Feeling stressed during pregnancy is not good for the baby's health. Pregnant women can feel worried because there are countless things that might make them anxious. When someone is pregnant, they have the important job of taking care of a new life, even in a world that can be messy and full of surprises.

In recent times, even doctors who specialize in women's health during pregnancy (called gynaecologists) suggest that it's a good idea for family members to be part of the entire pregnancy journey. It's usually recommended for one or two people to come along with the pregnant woman when she goes to see her doctor for check-ups (Bushra Kafeel, 2011). It makes it easier for family members to stay in touch and also helps them support the mother when she needs it. Small actions that show your family cares and is close to you are extremely important during and after pregnancy, even if they're hard to put into words. The initial step involves selecting a family member for continuous allocation throughout the entire course, ensuring their availability whenever needed. This role can be fulfilled by the expectant mother, father, in-laws, parents, or even a close friend. This individual should be the one upon whom expectant women can depend and feel at ease. On the contrary, it's important to be dedicated and support her right from the beginning of her pregnancy, as soon as she finds out she's pregnant. Being present with pregnant women during significant occasions can bring about feelings of happiness and joy. For example, when the special machine the doctor has shown a picture of the baby inside the mommy's tummy, or when they listen and hear the baby's heart beating for the very first time. The special things that happen before a baby is born become even more precious when we share them with the people who are important to us. Just because you're physically present doesn't mean the task is finished. Involving family members in aspects like understanding pregnancy and exploring potential means of providing support to an expectant mother can lead to a significant positive impact on women (Stapleton., 2012).



Women who receive consistent one-on-one support from their husbands are more inclined to give birth without pain medication and are less prone to characterize their birth experience in a negative or distressing manner (Haobijam et al., 2010). While a direct correlation between continuous support and reduced labour pain might not exist, the presence of a support person does contribute to a sense of relaxation and reduced fear in mothers. This presence can be seen as a mediator in the relationship between stress and pain during labour. In a study involving Asian women, it was found that when women were supported by their partners and had a midwife helping them during childbirth, they needed less pain-relieving medicine like epidurals and anaesthesia. They also had fewer cuts called episiotomies, and they felt more in control during the labour process (Sakala, 1988). Compared to emotional, social, and financial support, the greatest demand for assistance generally lies in obtaining informational support during pregnancy. The way that families help and support pregnant women is closely linked to how healthy both the mothers and their babies are. This connection shows a very strong positive relationship (Orr, 2004).

Pregnant women who experienced elevated stress levels before conception and lacked sufficient support exhibited the highest incidence of infant complications, pregnancy-related issues and emotional imbalances (Pagel et al., 1990). The level of life satisfaction varies among individuals based on the amount of support they receive from multiple sources. The main emphasis from healthcare professionals, friends and family of expectant parents when it comes to pregnancy experiences tends to revolve around the physical changes in the woman's health status. The way a pregnant woman feels and thinks can change a lot when they're going to have a baby and when the baby is born. This can make parents have big feelings, but sometimes people don't pay much attention to these feelings. In this situation, the husband acts like a referee for the environment, which can affect how a woman feels during her pregnancy and what happens with the pregnancy. (Kurdek & Schmitt, 2001).

Having your family's help and care is really important for being happy. Pregnancy is a beautiful and complicated journey. During this period, the pregnant mother greatly benefits from the support of her partner and family. When those around her are understanding and work together harmoniously, it can lead to a sense of mental tranquility for her. Not a lot of individuals realize how valuable it is to have your family's help when you're pregnant. Research indicates that during pregnancy, the presence of perceived family support can have positive impacts on pregnancy and birth outcomes (Koszycki et al., 2009), the attainment of appropriate infant birth size (Appleton et al., 2019), the promotion of breastfeeding (Oliveira & Leal, 2017), and the regulation of infant adiposity (Katzow et al., 2019). When young people become pregnant, the support they feel from their families becomes really important. This is because teenagers who are pregnant have a bigger chance of not gaining enough weight during pregnancy, which can lead to the baby being born too small. So, along with the usual needs that teenagers have, pregnant teenagers need extra help and care from their families (Branje, 2018). Evidently, the positive influence of perceived family assistance during adolescent pregnancy is well-documented, particularly when this support originates from a female family member like the mother or an older sister (Wieler et al., 2018). However, it's worth noting that additional family members also play a role in providing support to the adolescent in such situations, as highlighted by (Lamarca et al., 2013).

**Perceived family support and psychological wellbeing.** The level of family support that is perceived can greatly influence a woman's ability to cope effectively during pregnancy. Pregnancy is a time when a lot of things change (i.e., physical, emotional, and psychological) in a woman's body and how they feel inside. It's important for pregnant women to have people around who can help them and make them feel better when things get tough. The level of family support that a woman perceives during pregnancy can greatly impact her psychological well-

being. Pregnant people who receive lots of care from their families usually have better feelings in their minds compared to those who feel alone or left out (Yuksel & Bayrakci, 2019).

Receiving support and nurturing from family members can boost the self-esteem and confidence of expectant mothers. This form of positive reinforcement can play a role in enhancing a more favorable self-perception and an increased sense of self-value while experiencing pregnancy. Pregnant women who feel a significant level of family support are more adept at managing the various difficulties and requirements that come with pregnancy.

**The family systems theory.** The main idea of Family Systems Theory is to understand how family members communicate with each other and how the family collaborates with other groups. A system is like a group of things that work together and affect each other. A family is like a team where everyone depends on each other. If something big happens to one person, like getting very sick, it can affect the whole family (Leahey et al., 2007). In Family Systems Theory, one big idea is that a family is like a team where being together is more important than just adding up each person. A family is like a puzzle piece in a bigger puzzle, and it's made up of smaller pieces inside it (Leahey et al., 2007). You can't completely understand a family by looking at just one person or part of the family. You also need to consider how they all relate to each other and how they fit into the bigger groups they're a part of. In palliative care, think of different groups like communities, the healthcare system, and the team that takes care of patients at home. These are like big systems that surround and include the family. Understanding how these different parts are connected is important. It helps us grasp the needs of the entire family.

Another key idea in Family Systems Theory is that families can find a way to balance between making changes and staying stable. Families who are taking care of a loved one in palliative care sometimes have to deal with not being sure about how to make the patient feel

better and how long the patient will live. This could potentially lead to them experiencing ongoing anxiety and a sense of instability, frequently encountering difficulties in achieving the desired state of balance (Mehta et al., 2009). So, we have strong proof that it's really important for people in palliative care to feel supported by their family members and those closest to them. This also shows that looking at the whole family system, like using Family System Theory, can make palliative care even better. Nevertheless, limited research exists that is grounded in theory and examines the elements associated with the perception of supportive care among family members within the context of palliative home care. Before, most of the studies looked at how family and friends take care of patients at home. Now, we're looking at how they take care of patients in the hospital when the patients are receiving end-of-life care (Carolan et al., 2015). As the global trend shifts from providing palliative care mainly within hospital settings to offering more home-based palliative care to accommodate the preferences of patients and their families, it becomes crucial to enhance our understanding of effectively assisting families in this new context.

**Resilience.** The term resilience originates from the Latin term *resiliens*, denoting the flexible or elastic quality of a substance (Greene & Conrad, 2002). Masten (2005) explains that resilience means achieving good results even when facing tough situations that could hinder personal growth and adjustment. The word resilience, created by James in 2002, means the ability to bounce back and recover after tough times, like when things go wrong or when you feel upset or unlucky. Resilience means being able to handle tough situations in a positive way. It's like being able to adjust and bounce back when things are difficult.

Tugade and Fredrickson (2004) asserted that the presence of positive emotions triggers the development of resilience. People who can bounce back from tough situations use a positive attitude to help them control their feelings in a smart way. Resilience is when certain individuals are skilled at dealing with hard times and can recover from them. They might even

discover positive or meaningful things during these difficult situations (Ong et al., 2010, Skodol, 2010, Tugade & Fredrickson, 2004).

People who study resilience generally agree that being able to bounce back from tough situations depends on how each person reacts when faced with challenges or risks. Some people give in when things get tough, but others keep trying hard to survive even when their lives are in danger (Rutter, 1987). Martin (2002) suggests that resilience plays a role in shaping scholastic achievement. So, being resilient is seen as a good thing. It's like a quality or tool that can help a person do well, achieve things, stay healthy and feel good.

**Resilience theory.** Resilience theory is a topic that many researchers like social workers, psychologists, sociologists, and educators have been studying for a while. It's all about how people can bounce back from tough situations and how different aspects of life play a role in this. The concept of resilience has been widely acknowledged and applied across various disciplines. In psychology, being resilient means having the ability to bounce back and overcome tough situations by building yourself up again (Higgins, 1994). Resilience means being able to handle and manage tough situations or stress without getting too overwhelmed. It's like having a strong inner strength that helps you bounce back when things are difficult (Werner & Smith, 2001). It means being strong and steady while things are changing, without too much confusion. It's like staying calm and steady when things are being changed (Conner, 1993).

Resilience theory looks at how some people and things can show strength and bounce back from tough situations. The rise of resilience theory is linked to a shift from focusing mainly on problems and weaknesses to focusing more on strengths and abilities (Rak & Patt 1996). Resilience is like a superpower that grows in people as they keep overcoming tough situations and facing problems. It's a set of abilities, knowledge, and strength that builds up

over time, which they can use to help them deal with the difficulties they're going through right now (Garmezy & Masten, 1994).

Resilience is primarily defined by the existence of safeguarding elements (individual, social, familial, and institutional support systems) that empower individuals to endure the challenges of life's stress. When people face tough and unsafe situations in life, their personal strengths can help them stay strong. But how well they can handle these situations depends on the balance between their inner strengths and the difficult things happening around them (Kaplan et al., 1996).

Polk (1997) developed a framework comprising four distinct patterns of resilience. The dispositional pattern means certain personality traits and attitudes that are connected to our body and how we see ourselves. These things help us to be strong and bounce back from tough situations. These are the qualities in a person that help them stay strong when dealing with tough situations in life. These qualities might include feeling capable on your own, feeling good about who you are, being in good health, and looking after yourself. The relational pattern pertains to an individual's societal positions and their interactions with others. These positions and connections may range from those within the broader social framework to those found within close and intimate relationships. The situational pattern talks about how a person is connected to a difficult situation and what happens in that situation. This could mean how good someone is at solving problems, understanding situations and how people react, and being able to do something about it when things happen. The philosophical pattern is about how a person sees the world and how they choose to live their life. This could involve various thoughts that help people stay strong in tough times, like thinking that everything we go through teaches us something important, understanding that personal growth is important, and feeling that life has a purpose (Breda, 2001).

For an individual to experience resilience, two fundamental conditions must be satisfied. The first thing is when something risky is happening to a person, and the second thing is when the person deals with the bad outcomes of that risk and manages to turn them into positive results (Kaygisiz & Zeliha, 2019). In the perspective of Tugade and Fredrickson (2007), resilience entails the capacity to adeptly manage and adjust to challenging circumstances (Sabouripur & Roslan, 2015). Resilience is regarded as a collection of psychological strengths that have the potential to amplify an individual's sense of subjective well-being. This concept of resilience has proven to be a valuable asset in addressing various mental health issues stemming from trauma or challenging life circumstances (Zubair, 2018). Abiola and Udofia (2011) proposed a connection between the ability to withstand challenges and enhanced quality of life, increased well-being, and better functional capacity. Resilience means having an inner strength that shows you're grown-up, able to stay positive, and can handle tough situations well. It's like having a shield against things that could go wrong, and also having tools like staying hopeful, having good friends, and knowing how to deal with problems. All of this helps you get better at handling the good and bad times that come your way in life (Abiola & Lidoria, 2011).

**Models of resilience.** Various researchers have described the same process of how people adapt to stress and maintain their well-being using different names for the three resilience models. These models include the Compensatory Model, Challenge Model, and the Defensive Aspect of Immunity versus Susceptibility Model. Despite the varying names, all of these models essentially explain how individuals respond to stress and work towards adapting positively to maintain their overall quality of life (Leary, 1998).

**Compensatory Model.** This is like when you balance things out. Imagine you have a scale. When stress puts pressure on one side (making things harder), you add weight to the

other side to even things out (making it easier). It's about finding ways to counter the effects of stress and keep things stable.

**Challenge Model.** Think of this as facing challenges head-on. When stress comes your way, you treat it like a challenge or a game. Instead of getting overwhelmed, you see it as an opportunity to grow and improve. It's like turning stress into something positive by using it to push yourself forward.

**Defensive Aspect of Immunity versus Susceptibility Model.** This is like your body's immune system. When you're exposed to something harmful, your body works to defend itself. In this model, when stress tries to affect your well-being, your "resilience immune system" kicks in. It helps you resist the negative effects of stress and stay strong. So, these models might have different names, but they're all talking about how people deal with stress and tough times.

In the compensatory model, resilience is seen as a factor that helps alleviate the impact of threat exposure. Forecasts can be changed by both possible problems and things that help fix those problems. Werner and Smith's (2001) study identified four fundamental characteristics exhibited by resilient young adults. These include a proficient approach to solving problems, a tendency to reframe challenging situations in a more positive light, an openness to accepting constructive support from others, and a strong reliance on faith to maintain a positive perspective on the world. Kumpfer and Hopkins (1993) identified a range of compensatory factors, including optimism, empathy, intuition, analytical maturity, self-worth, sense of purpose or direction, as well as commitment and determination. The challenge model suggests that when something not too dangerous happens, it might actually help a person learn to handle it better. Because of this, going through the experience helps the person get ready for the next difficult thing they have to do. In the protective factor model of resilience, a relationship exists between protective factors and risk factors. This relationship serves to lower



the likelihood of unfavourable outcomes and also functions to temper the impact of exposure to risks (Leary, 1998). This resilience approach centers on systems theory and developmental science principles. This suggests that even in the face of challenging or negative life circumstances, these beneficial factors contribute to the development of positive results and constructive personality traits (Bonanno & Ungar, 2004). Protective factors that were identified include skills in emotional cognition and interpersonal reflection, educational and vocational proficiencies, aptitude for enhancing self-esteem, strategic and practical problem-solving competencies (Lingar, 2004).

Studying how women stay strong during pregnancy in Pakistan can help us learn how to support their mental health during this time. An individual's resilience, characterized by their capacity to manage challenging circumstances, plays a role in diminishing the likelihood of mental health disorders (Yusriani & Alwi, 2018). This includes its potential to mitigate the risk of depression among expectant mothers. It's fascinating that during pregnancy, a person's ability to handle challenges becomes really important. This matters a lot when we think about how pregnancy affects not just the person, but also their role in the family and society. The way things are when someone is pregnant can either help them handle things better or make them feel more worried. When friends and family give support, it can make a big difference. The atmosphere at home and with family during pregnancy can be like a safety net. Similarly, if there is a lack of supportive environment, the pregnant woman could experience increased vulnerability. As per the resilience governance framework, resilience denotes the ability to adjust, assimilate, and undergo transformation when faced with a challenging circumstance (Saulnier et al., 2020). Put differently, individuals who possess resilience have the capacity to effectively handle stress and alleviate depressive symptoms (Tobe et al., 2020). This heightened resilience fosters a sense of positivity, empowering them to engage in uninhibited, creative thinking, and proficiently tackle challenges. As a result, they can adeptly navigate

taxing circumstances and the journey of pregnancy while maintaining their well-being (Gloria & Steinhardt., 2016).

## Literature review

**Prenatal anxiety.** Pregnancy is a time when vulnerability to heightened anxiety and depression can significantly increase (Conroy et al., 2016). The origins of pregnancy-related anxiety can be traced back as early as the 1950s. In 1956, researchers Pleshette, Asell, and Chase conducted a study aimed to clarifying the typical triggers of anxiety during pregnancy and the postpartum period. They surveyed fifty pregnant women to inquire about their experiences with a variety of twenty-four anxieties related to themselves and their unborn babies. They posed questions regarding concerns such as the fear of the baby's death before birth, worries about the baby causing serious health issues, and anxieties about potential complications during labor, including fear of tearing or needing a caesarean section, labour pain, the baby's well-being, and foetal abnormalities.

Several studies have revealed fluctuating rates of anxiety during different stages of pregnancy, with a higher prevalence during the first three months and the last trimester. This specific pregnancy-related anxiety encompasses concerns, fears, and worries regarding pregnancy itself, the childbirth process, the health of the newborn, and apprehensions about future parenting responsibilities (Visser et al., 2004). The highest levels of pregnancy anxiety were reported during the third trimester. Throughout pregnancy, elevated levels of PSA were observed during both the initial trimester and the final trimester, while anxiety levels decreased during the second trimester, forming a U-shaped pattern (Lee et al., 2007 & Teixeira et al., 2009). During the third trimester, most pregnant women experienced varying degrees of anxiety, ranging from moderate to severe levels.

Hamid, Asif, and Haider (2008) conducted a study with the objective of investigating how often pregnant women encounter symptoms of anxiety. Their findings revealed that pregnant women experience higher levels of anxiety when compared to their non-pregnant counterparts. Furthermore, the study highlighted that a significant portion of these pregnant

women were not being adequately monitored during this period. They determined that more efforts are needed in the diagnosis, referral and treatment of anxiety in pregnant women.

A study was conducted on expectant first-time mothers experiencing marital discord, who were referred to healthcare facilities for the evaluation of pregnancy-related anxiety. Recommendations for parental care programs include screening pregnant mothers based on their levels of relationship satisfaction, with a focus on understanding the potential predictive influence of relationship satisfaction on pregnancy-related anxiety. This underscores the significance of the spouse's role as a primary concern for healthcare providers, particularly midwives, during the pregnancy period (Salehi & Shahhosseini, 2017).

New studies have shown that it's really important for women to feel mentally well during the early part of pregnancy, from when they first become pregnant until they give birth. This is because being pregnant can be quite stressful. Studies have shown that when a pregnant woman goes through really tough and stressful situations, it can increase the chances of her baby being born too small or too early. The dangers that might be connected to experiencing a stressful event in the first three months of pregnancy. They pointed out that chemical reactions can happen when someone is pregnant and stressed, comparing them to travellers going on the same trip. The chemicals released during a mother's stress response can potentially impact the brain development of the fetus. These effects appear to be most pronounced during the initial stages of pregnancy, particularly in the first trimester, when there is a relatively weaker protective barrier separating the mother from the developing fetus (Kenny et al., 2008).

A study was done with 14,000 women to understand how their moods change during and after pregnancy. They looked at how stressed these women felt and compared the scores for their symptoms. They also checked how many mothers had a high score that could mean they were likely to have depression at different times during and after pregnancy (Evans et al., 2001).

According to research published in the *Journal of Applied Psychology*, pregnant women experiencing anxiety may give birth earlier than anticipated, as suggested by the study's findings (Bauer et al., 2022). Scientists studied 1,000 pregnant women at various points during their pregnancies. They checked how worried these women were about their pregnancy and how anxious they felt in general. They discovered that women who were really worried during the early and late stages of pregnancy were more likely to give birth to their babies before the expected due date (Thompson, 2022). The research says that when women are pregnant, doctors should check if they are feeling very worried or anxious. If they are, doctors should do things to help them feel better and manage their worries (ScienceDaily, 2022).

A research study conducted by (Fairbrother et al., 2016) looked at how common and connected to other things anxiety during pregnancy is in a big group of pregnant women in Canada. They discovered that about 15.6% of the women in their study had anxiety problems during pregnancy. They also found that this anxiety was more likely in women with lower income, less education, a history of being hurt, not having many friends or family to help, and having struggled with mental health before. The study also showed that when women experienced anxiety during pregnancy, it could lead to bad outcomes for both the mom and the baby. These outcomes included having the baby too early, the baby being smaller than usual when born, and the mom getting depressed after giving birth.

In 2015, a study conducted by Glover examined the influence of maternal stress during pregnancy on foetal growth and subsequent outcomes for the newborn (Glover, 2015). Glover thought that when a pregnant mom is stressed, it can change the baby's environment inside her tummy. This happens because of things like hormones, the mom's immune system, and the stuff that's in the mom's tummy that helps the baby grow. These changes can then affect how the baby's brain grows and how its genes work. The study also said that if a mom is stressed

during pregnancy, it can make her act differently with her baby after it's born, and that can also affect how the baby grows and behaves.

In a 2011 review, it was revealed that a minimum of 13 studies had investigated anxiety during pregnancy. These studies showed that when you combine measures of pregnancy anxiety with a state anxiety scale, you can predict when a baby is likely to be born preterm birth (Dunkel-Schetter, 2011). The author of the review said that this evidence strongly suggests that pregnancy anxiety is a unique type of anxiety that can help us predict when a baby will be born early, and the effects are quite big even bigger than the effects of well-known risk factors like smoking and medical problems during pregnancy.

Studies conducted by Brunton, Dryer, Saliba, and Kolhoff (2015) revealed 60 relevant studies after the application of specific criteria. This review discovered that high pregnancy-related anxiety (PrA) can lead to negative outcomes for the child, such as premature birth, and increase the risk of postpartum depression in mothers. However, the quality of the various tools used to measure PrA is uncertain. The authors concluded that there are currently no good scales available to measure pregnancy-related anxiety, and they suggest that future research should focus on creating a reliable and valid scale specifically for this purpose.

**Prevalence of prenatal anxiety.** PRA poses a significant challenge for many expectant mothers throughout their pregnancies. In developing nations, the occurrence of PRA ranged from 23.6% to 55%, as reported by (Alqahtani et al., in 2018). International studies estimated the prevalence of PRA in developing countries to be between 6% and 29%. Prior to 2016, the prevalence of PRA in China was approximately 21-30% during the era of the one-child policy. Subsequently, under the two-child policy before May 2021, it ranged from 29-32% (Wang et al., 2021). In Chongqing municipality, about 15% of pregnant women experienced anxiety during the early stages of pregnancy (Tang et al., 2019). Certainly! China switched from letting families have a maximum of two kids to allowing them to have up to three kids on May 31,

2021 (Tatum, 2021). Over time, Chinese culture has traditionally shown a strong inclination towards favouring sons over daughters within families. The three-child policy allows couples with a strong preference for sons to keep having more children until they achieve the desired number of boys in the family. This could potentially heighten the risk of anxiety during pregnancy. Absolutely, there's a shortage of research on prenatal anxiety that how the three-child policy in China is impacting pregnant women, particularly in areas like Chongqing municipality (Lung et al., 2021).

Certainly, Researchers studied factors affecting PRA in pregnant women. They discovered that age, education, number of pregnancies, gestational stage, financial situation, and relationship status with their partner can impact it (Yeşilçınar et al., 2023; Rosario et al., 2017). Moreover, it's been determined that the perceived social support and functioning of the family play crucial roles as protective factors for PRA (Naja et al., 2020). According to the psychological stress theory, social support serves as a crucial buffer mechanism during challenging situations, helping individuals cope with stress and fostering both their physical and mental well-being (Ozbay, et al., 2007). Family function means how well a family works together to handle things that might stress them out from outside, like situations or events. This teamwork is really important for personal growth and making society better (Cao et al., 2013). In places influenced by Asian and Confucian cultures, pregnant women really need their families. Family support is super important during this special time (Chang et al., 2017). In a cross-sectional study conducted in China, it was observed that pregnant women with inadequate family functioning faced a 3.67-fold higher risk of experiencing symptoms of depression compared to those in the group with better family functioning (Zheng et al., 2020).

Apart from how much friends and family help and how well the family works together, many studies show that being resilient can really help reduce anxiety during pregnancy (Naja et al., 2020). Resilience is the ability to endure, bounce back, or recover from trauma, threats,

adversity, and other substantial sources of stress. (Richardson, 2002). People who are really good at bouncing back from tough times tend to handle stress well and adjust their minds better (Norris et al., 2008). Other research has shown that nurses who are better at bouncing back from tough situations are more prepared to handle challenges and difficult experiences, and they're less likely to feel overwhelmed or burned out (Jamebozorgi et al., 2022). Additionally, resilience played a role in connecting challenging situations with our mental health status (Howell et al., 2020). The anxiety during pregnancy is compounded by the interplay of three factors, creating a complex and interconnected web of influences. The internal connections among family functioning, perceived social support, resilience, and prenatal risk assessment (PRA) in pregnant women remain largely unexplored. Reports have highlighted that factor like social support, family backing, and other forms of assistance are recognized as integral elements of resilience resources that can positively contribute to it (Martínez-Martí et al., 2017). Resilience was identified as a mediating factor in the relationship between perceived family support and mental quality of life in a study focusing on migrant older adults. (Kong et al., 2021). We suspect that the resilience of pregnant women might play a role in moderating the connection between family functioning, perceived family support, and PRA.

Earlier research has similarly identified that a combination of low household income, unemployment, and limited educational attainment constitutes elevated risk factors for anxiety in both mothers and fathers (Cena et al., 2020; Philpott et al., 2019).

Additionally, like maternal perinatal anxiety, a significant portion of research on paternal perinatal anxiety originates from countries other than the United States. In a systematic review of paternal perinatal anxiety, only 16% of the studies analysed were based on samples from the US (Leach et al., 2016). The reported prevalence rates for paternal PPA vary widely, ranging from 2% to 51%. However, it seems that paternal PPA remains relatively consistent



during the transition to parenthood and may even show a slight decrease postpartum (Leach et al., 2016; Philpott et al., 2019).

**Psychological wellbeing.** Psychological well-being consists of an overall sense of positivity and emotional connections. When you're generally feeling good, it means you're happy, carefree, and relaxed. Emotional connections happen when you feel loved and valued, and you don't feel lonely (Veit & Ware, 1983). Ryff and Keyes (1995) claim that the exploration of psychological well-being has been shaped by two main ideas regarding positive functioning. The initial distinction between positive and negative affective states originated from Bradburn's work in 1969.

According to Bradburn (1969), achieving happiness involves finding a balance between the two emotional domains. The second fundamental idea highlights life satisfaction as the primary measure of well-being. However, Ryff (1989) proposes a multidimensional psychological well-being model that focuses on promoting wellness rather than addressing illness. She argued that a person's psychological well-being is composed of six dimensions, including personal growth, purpose in life, self-acceptance, environmental mastery, autonomy, and positive relations with others. A person demonstrating strength in all dimensions would indicate positive psychological well-being, while the opposite holds true.

Upon receiving a high-risk pregnancy diagnosis, expectant individuals may find it challenging to confront and adapt to this new reality, giving rise to psychological and emotional consequences (Öhman et al., 2004). The literature indicates that women undergoing or having undergone high-risk pregnancies often grapple with a range of emotional challenges, encompassing feelings such as fear, guilt, shock, grief, frustration, worry, loneliness and isolation (Naar & Teroni 2017). According to Currie and Barber (2016), the presence of a health threat during pregnancy increases the likelihood of women facing psychological distress. In the study by (Simmons & Goldberg 2011), it was found that the term 'high-risk' pregnancy

is linked to elevated levels of psychological distress. Certain women might encounter the emergence or recurrence of significant psychological disorders (Roomaney et al., 2014). Pregnant individuals facing psychological disorders may encounter outcomes such as low birth weight and preterm delivery. Additionally, those with bipolar disorder may undergo the onset of mood instability (Campillo et al., 2017). When women receive a diagnosis of major depressive disorder with postpartum onset, they may experience intrusive thoughts about harming their child and may also grapple with suicidal ideation (Currie & Barber 2016). Pregnancies vary, and not all of them unfold as uncomplicated, straightforward events.

Past studies have shown that psychosocial factors play a role in shaping the psychological well-being of expectant mothers, impacting health disparities in birth outcomes, such as an elevated likelihood of pre-term birth (Giurgescu & Misra, 2018). Nutor and colleagues (2019) discovered that expectant mothers who expressed signs of depression were 70% more prone to experiencing pre-term birth compared to those without such symptoms. Additionally, the study highlighted that both prospective mothers and fathers encounter depressive symptoms during pregnancy (Caldwell et al., 2018). Additionally, pregnant women experiencing a lack of social support are at a higher risk of giving birth to infants with low weight compared to those who report robust social support during pregnancy (Feldman et al., 2000).

Several studies have indicated a positive correlation between the active participation of fathers during pregnancy and enhanced psychological well-being. In a Boston-based study focused mainly on expectant white mothers, it was observed that lower levels of father involvement correlated with elevated pregnancy-related anxiety and prenatal depression during the middle stages of pregnancy (Cheng et al., 2016). In research involving 95 pregnant Black women, those who indicated father involvement exhibited lower levels of depressive symptoms

and higher levels of psychological well-being in comparison to women who reported no father involvement (Giurgescu & Templin, 2015).

Past studies on high-risk pregnancies predominantly concentrated on the medical facets, with inadequate recognition of the emotional and psychological dimensions of the experience. Across Europe, Africa, and North America, numerous insightful studies have explored the medical, emotional, and psychological aspects of women who have faced high-risk pregnancies (Simmons & Goldberg 2011). These investigations indicate a clinical correlation between the medical facets and the emotional and psychological hurdles faced by women during a high-risk pregnancy. Further research should delve into these aspects concurrently.

**Family support.** Studies indicate that the perceived family support from one's family plays a crucial role in predicting psychological well-being. Psychological wellbeing is found to have a positive correlation with the perceived support from one's family. Various research findings suggest that an enduring sense of family support contributes positively to one's psychological well-being over time (Huffman, 2015).

Having the backing of parents and siblings has been linked to decreased stress levels during pregnancy. The research hints that when people get unwavering support, especially during pregnancy, it's linked to surprisingly good outcomes for the pregnancy (Winston & Oths, 2000; Kalufomos & Palinkas, 1999; Balarar et al., 1996; Scribner & Dwyer, 1989). Family support refers to the positive or helpful emotional, informational, or material assistance provided by others and perceived as beneficial by the recipient (Clark 2001; Wills & Fegan, 2001).

The former studies were supported by an examination of the work by (Rianne Kok et al., 2012). Their findings suggested that maternal stress has the potential to influence both parenting behaviors and child development. They conducted a cohort study on a big population.

They investigated how maternal discipline acted as a mediator in the link between maternal stress during pregnancy and child compliance. As part of their study, researchers also asked expected mothers to share information about stress in their families and in general. Maternal positive discipline was identified as a mediating factor in the relationship between stress within the family during pregnancy and a child's committed compliance.

The majority of research on current phenomena was conducted in the Western world, with comparatively limited research being carried out in Asia. There's been extensive research on stress during pregnancy among Asian populations, delving into its various determinants within the context of values, culture, and society. This heightened focus on stress reflects a growing concern among medical practitioners. Stress during pregnancy can have detrimental effects on both the baby and the parents, potentially leading to neglect of the child or the breakdown of the family through self-destructive behaviours. Most commonly shared worries revolve around challenges in emotions and behaviours, as well as issues related to cognitive functioning (Shaikh et al., 2011).

Typically, there is a positive association between the perceived support from family and the well-being of pregnant women (Fernandes & Newby, 2010). Perceived Family support within Mexican culture has been suggested as a key element that protects maternal and child health. Exploring the extent of support a pregnant woman receives from her family and spouse, and understanding how this support may impact her health-promoting behaviours during pregnancy is a compelling phenomenon. Additionally, examining the conditions under which a woman might experience a withdrawal of support adds depth to this investigation. The researchers concentrated on the aspect of perceived family support, both in terms of practical assistance (such as aiding with household tasks, providing gifts for the baby and mother, cooking, offering financial support, and transportation) and emotional support (including companionship and advice). Mothers and mothers-in-law were the initial sources of guidance

for expectant mothers, sharing insights into the various stages of pregnancy and beyond. They also extended their support by assisting with meal preparation, laundry, and household tasks. A few respondents also shared that their mother or mother-in-law intended to stay with them for a few weeks following the arrival of the new family member.

Interestingly, a majority of women noted that their family members exhibited a noticeable change after their pregnancies. They were more attentive, nurturing, and supportive compared to their behaviour before the pregnancies. Nevertheless, they also noted that their families, particularly their mothers, were readily available to provide assistance. Over fifty percent mentioned that they regularly received advice from their mothers or mothers-in-law on caring for newborns (Slade et al., 2009).

Support came in various forms throughout the pregnancy, including assistance with meal preparation, household chores, financial support, gifts, companionship, and guidance at every stage. Their positive attitudes and behaviours were closely tied to the favourable reception of the pregnancy by their families. In most instances, this reception was rooted in well-established and harmonious relationships between the expectant mother, her family of origin, and her male partner, contributing to a supportive environment. Sherraden & Barrera (1997) observed this consistent that robust familial support tends to endure in the connections between women and their spouses.

Several compelling pieces of evidence indicate that emotional distress in pregnant women raises the likelihood of unfavourable outcomes for both the women and their newborns. Examining and addressing mood and anxiety issues during pregnancy involves exploring life stressors and evaluating interpersonal relationships with one's spouse, friends, and other family members. When discussing stress, their attention was directed towards issues such as conflicts within marriage, significant life events, and the support provided by family. Certainly! Women without family support demonstrated more pronounced connections between stress and

symptoms such as depression and anxiety compared to those benefiting from strong family support. Family support appears to play a moderating role in this context. In line with previous research, findings indicate that conducting psychosocial assessments for expectant mothers and their partners can help in designing interventions to monitor support systems, ultimately mitigating the likelihood of emotional distress (Baluku et al., 2020).

Demonstrating the favourable influence of social connections on expectant mothers and their unborn children, another researcher, Mechanic (1980), highlighted in his study that adopting a family-centered approach promotes active involvement of the family. Initially perceived as a reproductive or biological unit focused on childbearing, the family evolved into a fundamental source of individual support across diverse cultures. As individuals share their challenges and difficulties, a deeper connection forms, naturally inspiring a willingness to lend a helping hand to those facing adversity.

Brown (2010) found that support manifests in diverse forms and through various channels, as indicated by their research. Expectant mothers who have a robust family support system tend to exhibit a positive correlation with their attachment to the fetus, which is quite intriguing. Once more, it shows that having someone there to support women during labour is really helpful.

Providing substantial support to mothers during labour significantly contributes to shorter labour durations, decreased reliance on pain-relieving medications and an increased likelihood of successful normal deliveries (Cranley, 1982). He observed that individuals who receive support from multiple sources tend to have varying levels of satisfaction compared to those who receive support from just one source. Research consistently indicates that perceiving strong family support during childbirth tends to lower the risks of maternal and infant health issues while decreasing the likelihood of encountering complications during the delivery process.

The most significant influence on women facing an unplanned first pregnancy seems to stem from the absence of emotional support and acceptance within their families, especially from the expectant mother's own mother (Turner et al., 1990). It's probable that individuals acquire knowledge or behaviours from their mothers or the information they receive from them.

Pregnancy is commonly recognized as a highly anticipated and joyous life event embraced by a woman and her loved ones. While a woman is pregnant, having good relationships with her family can be really helpful. It can make her feel supported and less stressed. People say that when a pregnant woman gets a lot of help from her family, it can make her pregnancy healthier (Cutrona et al., 1992).

Individuals with a collectivist orientation in life tend to exude warmth, engage in emotionally positive social interactions, and attach significant importance to close family relationships, as observed by cultural psychologists (Sanchez-Burks et al., 2000; Triandis et al., 1984).

As early as the 17th week after conception, stress encountered by a pregnant woman could have adverse effects on the fetus, potentially impacting its brain development and overall growth (Mother's stress harms fetus, 2007). The research, detailed in the *Clinical Endocrinology* journal, conducted experiments on animals. It revealed that elevated stress levels in a pregnant mother could impact the brain function and behaviour of her offspring. This evidence indicates a correlation between maternal stress in humans and its potential influence on a child's cognitive development, possibly leading to a decrease in intelligence. The process and consequences of this occurrence for the baby, both preceding and following birth, remain unaddressed. Their research highlighted the significance of maternal support for pregnant women as a means of providing provisions and encouragement to help them cope with stress.

Pregnant women who receive support from their families show enhanced child care, better health outcomes, and an overall improvement in their quality of life, according to research. Numerous studies across diverse populations consistently indicate that the perception of family support exerts a beneficial influence on the psychological well-being of expectant mothers and the health of their newborns (Suzan, 2003).

Bini (2001) conducted a comparable study on an Asian sample, emphasizing the impact of spousal care on postnatal mothers' pregnancy outcomes. The findings indicated that a majority of husbands provided positive support in terms of emotions, social aspects, finances, and information throughout the pregnancy. The results of the research on the relationship between perceived family support and pregnancy behaviour in two Mexican border cities challenge the notion that support during pregnancy is a universally ingrained and unconditional cultural norm within specific cultural groups. Moreover, in line with findings from other research, instances of family support typically originated well in advance of the ongoing pregnancy (Sherraden & Barrera, 1997). Family support seems to be linked to the conditions surrounding a pregnancy. Pregnant women lacking family support, whether due to various reasons, often view their pregnancy as a challenge due to emotional and financial instability.

Certainly, a significant challenge for pregnant women is undoubtedly the presence of their spouse (Mullings et al., 2001). Hoffman and Hatch (1996) found that the support from a partner has a significant impact on alleviating maternal psychosocial stress, whether it's related to financial concerns or general challenges. The role of a spouse is crucial in this regard.

Qualitative research has highlighted a link between women's psychological well-being and the support they receive from their families. It has also pinpointed specific challenges in family support that need addressing. However, there is a dearth of quantitative studies on this topic, and our understanding of the current state of family support remains limited.



**Resilience.** Resilience means being able to handle tough situations in life. It's like having inner strength, being good at dealing with problems, and being flexible when things don't go as planned. It could exhibit an inverse correlation with depression, stress perception, and anxiety (Wagnild & Collins 2009). In the assessment of elderly adults, it has been demonstrated that this trait is dynamic in nature, according to research findings. Certain authors propose that resilience tends to grow throughout adulthood, potentially influenced by the positive outcomes of surmounting challenges and adversities over the course of life (Bauman et al., 2001). It's not consistently a fixed trait, instead it's a behaviour that can adapt relative to individual circumstances and contexts. Individuals who effectively navigate stress and adversity in one phase of life might experience challenges and adverse reactions in different situations or at other times (Kocalevent et al., 2015).

Initially, resilience research was confined to the medical realm, employing a deficit model that concentrated on identifying, reducing, preventing, and eliminating factors associated with unfavourable development. In the past, ways of doing things were a bit limited. Nowadays, new research prefers using models that focus on finding and boosting the strengths we already have, leading to positive growth (Benson et al, 2004).

Resilience, especially in childhood, is like looking at how kids can bounce back from tough times. We study it to find out what things help them develop well and stay positive even when things are hard. It's all about figuring out the factors that make them adapt and grow in a good way despite facing challenges. On the contrary, resilience in adulthood is considered a key element for individuals to thrive in challenging situations and uphold a robust level of functionality, contributing to their success (Banonno, 2006). Resilience during adolescence integrates elements from both approaches. The available research indicates that assessing resilience in young individuals involves examining both their unique characteristics and the surrounding environment. Developmental systems theory places emphasis on both the

individual and the dynamic, interactive context of youth. It recognizes young individuals as catalysts actively shaping their immediate environment. This theory highlights the reciprocal relationship between individuals and their surroundings, emphasizing how the dynamic interaction contributes to enhancing individual capabilities (Theokas, 2005). When delving into this area, most research directs its attention toward resources and assets. Assets, being inherent components, foster resilience by encouraging self-sufficiency and coping skills. On the other hand, resources, being external factors, trigger resilience in adolescence through supportive family and community structures (Fergus & Zimmerman, 2005).

In the beginning, people focused on figuring out what makes individuals invulnerable, but over time, this idea evolved into a new concept called resilience. The latest resilience model looks at three main things: your social connections, biological factors, and how you think. It also considers the support you get from your bigger community, organizations, societies, your neighbourhood, and both your extended and nuclear family (Condly & Luthar, 2006).

Several recent studies have indicated that the presence of resilient qualities in couples is linked to a harmonious mental state for both partners. Huber and team (2010) discovered that positive psychological outcomes were linked to resilient partner traits, such as an adaptive coping style, elevated self-efficacy, and optimistic expectations for relationships.

Skodol's (2010) research highlights that women with high resilience exhibit qualities enabling them to effectively utilize adaptive coping strategies when navigating challenging situations, particularly during the pregnancy stage. He believes that women with resilient traits experience a more positive psychological well-being, contributing to the establishment of a strong family foundation. Cognitively resilient individuals possess a robust belief in their ability to navigate challenges within their marital life, demonstrating a high level of self-confidence (Rutter, 1985). People who are very resilient don't give up easily when they want to achieve something. They always focus on their goals and stay positive (Skodol, 2010).

Resilient women often showcase a heightened ability to express emotions accurately, comprehend others, and engage effectively in interpersonal communication (Greef & Ritman, 2005).

Women exhibiting strong resilience are likely to navigate the challenges of pregnancy adeptly, responding to adversity in a manner conducive to their overall well-being. Previous studies have shown that maintaining mental health in pregnant women is dependent on their resilience (Gagnon et al., 2014). Recent studies have discovered that resilience acts as a moderator in the relationship between mindfulness and anxiety in pregnant women (Ma, X. et al., 2019).

Chinese pregnant women might find relief from symptoms of prenatal anxiety through resilience, according to recent research. Resilience seems to act as a mediator in the connection between maternal stress and prenatal anxiety symptoms (Ma, X. et al., 2019). There is a limited amount of research available that assesses resilience in Chinese pregnant women and its correlation with symptoms of prenatal anxiety.

In a European study involving 151 pregnant women, findings revealed that individuals exhibiting higher levels of resilience demonstrated elevated scores in self-acceptance, experienced enhanced psychological well-being, and reported lower levels of pregnancy-related stress and postpartum depression compared to their less resilient counterparts (García-León et al., 2019).

Researchers have looked at how feeling supported by your family is linked to being able to bounce back from tough times. This ability to bounce back, called resilience, comes from having strong connections with your family and supportive relationships with others (Howard & Hughes 2012). So, numerous past studies have consistently affirmed that perceived family support is widely recognized as an external factor that contributes to resilience, acting

as a protective element (Rutter, 2012). In addition, there is a positive correlation between resilience and the perception of family support (Huang et al., 2020).

Resilience, once categorized as a personality trait, is now seen as an acquired skill that emerges in response to life's challenges (Kuldas & Foody 2022). Greater resilience is linked to lower levels of anxiety and depression, and women exhibiting resilient traits are more adept at navigating environmental challenges. Poor pregnancy outcomes are linked to low resilience, while greater resilience enhances one's ability to cope (Alves et al., 2021). Resilience emerged as a key factor that played a mediating role in facilitating a smooth pregnancy, according to a study (Tobe et al., 2020).

The period of pregnancy is viewed as a unique opportunity to nurture resilience and adaptation in both mothers and their newborns (Davis & Narayan 2020). Our exploration of existing literature reveals a limited body of research on positive psychological interventions in Pakistan, particularly in the context of pregnant women. Our goal is to close the gap by making a meaningful contribution to evidence-based literature. We're concentrating on enhancing strengths and fostering positive psychological well-being in women during the perinatal period. This entails developing and validating a resilience-building module that specifically focuses on individual strengths. This paper talks about creating and checking a special program called Safe Motherhood-Accessible Resilience Training (SM-ART) for pregnant women in Pakistan.

## **Rationale**

The study aims to explore how the perceived support from family and the resilience of expecting mothers play a crucial role in the connection between prenatal anxiety and psychological well-being. Perceived family support and resilience act as significant moderators that can impact the health of expectant mothers, either positively or negatively. In this context, resilience refers to a mother's ability to endure mental, emotional, and behavioural challenges, and it examines how the family contributes to supporting her through these significant life changes.

No prior research has studied moderating effects of perceived family support and resilience in the relationship between prenatal anxiety and psychological wellbeing among expecting mothers. Furthermore, this research sought to scrutinize how perceived family support and resilience played an active role in diminishing prenatal anxiety and bolstering psychological well-being in women during pregnancy. We also took into account demographic variables to investigate the interrelationships among prenatal anxiety, psychological well-being, and resilience and perceived family support.

Qualitative Researches highlighted link between women's psychological wellbeing and support they receive from their families, while there is a dearth of quantitative studies on this topic and understanding of the current state of family support remains limited.

In our research endeavour, our goal was to unravel the complex interconnections among prenatal anxiety, psychological well-being, perceived family support, and resilience in expecting mothers. We aimed to explore how the emotional state during pregnancy, particularly prenatal anxiety, intricately weaves into a mother's overall psychological well-being. Furthermore, our objective was to gain insights into the pivotal roles played by two essential factors perceived family support and resilience in shaping and influencing this intricate relationship (Ilska & Przybyła-Basista 2020).

There is a limited amount of research available that assess resilience in pregnant women and its correlation with symptoms of prenatal anxiety. There is limited body of research on positive psychological interventions in Pakistan in the context of pregnant women. The aim is to close the gap by enhancing strengths and fostering positive psychological wellbeing in women during the perinatal period.

## **Objectives**

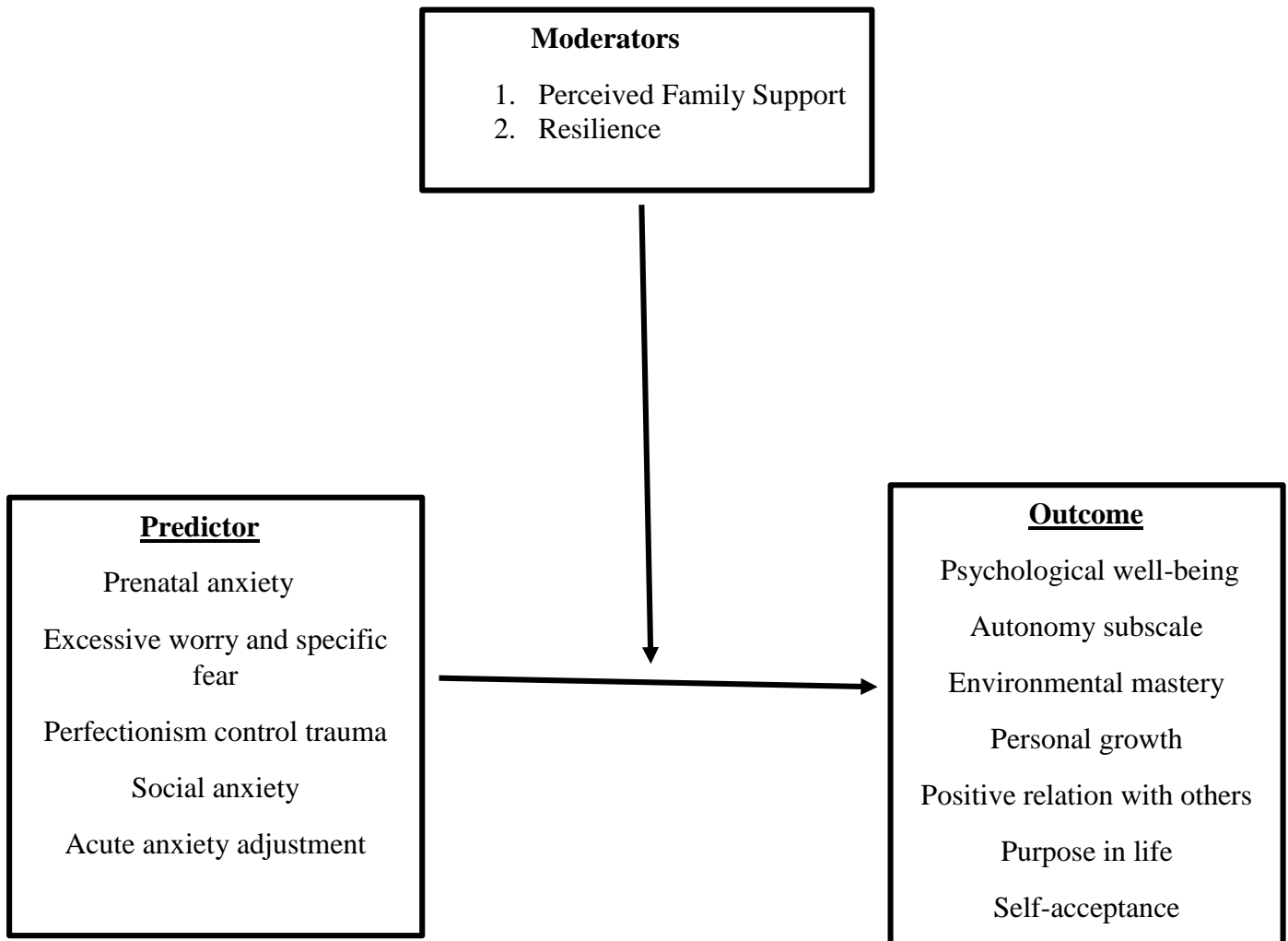
The current study has the following objectives:

- To explore the relationship between prenatal anxiety and psychological well-being, perceived family support and resilience among expecting mothers.
- To explore moderating role of perceived family support and resilience between prenatal anxiety and psychological well-being among expecting mothers.
- To assess trimester wise differences on perceived family support, resilience, prenatal anxiety and psychological well-being among expecting mothers.
- To assess the psychometric properties of the scales used in the study.
- To examine differences on perceived family support, resilience, prenatal anxiety and psychological well-being demographic variables such as age, socioeconomic status, miscarriage history, family type, gynae complications and educational level among the pregnant women

## **Hypotheses**

- Prenatal anxiety significantly and negatively relates to psychological well-being in pregnant women.
- Perceived family support and resilience serves as a moderator between prenatal anxiety and psychological well-being.
- Resilience and perceived family support are negatively correlated with prenatal anxiety and psychological well-being.
- Expecting mothers in 1st trimester show high prenatal anxiety as compared to expecting mothers in 2nd and 3rd trimester.
- Younger women were experiencing high anxiety during pregnancy as compared to elder women.

## Conceptual Framework



**Figure 1:** *Moderating Role of perceived family support and resilience in the relationship between prenatal anxiety and psychological wellbeing among expecting mothers.*



## Chapter 2

### Method

In this chapter, a thorough examination is presented, covering the research design, sampling method, participant selection, measurement instrument, which includes scoring guidelines and the overall procedure of the research.

### Research Design

The research is based on a correlational survey approach as its methodological framework. In correlational studies, researchers examine relationships between variables, without manipulating the variables themselves. The focus of this research is to explore the influence of perceived family support and resilience in the connection between prenatal anxiety and psychological well-being in expectant mothers. The data collection method employed is quantitative in nature.

### Sample/ participants

A group of 200 pregnant women was chosen through a convenient sampling method from various gynaecology departments in Islamabad and Rawalpindi hospitals. The participants, aged between 18 and 40, had diverse educational backgrounds ranging from matriculation and above. The study included individuals from low, average and high socioeconomic statuses.

**Inclusion Criteria.** Data collection utilized the Brief Resilience Scale, Prenatal Anxiety Screening Scale, Psychological Well-being Scale (PWB-S), and Perceived Family Support. The study specifically included expecting mothers aged 18 to 40 with an educational background of matriculation or above.

**Exclusion criteria.** Those Expecting women who were unable to complete an English language questionnaire, uneducated mothers-to-be. Additionally, participants outside the

specified age range (below 18 and above 40) were not included. Exclusion criteria also applied to individuals displaying a lack of responsiveness in providing answers on the Brief Resilience Scale (BRS), Prenatal Anxiety Screening Scale, Psychological Well-being Scale (PWB-S), and Perceived Family Support Scale.

### **Operational definitions**

**Prenatal anxiety.** The Perinatal Anxiety Screening Scale (PASS; 37) is a 31-item self-rated questionnaire investigating anxiety symptoms during the last month in child-bearing women. Each item is rated on a Likert 0–3 scale. This scale assesses four categories of anxiety: (1) acute anxiety and adjustment, (2) general worry and specific fears, (3) perfectionism, control and trauma and (4) social anxiety. Minimal anxiety (PASS score of 0-20), mild-moderate anxiety (score of 21-41), and severe anxiety (score of 42-93). The total score is the addition of scores on each item, with higher scores representing more anxiety (Rini et al., 1999).

**Psychological well-being.** Psychosocial well-being is an overarching concept that encompasses not only emotional or psychological well-being but also social and collective well-being. The Autonomy subscale items are Q15, Q17, and Q18. The Environmental Mastery subscale. Items are Q4, Q8, and Q9. The Personal Growth subscale items are Q11, Q12, and Q14. The Positive Relations with Others subscale items are Q6, Q13, Q16. The Purpose in Life subscale items are Q3, Q7, Q10. The Self-Acceptance subscale items are Q1, Q2 and Q5. Q1, Q2, Q3, Q8, Q9, Q11, Q12, Q13, Q17, and Q18 should be reverse-scored. Reverse-scored items are worded in the opposite direction of what the scale is measuring. To calculate subscale scores for each participant, sum respondents' answers to each subscale's items. Higher scores mean higher levels of psychological well-being. The total score is in the range of 18–108, with higher scores representing greater wellbeing

**Resilience.** The BRS is scored by reverse coding items 2, 4, and 6 and finding the mean of the six items. Add the responses varying from 1-5 for all six items giving a range from 6-30. Divide the total sum by the total number of questions answered. The Brief Resilience Scale was created to assess the perceived ability to bounce back or recover from stress. The scale was developed to assess a unitary construct of resilience, including both positively and negatively worded items. The possible score range on the BRS is from 1 (low resilience) to 5 (high resilience).

**Perceived Family support.** Never, rarely, often, and always options scored from 1-4; total score ranges from 13-52. Family support was categorized into good (higher than the mean data) and poor (less than the mean data). The point received from the scale varies between 0 and 40. The bigger the point received, the more support the family provides

## **Instruments**

**Demographic Sheet.** The study utilized informed consent to secure participants' approval and assure them of the confidentiality and protection of their identity. The demographic questionnaire gathered data on age, total number of pregnancies, trimester, education, family type (nuclear, joint), socio-economic status, gynaecological complications, and miscarriages.

**Brief Resilience Scale.** (Smith et al., 2008) developed a 6-item scale assessing the ability to rebound from adversity. It gauges the ease of bouncing back after facing challenges, utilizing a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). The scale is deemed suitable for individuals aged 19-62. Internal consistency reliability was found to be satisfactory with a range of  $\alpha = .80 - .91$ . Convergent, discriminant, and concurrent validity were assessed by comparing it with three other resilience measures and personal

characteristic assessments. The scale exhibited strong internal consistency reliability, indicated by a reported Cronbach's alpha of .93.

**Prenatal Anxiety Screening Scale.** The Prenatal Anxiety Screening Scale (PASS) is a self-report questionnaire designed by (Somerville et al., 2014) to assess specific anxiety symptoms related to pregnancy. Participants rate symptoms experienced in the past month on a 4-point Likert scale, ranging from 0 (Not at all) to 3 (Almost Always). Comprising 31 items, the PASS measures four subscales: (1) acute anxiety, (2) general worry and specific phobias, (3) perfectionism, control, and trauma, and (4) social anxiety. Total scores, ranging from 0 to 93, are obtained by summing individual item scores. The clinical cutoff for the PASS is set at a score of 26 or higher (Koukopoulos et al., 2021). The subscales exhibit excellent reliabilities ranging from .86 to .90, and the overall scale demonstrates a high reliability of .96. The PASS has been validated and proven reliable across diverse populations and languages, as evidenced by studies (Barros et al., 2021; Jradi et al., 2020; Priyadarshanie et al., 2020).

**Psychological well-being scale (PWB-S).** The assessment of psychological well-being utilized the 18-item Psychological Well-Being Scale (PWB-S) created by Ryff and Keyes (1995). The scale is an organized self-report tool grounded in the six dimensions of psychological well-being: Autonomy, environmental mastery, personal growth, positive relationships with others, purpose in life, and self-acceptance. The scale consists of 18 items, including statements like "I tend to be influenced by people with strong opinions" and "I am quite adept at managing the many responsibilities of my daily life." Participants rated each item on a 5-point Likert scale, ranging from (1) strongly disagree to (5) strongly agree. Notably, some items (1, 5, 9, 10, 12, 13, 15, and 18) are scored in reverse. Ryff reported psychometric properties for the six dimensions ranging from .86 to .93. However, in this study, a Cronbach's Alpha of .67 was reported for the same scale.

**Perceived Family Support Scale.** Abbas Uddin (2019) introduced the Perceived Family Support Scale (PFS Scale), a self-administered questionnaire consisting of two parts. The first part comprised a demographic data profile with 9 items, while the second part featured the Perceived Family Support Scale with 11 items. Respondents rated each item on a 4-point Likert scale, ranging from 0 (no) to 3 (much), resulting in total scores between 0 and 60. Higher scores indicated a stronger perception of family support. The proposed instrument demonstrated reliability, with an internal consistency level of 0.94 (Cronbach's Alpha Coefficient).

### **Data Analysis**

Analysis of data was analysed by using SPSS version 26. To evaluate the mean difference between two groups for parametric data, an independent sample t-test was employed. To explore the statistical relationship between three or more variables, the ANOVA was utilized.

### **Ethical Consideration**

I obtained ethical approval for my research from the Ethical Review Board at the Department of Psychology, IIUI, Ethics Committee, and the heads of the respective institutes. Furthermore, participants provided informed consent, and measures were taken to ensure privacy and confidentiality regarding all matters.

### **Procedure**

With approval from the appropriate authorities, the researcher engaged with expectant mothers. After a concise overview of the study, participants were sought for their informed consent. Subsequently, data collection took place, and any potential misunderstandings were addressed. The distribution of questionnaires included explicit and thorough instructions. Initially, participants were directed through general guidelines before delving into responding

to the questionnaires. Clear guidance was given for individual and honest completion, with the flexibility to skip any question causing discomfort. Participants were reassured that the information shared would be exclusively utilized for research purposes.

### Chapter 3

Research data were analysed using SPSS version 21. To examine the relationship between study variables, correlation coefficient was calculated. To assess the predictive role of prenatal anxiety on psychological wellbeing, linear regression analysis was used to measure the role of perceived family support and resilience as a moderator between prenatal anxiety and psychological wellbeing. For this moderation PROCESS 4.1 by Andrew F Hayes was used. The difference between miscarriage and no miscarriage among expecting mothers was explored using independent sample t test.

**Table 1**

*Frequency and percentages of demographic variables of study (N=200)*

<b>Variables</b>	<b>Categories</b>	<b><i>n</i></b>	<b>%</b>
Age	Young adult (18-30)	141	68.8
	Middle age (31-40)	59	28.8
Total no of pregnancies	First and second pregnancy	131	63.9
	Third and fourth pregnancy	54	26.3
	Fifth and above pregnancy	14	6.8
Trimester	One to three months	56	27.3
	Fourth to six months	54	26.3
	Seven to nine months	90	43.9
Education	Undergraduate	40	19.5
	Graduate	115	56.1
	Postgraduate	43	21.0
Family type	Nuclear	77	37.6

	Joint	123	60.0
Self-perceived Socio-economic status	Middle	189	92.2
	Upper	11	5.4
History of Gynae complications	Physical complications	65	31.7
	Psychological complications	23	11.2
	no complications	112	54.6
History of Miscarriages	Miscarriage	54	26.3
	No miscarriage	146	71.2

Table 1 presents the frequency (f) and percentage (%) distribution of demographic variables. The sample comprises 200 pregnant women, categorized into two age groups based on Erickson's theory. Specifically, 68% fall into the young adult category, while 28% belong to the middle adult category. In the present research, we've classified family structures into two categories. Thirty-seven percent of women are linked to nuclear families, while 60% are connected to joint family systems. Similarly, self-perceived socioeconomic status is divided into two groups, with 92% of women recognizing themselves as having a middle socioeconomic status and 5% attributing themselves to the upper status.

The distribution of total pregnancies falls into three groups: 63% of women experience their first and second pregnancies, 26% undergo their third and fourth pregnancies, and 6% have their fifth pregnancy and beyond. Additionally, 26% of women face miscarriages, while 71% have no history of miscarriage. Women's education levels are distributed across three categories, with 19% at the undergraduate level, 56% at the graduate level, and 21% at the postgraduate level. When it comes to the history of gynaecological complications, 31% of



women experienced physical issues, 11% faced psychological challenges, and 54% reported no complications. Additionally, the distribution of women in different trimesters is as follows: 27% in the first trimester, 26% in the second trimester, and 43% in the final trimester.

**Table 2***Descriptive statistics and reliability Co-efficient (a) of scales (N=200)*

Variables	K	a	M	(S.D)	Range		Skewness	Kurtosis
					Actual	Potential		
PFS	20	.80	19.87	3.16	10-30	0-60	.08	.69
BRS	6	.73	64.63	14.96	11-22	6-30	.17	.91
PASS								
EWSF	10	.80	14.27	5.90	2-28	0-30	.26	-.57
PCT	8	.72	11.04	4.37	0-24	0-24	.14	-.07
SA	5	.73	4.70	3.17	0-14	0-15	.49	-.30
AAA	8	.80	8.52	4.68	0-22	0-24	.26	-.13
PWBS								
ASS	3	.70	14.19	2.78	4-21	3-21	.02	.90
EMS	3	.73	13.92	3.43	5-21	3-21	-.77	.29
PGS	3	.69	15.38	2.88	4-21	3-21	-.46	.25
PRO	3	.72	13.28	3.62	3-21	3-21	.18	.68
PLS	3	.67	12.48	3.19	5-21	3-21	-.08	.94
SAS	3	.62	15.59	3.25	4-21	3-21	-.69	.64

*Df=198*

*Note.* k= No of items, a=alpha reliability, M=Mean, SD=Standard deviation PFS= perceived family support; BRS= Brief resilience scale; PASS= Prenatal anxiety screening scale; EWSF=excessive worry and specific fears; PCT= perfectionism, control and trauma; SA=social anxiety; AAA= acute anxiety adjustment; PWBS= psychological wellbeing scale; ASS=autonomy subscale; EMS=environmental subscale; PGS=personal growth subscale; PRO=positive relation with others; PLS= purpose in life; SAS= self-acceptance.

Table 2 displays descriptive statistics and psychometric properties of the scales utilized in this study. The alpha reliability coefficients for the scales are as follows: PFS .80, BRF .93, EWSF .80, PCT .72, SA .73, AAA .80, ASS .70, EMS .73, PGS .69, PRO .72, PLS .67, and SAS .62. All scales demonstrate an acceptable level of alpha reliability (i.e.,  $>.50$ ). Mean and standard deviation values are provided, and skewness and kurtosis fall within the range of  $\pm 2$ , indicating normal distribution of data.

**Table 3***Mean, Standard Deviations and t-values along age on Variables (N=200)*

Variables	Young Adult	Middle adult	<i>t</i>	<i>p</i>	95% <i>CI</i>		Cohen's <i>d</i>
	( <i>n</i> = 141)	( <i>n</i> = 59)			<i>LL</i>	<i>UL</i>	
	<i>M (SD)</i>	<i>M (SD)</i>					
PFS	63.9(14.8)	66.3(15.1)	-1.02	.30	-6.94	2.20	
BRS	19.9(3.19)	19.6(3.10)	.66	.50	-.64	1.29	
EWSF	14.7(6.11)	13.1(5.26)	1.71	.08	-.23	3.35	
PCT	11.4(4.56)	10.0(3.75)	2.16	.03	.13	2.78	0.33
SA	4.95(3.25)	4.10(2.91)	1.74	.08	-.10	1.82	
AAA	8.82(4.68)	7.79(4.64)	1.41	.15	-.40	2.45	
ASS	14.3(2.78)	13.7(2.76)	1.35	.17	-.26	1.43	
EMS	13.9(3.64)	13.9(2.89)	-.12	.90	-1.11	.98	
PGS	15.4(2.85)	15.2(2.95)	.52	.60	-.64	1.11	
PRO	13.3(3.65)	13.2(3.58)	.12	.90	-1.04	1.17	
PLS	12.4(3.41)	12.6(2.62)	-.35	.72	-1.15	.80	
SAS	15.4(3.40)	16.0(2.85)	-1.2	.21	-1.62	.36	

*df=198*

*Note.* *CI* = *Confidence Interval*; *LL* = *Lower Limit*; *UL* = *Upper Limit*; PFS= perceived family support, BRS= Brief resilience scale, PASS= Prenatal anxiety screening scale, EWSF=excessive worry and specific fears, PCT= perfectionism, control and trauma, SA=social anxiety, AAA= acute anxiety adjustment, PWBS= psychological wellbeing scale, ASS=autonomy subscale, EMS=environmental subscale, PGS=personal growth subscale, PRO=positive relation with others, PLS= purpose in life, SAS= self-acceptance.

Table 3 displays the outcomes of an independent sample t-test examining mean differences in perceived family support, brief resilience, prenatal anxiety, and psychological well-being scales based on family types. The results suggest a significant difference ( $p > .03$ ) between young adult expected women and middle adult expected women regarding perfectionism control trauma. Specifically, the mean value of young adult women (11.4) suggests a higher susceptibility to prenatal anxiety compared to middle adult expected women.

**Table 4***Mean, Standard Deviations and t-value along socioeconomic status Variables (N=200)*

Variables	Middle class	Upper class	<i>t</i>	<i>p</i>	95% <i>CI</i>		Cohen's <i>d</i>
	( <i>n</i> = 189)	( <i>n</i> = 11)			<i>LL</i>	<i>UL</i>	
	<i>M (SD)</i>	<i>M (SD)</i>					
PFS	64.5(14.7)	66.4(18.7)	-.41	.67	-11.0	7.24	
BRS	19.9(3.10)	18.9(4.10)	1.04	.29	-.91	2.95	
EWSF	14.1(5.74)	15.8(8.41)	-.89	.37	-5.25	1.97	
PCT	11.0(4.33)	11.3(5.33)	-.24	.80	-3.02	2.34	
SA	4.71(3.11)	4.45(4.20)	.26	.78	-1.68	2.21	
AAA	8.43(4.58)	9.90(6.31)	-1.01	.31	-4.33	1.39	
ASS	14.2(2.79)	14.0(2.68)	.23	.81	-1.50	1.90	
EMS	13.9(3.41)	13.1(3.86)	.73	.46	-1.32	2.88	
PGS	15.3(2.87)	15.4(3.20)	-.18	.85	-1.93	1.59	
PRO	13.2(3.65)	14.0(3.20)	-.75	.45	-3.07	1.36	
PLS	12.4(3.20)	12.3(3.23)	.12	.89	-1.83	2.08	
SAS	15.6(3.29)	13.8(2.04)	1.8	.06	-.10	3.85	

*df*=198

*Note.* *CI* = Confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit; PFS= perceived family support, BRS= Brief resilience scale, PASS= Prenatal anxiety screening scale, EWSF=excessive worry and specific fears, PCT= perfectionism, control and trauma, SA=social anxiety, AAA= acute anxiety adjustment, PWBS= psychological wellbeing scale, ASS=autonomy subscale, EMS=environmental subscale, PGS=personal growth subscale, PRO=positive relation with others, PLS= purpose in life, SAS= self-acceptance.

Table 4 present the results of an independent sample t-test comparing mean scores on the perceived family support scale, brief resilience scale, prenatal anxiety screening scale, and psychological wellbeing scale by family type show that there is no statistically significant difference between the middle-class and upper-class groups.

**Table 5**

*Mean, Standard Deviations and t-values of miscarriage history of expecting women on prenatal anxiety, perceived family support, resilience and psychological wellbeing (N=200)*

Variables	Miscarriage History (n = 54)	No miscarriage History (n = 146)	t	p	95% CI		Cohen's d
	M (SD)	M (SD)			LL	UL	
PFS	62.2(16.5)	65.5(14.2)	-1.34	.17	-7.89	1.48	
BRS	19.9(2.76)	19.8(3.31)	.18	.85	-.90	1.09	
EWSF	15.0(5.86)	14.0(5.91)	1.06	.28	-.86	2.85	
PCT	11.3(4.09)	10.9(4.49)	.52	.59	-1.00	1.74	
SA	4.77(3.42)	4.67(3.08)	.19	.84	-.899	1.09	
AAA	9.27(4.42)	8.23(4.76)	1.39	.16	-.430	2.50	
ASS	13.8(3.41)	14.3(2.51)	-1.04	.29	-1.33	.410	
EMS	13.3(3.93)	14.1(3.21)	-1.47	.14	-1.87	.271	
PGS	15.1(3.43)	15.4(2.65)	-.76	.44	-1.25	.556	
PRO	13.0(3.69)	13.3(3.61)	-.49	.61	-1.43	.852	
PLS	11.9(3.42)	12.6(3.09)	-1.45	.14	-1.74	.260	
SAS	14.6(3.44)	15.9(3.12)	-2.56	.01	-2.32	-.305	0.39

*df=198*

*Note.* CI = Confidence Interval; LL = Lower Limit; UL = Upper Limit; PFS= perceived family support, BRS= Brief resilience scale, PASS= Prenatal anxiety screening scale, EWSF=excessive worry and specific fears, PCT= perfectionism, control and trauma, SA=social anxiety, AAA= acute anxiety adjustment, PWBS= psychological wellbeing scale, ASS=autonomy subscale, EMS=environmental subscale, PGS=personal growth subscale, PRO=positive relation with others, PLS= purpose in life, SAS= self-acceptance.



Table 5 presents the outcomes of an independent sample t-test are presented, examining the mean differences in perceived family support, brief resilience, prenatal anxiety, and psychological well-being based on family type. The findings indicate a noteworthy distinction ( $p > .05$ ) in self-acceptance between expected women with a history of miscarriage and those without. Specifically, the mean value of self-acceptance for individuals without a miscarriage history is 15.9, suggesting that women with no prior miscarriages tend to have elevated levels of self-acceptance.

**Table 6**

*Mean, Standard Deviations and t-values of family type of expecting women on prenatal anxiety, perceived family support, resilience and psychological wellbeing (N=200)*

Variables	Nuclear	Joint	<i>t</i>	<i>P</i>	95% <i>CI</i>		Cohen's <i>d</i>
	( <i>n</i> = 77)	( <i>n</i> = 123)			<i>LL</i>	<i>UL</i>	
	<i>M (SD)</i>	<i>M (SD)</i>					
PFS	67.3(14.5)	62.9(14.9)	2.07	.03	.227	8.73	0.29
BRS	20.2(2.96)	19.6(3.27)	1.36	.17	-.279	1.53	
EWSF	13.7(6.28)	14.6(5.65)	-1.07	.28	-2.61	.766	
PCT	10.8(4.20)	11.1(4.49)	-.479	.63	-1.56	.951	
SA	3.68(3.01)	5.34(3.11)	-3.69	.000	-2.53	-.771	0.54
AAA	7.71(4.33)	9.02(4.84)	-1.93	.05	-2.64	.023	0.28
ASS	14.5(2.71)	13.9(2.81)	1.38	.16	-.238	1.35	
EMS	14.2((3.07)	13.6(3.63)	1.15	.25	-.409	1.55	
PGS	15.7(2.68)	15.1(2.99)	1.28	.20	-.289	1.36	
PRO	13.5(3.49)	13.0(3.70)	.923	.35	-.553	1.52	
PLS	12.5(3.18)	12.4(3.21)	.347	.72	-.756	1.07	
SAS	15.9(3.11)	15.3(3.33)	1.23	.22	-.350	1.51	

*df=198*

*Note.* CI = Confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit; PFS= perceived family support, BRS= Brief resilience scale, PASS= Prenatal anxiety screening scale, EWSF=excessive worry and specific fears, PCT= perfectionism, control and trauma, SA=social anxiety, AAA= acute anxiety adjustment, PWBS= psychological wellbeing scale, ASS=autonomy subscale, EMS=environmental subscale, PGS=personal growth subscale, PRO=positive relation with others, PLS= purpose in life, SAS= self-acceptance.

Table 6 presents the outcomes of an independent sample t-test, examining the mean differences in the perceived family support scale, brief resilience scale, prenatal anxiety screening scale, and psychological well-being scale based on family type. The results indicate a noteworthy difference ( $p > .05$ ) between nuclear and joint family systems in terms of perceived family support. Specifically, women from nuclear family systems exhibit a higher mean value (67.3), suggesting elevated perceived family support.

Furthermore, a significant difference ( $p > .000$ ) is observed between nuclear and joint family systems in relation to social anxiety. Women belonging to joint family systems report a higher mean value (5.34), indicating heightened levels of social anxiety. Additionally, there is a significant difference ( $p > .05$ ) between nuclear and joint family systems concerning acute anxiety adjustment. Women from joint family systems demonstrate a higher mean value (9.02), suggesting a greater level of acute anxiety adjustment.

**Table 7**

*Mean, Standard Deviations and t-values above and below mean of prenatal anxiety in expecting women (N=200)*

Variables	Above mean	Below mean	<i>t</i>	<i>P</i>	95% <i>CI</i>		Cohen's <i>d</i>
	( <i>n</i> = 107)	( <i>n</i> = 93)			<i>LL</i>	<i>UL</i>	
	<i>M (SD)</i>	<i>M (SD)</i>					
PFS	60.4(15.9)	69.4(12.1)	-4.40	.000	-12.9	-4.94	0.63
BRS	20.6(2.71)	19.0(3.43)	3.71	.000	.75	2.47	0.51
EWSF	17.7(5.07)	10.2(3.91)	11.5	.000	6.22	8.77	1.65
PCT	13.3(3.78)	8.40(3.44)	9.57	.000	3.91	5.93	1.35
SA	6.12(3.19)	3.07(2.23)	7.70	.000	2.26	3.82	1.10
AAA	11.0(4.20)	5.58(3.28)	10.1	.000	4.43	6.55	1.43
ASS	14.0(2.83)	14.3(2.72)	-.67	.49	-1.04	.51	
EMS	13.8(3.35)	14.0(3.53)	-.47	.63	-1.19	.73	
PGS	15.2(2.94)	15.4(2.81)	-.50	.61	-1.01	.602	
PRO	13.5(3.93)	13.0(3.23)	1.03	.30	-.48	1.54	
PLS	12.3(3.28)	12.6(3.10)	-.74	.45	-1.23	.55	
SAS	15.4(3.37)	15.7(3.13)	-.74	.45	-1.25	.56	

*df*= 198

*Note.* CI = Confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit; PFS= perceived family support, BRS= Brief resilience scale, PASS= Prenatal anxiety screening scale, EWSF=excessive worry and specific fears, PCT= perfectionism, control and trauma, SA=social anxiety, AAA= acute anxiety adjustment, PWBS= psychological wellbeing scale, ASS=autonomy subscale, EMS=environmental subscale, PGS=personal growth subscale, PRO=positive relation with others, PLS= purpose in life, SAS= self-acceptance.

Table 7 outlines the outcomes of an independent sample t-test analysis investigating prenatal anxiety concerning expecting women falling below and above the mean. The findings indicate significant statistical distinctions between these two groups of expecting women. Specifically, those above the mean exhibit higher mean scores compared to those below the mean in various domains: Perceived family support, Brief resilience scale, Excessive worry and specific fears, Perfectionism, control and trauma, social anxiety, Acute anxiety adjustment, psychological wellbeing, Autonomy, Environmental mastery, Personal growth, Positive relation with others, Purpose in life, and Self-acceptance. It's noteworthy that the p-values derived from the analysis are statistically significant.

**Table 8**

*One way ANOVA to investigate Mean, Standard Deviations and F-value along trimester of expecting women on prenatal anxiety, perceived family support, resilience and psychological wellbeing (N=200)*

	1 <sup>st</sup> trimester (n=56)	2 <sup>nd</sup> trimester (n=54)	3 <sup>rd</sup> trimester (n=90)	F	P	Post hoc
Variable	M (SD)	M (SD)	M (SD)			1<2<3
PFS	65.3(15.1)	65.0(14.2)	63.9(15.4)	.16	.84	1<2<3
BRS	19.8(3.10)	20.6(2.72)	19.4(3.37)	2.6	.07	
EWSF	12.8(5.86)	15.3(5.82)	14.5(5.86)	2.6	.07	
PCT	10.3(3.39)	12.3(4.96)	10.6(4.41)	3.6	.02	
SA	5.08(3.49)	4.79(2.89)	4.41(3.12)	.81	.44	
AAA	7.76(4.15)	9.81(4.61)	8.21(4.92)	3.0	.05	
ASS	13.8(2.72)	14.2(3.52)	14.3(2.27)	.64	.52	
EMS	13.8(3.66)	14.5(3.40)	13.6(3.28)	1.3	.26	
PGS	14.9(2.85)	15.8(3.22)	15.3(2.65)	1.5	.21	
PRO	13.1(3.78)	13.27(3.31)	13.3(3.74)	.02	.97	
PLS	12.3(3.28)	12.8(3.90)	12.3(3.19)	.43	.64	
SAS	15.8(2.94)	15.4(3.86)	15.4(3.06)	.29	.74	

*Note.* M= Mean; SD=Standard Deviation; PFS= perceived family support, BRS= Brief resilience scale; PASS= Prenatal anxiety screening scale; EWSF=excessive worry and specific fears; PCT= perfectionism, control and trauma; SA=social anxiety; AAA= acute anxiety adjustment; PWBS= psychological wellbeing scale; ASS=autonomy subscale; EMS=environmental subscale; PGS=personal growth subscale; PRO=positive relation with others; PLS= purpose in life; SAS= self-acceptance.

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Table 8 outlines the results of a one-way ANOVA investigating mean variations in perceived family support, brief resilience, prenatal anxiety, and psychological well-being across diverse family structures. The results reveal a notable disparity ( $p > .05$ ) in Perfectionism Control Trauma (PCT) history among the 1st, 2nd, and 3rd trimesters. Specifically, the mean value for the 2nd trimester (12.3) suggests that women in this period have encountered Perfectionism Control Trauma. Likewise, a significant distinction ( $p > .05$ ) appears in Acute Anxiety Adjustment (AAA) across the 1st, 2nd, and 3rd trimesters, with the mean value for the 2nd trimester (9.81) indicating experiences of Acute Anxiety Adjustment among women at that stage.

**Table 9**

*Mean, Standard Deviations and F-value along gynae complications of expecting women on prenatal anxiety, perceived family support, resilience and psychological wellbeing (N=200)*

	Physical Complication (n=65)	Psychological Complication (n=23)	No complication (n=112)	<i>F</i>	<i>p</i>	Post hoc
Variable	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>			1<2<3
PFS	65.0(16.1)	59.5(15.7)	65.4(13.9)	1.5	.22	1<2<3
BRS	20.3(3.05)	20.6(3.08)	19.4(3.20)	2.3	.10	
EWSF	14.1(5.78)	16.5(6.78)	13.8(5.73)	1.9	.14	
PCT	11.0(4.10)	12.5(4.32)	10.7(4.51)	1.5	.20	
SA	4.07(2.87)	6.21(3.10)	4.75(3.26)	4.0	.01	
AAA	9.00(4.70)	9.65(5.07)	8.00(4.56)	1.6	.18	
ASS	14.1(2.37)	14.0(3.93)	14.2(2.74)	.08	.91	
EMS	13.8(3.41)	13.6(3.91)	13.9(3.37)	.06	.93	
PGS	15.6(2.46)	15.6(4.39)	15.1(2.73)	.65	.52	
PRO	13.1(3.17)	12.1(4.80)	13.6(3.57)	1.7	.18	
PLS	12.5(2.97)	12.1(3.84)	12.5(3.20)	.13	.87	
SAS	15.5(2.92)	14.3(4.88)	15.8(2.99)	2.0	.13	

*Note. M=Mean; SD=Standard Deviation; PFS= perceived family support, BRS= Brief resilience scale, PASS= Prenatal anxiety screening scale, EWSF=excessive worry and specific fears, PCT= perfectionism, control and trauma, SA=social anxiety, AAA= acute anxiety adjustment, PWBS= psychological wellbeing scale, ASS=autonomy subscale, EMS=environmental subscale, PGS=personal growth subscale, PRO=positive relation with others, PLS= purpose in life, SAS= self-acceptance.*



Table 9 presents the outcomes of a one-way ANOVA assessing the mean differences in perceived family support, brief resilience, prenatal anxiety, and psychological wellbeing scales across different family types. The findings indicate a noteworthy distinction ( $p < .01$ ) among those with physical complications, psychological complications, and no complications concerning their history of social anxiety. Specifically, the mean value for psychological complications is 6.21, suggesting that women experiencing psychological issues are expected to exhibit higher levels of social anxiety.

**Table 10**

*Mean, Standard Deviations and F-value along education of expecting women on prenatal anxiety, perceived family support, resilience and psychological wellbeing Variables (N=200)*

Variable	Undergraduate	Graduate	Postgraduate	F	p	Post hoc
	(n=40)	(n=115)	(n=43)			
	M (SD)	M (SD)	M (SD)			1<2<3
PFS	63.0(15.6)	65.4(14.8)	63.9(15.1)	.31	.81	1<2<3
BRS	20.6(3.14)	19.5(3.01)	19.6(3.39)	3.0	.03	
EWSF	14.8(5.82)	14.4(5.70)	13.4(6.61)	.61	.60	
PCT	11.6(4.13)	11.3(4.22)	10.0(4.81)	2.4	.06	
SA	5.80(3.06)	4.74(3.19)	3.79(2.86)	4.4	.00	
AAA	9.57(4.96)	8.70(4.56)	7.39(4.41)	3.3	.01	
ASS	14.5(1.78)	14.1(2.82)	14.2(3.26)	2.1	.09	
EMS	13.8(3.20)	13.7(3.73)	14.5(2.77)	.63	.59	
PGS	15.1(2.39)	15.4(3.08)	15.6(2.76)	1.1	.34	
PRO	13.7(3.35)	13.2(3.71)	13.1(3.72)	.41	.74	
PLS	12.1(3.03)	12.3(3.15)	13.0(3.50)	.75	.51	
SAS	15.0(2.59)	15.7(3.37)	15.0(3.46)	1.6	.17	

*Note.* M=Mean; SD=Standard Deviation; PFS= perceived family support, BRS= Brief resilience scale, PASS= Prenatal anxiety screening scale, EWSF=excessive worry and specific fears, PCT= perfectionism, control and trauma, SA=social anxiety, AAA= acute anxiety adjustment, PWBS= psychological wellbeing scale, ASS=autonomy subscale, EMS=environmental subscale, PGS=personal growth subscale, PRO=positive relation with others, PLS= purpose in life, SAS= self-acceptance.

Table 10 presents the outcomes of a one-way ANOVA assessing a significant difference ( $p > .03$ ) in mean scores for the perceived family support scale, brief resilience scale, prenatal anxiety screening scale, and psychological well-being scale based on the educational level. There exists a notable distinction among undergraduate, graduate, and postgraduate levels with regard to brief resilience, indicated by a p-value greater than ( $p > 0.03$ ). The mean score of 20.0 for undergraduate women implies a heightened level of resilience among women in the undergraduate academic tier.

There's a significant difference ( $p < .001$ ) in social anxiety levels among undergraduates, graduates, and postgraduates. Specifically, undergraduate women exhibit a mean score of (.00), signifying heightened social anxiety.

There's a notable difference ( $p < .01$ ) in how undergraduates, graduates, and postgraduates adapt to acute anxiety. Specifically, undergraduate women scored an average of 9.57, indicating a high level of adjustment to acute anxiety in this demographic.

**Table 11**

*Mean, Standard Deviations and F-value along total no of pregnancies of expecting women on prenatal anxiety, perceived family support, resilience and psychological wellbeing (N=200)*

Variable	1 <sup>st</sup> or 2 <sup>nd</sup> pregnancy (n=131)	3 <sup>rd</sup> or 4 <sup>th</sup> pregnancy (n=54)	5 <sup>th</sup> or above pregnancy (n=14)	<i>F</i>	<i>p</i>	Post hoc
	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>			
PFS	65.2(14.4)	64.1(14.4)	59.5(20.8)	.99	.39	1<2<3
BRS	19.6(3.10)	20.5(3.47)	19.5(2.34)	1.0	.37	
EWSF	13.7(6.38)	15.7(4.83)	13.9(4.39)	1.5	.21	
PCT	10.4(4.49)	12.4(4.03)	11.0(3.57)	2.7	.04	
SA	4.58(3.26)	4.83(2.87)	5.21(3.55)	.38	.76	
AAA	8.43(5.08)	8.59(3.86)	9.07(4.00)	.08	.96	
ASS	14.3(2.87)	13.7(2.79)	14.5(1.55)	1.0	.37	
EMS	14.2(3.48)	13.0(3.13)	14.7(3.66)	1.9	.12	
PGS	15.3(2.92)	15.1(2.78)	16.2(2.94)	.76	.51	
PRO	13.0(3.67)	13.4(3.50)	14.4(3.77)	.63	.59	
PLS	12.2(3.32)	13.0(2.80)	12.3(3.31)	1.1	.31	
SAS	15.4(3.39)	15.6(3.04)	16.2(2.89)	.45	.71	

*Note.* *M*=Mean; *SD*=Standard Deviation; PFS= perceived family support; BRS= Brief resilience scale; PASS= Prenatal anxiety screening scale; EWSF=excessive worry and specific fears; PCT= perfectionism, control and trauma; SA=social anxiety; AAA= acute anxiety adjustment; PWBS= psychological wellbeing scale; ASS=autonomy subscale; EMS=environmental subscale; PGS=personal growth subscale; PRO=positive relation with others; PLS= purpose in life; SAS= self-acceptance.

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Table 11 outlines the outcomes of a one-way ANOVA examining the mean differences in perceived family support, brief resilience, prenatal anxiety, and psychological well-being scales across various family types. The findings reveal a noteworthy distinction ( $p > .04$ ) among 1st or 2nd pregnancies, 3rd or 4th pregnancies, and 5th or above pregnancies concerning perfectionism, control, and trauma history. Specifically, the mean value for 3rd or 4th pregnancies is 12.4, indicating that women expecting their 3rd or 4th child tend to experience elevated levels of perfectionism, control, and trauma.

**Table 12**

*Correlation coefficient between study of Perceived family support, Brief resilience, prenatal anxiety and psychological wellbeing. (N=200)*

Variables	1	2	3	4	5	6	7	8	9	10	11	12
PFS		-.04	-.33**	-.05	-.27**	-.30**	.04	.02	.01	.01	.04	.06
BRS			.22**	.30**	.13	.22**	-.03	.02	-.04	-.04	-.03	-.09
EWSF				.52**	.40**	.51**	-.04	-.07	-.03	-.03	-.09	-.03
PCT					.25**	.46**	-.03	-.05	-.07	-.02	-.03	-.11
SA						.49**	-.15*	-.06	-.06	-.08	-.13	-.11
AAA							-.05	-.07	-.10	-.02	-.14*	-.10
ASS								.48**	.39**	.33**	.16*	.34**
EMS									.29**	.21**	-.01	.39**
PGS										.39**	.25**	.36**
PRO											.35**	.46**
PLS												.24**
SAS												

Note: \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$  PFS= perceived family support, BRS= Brief resilience scale, PASS= Prenatal anxiety screening scale, EWSF=excessive worry and specific fears, PCT= perfectionism, control and trauma, SA=social anxiety, AAA= acute anxiety adjustment, PWBS= psychological wellbeing scale, ASS=autonomy subscale, EMS=environmental subscale, PGS=personal growth subscale, PRO=positive relation with others, PLS= purpose in life, SAS= self-acceptance.

Table 12 presents the correlation findings suggest that as perceived family support increases, there is a notable decrease in various forms of anxiety. Specifically, there is a significant negative correlation of ( $r=-.33$ ) with excessive worry and specific fear, indicating that higher levels of perceived family support are associated with lower levels of these anxieties. Similarly, the negative correlation of ( $r= -.27$ ) with social anxiety implies that individuals who perceive stronger family support tend to experience lower levels of social anxiety. Additionally, the correlation of ( $r= -.30$ ) with acute anxiety adjustment indicates that higher perceived family support is linked to better adjustment and coping with acute anxiety.

Resilience is significantly and positively associated with heightened levels of excessive worry and specific fear ( $r=.22$ ). This implies that individuals with higher levels of resilience tend to also experience increased levels of excessive worry and specific fear. Perfectionism control trauma, ( $r=.30$ ) it indicates that people with higher resilience might have a stronger inclination toward perfectionism, especially when it comes to handling traumatic situations. The correlation coefficient " $r=.30$ " indicates a relatively strong positive relationship. So, those who are resilient may strive for perfection in managing and controlling difficult or traumatic events in their lives. Anxiety and acute anxiety adjustment ( $r=.22$ ), indicates a positive correlation between resilience and both general anxiety and the ability to adjust to acute anxiety.

Perfectionism shows a positive connection with increased levels of both excessive worry and specific fear. Significant correlations are evident in control trauma ( $r = .52$ ), social anxiety ( $r = .40$ ), and acute anxiety adjustment ( $r = .51$ ). In simpler terms, perfectionism seems to go hand-in-hand with heightened concerns, fears, and difficulties in handling different types of stressful situations.

Perfectionism control trauma shows a noteworthy positive association with both social anxiety ( $r = 0.25$ ) and acute anxiety adjustment ( $r = 0.46$ ). Individuals who experience higher levels of perfectionism control trauma are more likely to also experience increased social anxiety and have challenges in adjusting to acute anxiety situations.

The statistical correlations indicate that as social anxiety increases, there is a notable tendency for acute anxiety adjustment to also increase positively ( $r = 0.49$ ). This implies that individuals experiencing higher levels of social anxiety may find it more challenging to adjust to acute anxiety situations. On the other hand, the negative correlation with autonomy ( $r = -0.15$ ) indicates that as social anxiety increases, autonomy tends to decrease. In other words, individuals with higher social anxiety may feel a reduced sense of independence or self-determination.

The relationship between acute anxiety adjustment and a sense of purpose in life is characterized by a negative correlation of ( $r = -.14$ ). The negative correlation suggests that as one variable (acute anxiety adjustment) increases, the other variable (sense of purpose in life) tends to decrease, and vice versa.

Autonomy exhibits notable positive correlations with various aspects: environmental mastery ( $r = .48$ ), personal growth ( $r = .39$ ), interpersonal relationships ( $r = .33$ ), purpose in life ( $r = .16$ ), and self-acceptance ( $r = .34$ ). Individuals who have a greater sense of autonomy are likely to experience increased competence in managing their environment, personal development, positive relationships with others, a sense of purpose, and self-acceptance.

Environmental mastery exhibits a positive correlation with personal growth ( $r = 0.29$ ), a favourable association with positive relation with others ( $r = 0.21$ ), and a strong positive link with self-acceptance ( $r = 0.39$ ). These findings suggest that a sense of environmental mastery



is not only linked to personal growth but also plays a role in fostering positive relationships with others and promoting self-acceptance.

There is a noteworthy positive correlation between personal growth and positive relationships with others ( $r = 0.39$ ), a sense of purpose in life ( $r = 0.25$ ), and self-acceptance ( $r = 0.36$ ). The statement suggests that as individuals undergo personal growth, they are likely to experience positive changes in their relationships with others, find a greater sense of purpose in life and enhance their self-acceptance.

Having a positive connection with others is positively linked to both purpose in life ( $r = 0.35$ ) and self-acceptance ( $r = 0.46$ ). In simpler terms, when individuals foster positive relationships with others, it tends to be associated with a greater sense of purpose in life and a higher level of self-acceptance.

Self-acceptance shows a positive correlation ( $r = 0.24$ ) with the sense of purpose in life. A positive correlation ( $r = 0.24$ ) between self-acceptance and the sense of purpose in life, means that as levels of self-acceptance increase, there is a corresponding increase in the sense of purpose. The correlation coefficient of ( $r=0.24$ ) indicates a mild positive relationship suggesting that these two factors tend to go hand in hand, but the relationship isn't extremely strong. So, individuals who are more accepting of themselves are likely to experience a somewhat higher sense of purpose in their lives.

**Table 13**

*Simple Linear Regression showing prenatal anxiety as Predictor of psychological wellbeing  
(N=200)*

Scales	<i>B</i>	<i>SEB</i>	<i>B</i>	<i>t</i>	<i>p</i>
Constant	89.63	2.57		34.82	.00
Prenatal anxiety	-.21	.06	-.139	-1.97	.05

*Note. R=.139, R<sup>2</sup>= .019*

Table 13 shows predictive role of prenatal anxiety on psychological wellbeing. It shows that prenatal anxiety is significantly predicts the negative relationship with psychological wellbeing (PWB) ( $\beta=-.13$ ). The R2 value is .019 which indicates 1 % change in psychological wellbeing.

**Table 14***Moderating effect of perceived family support on excessive worry and autonomy (N=200)*

Predictors	Perceived family support					
	Model 1		Model 2		95% CI	
	B	SE	<i>t</i>	<i>p</i>	LL	UL
Constant	9.32	2.99	3.11	.002	3.42	15.23
Excessive worry	.27	.17	1.58	.11	-.06	.623
Perceived family support	.41	.04	1.75	.08	-.00	.157
Excessive worry*perceived family support	-.004	.002	-1.71	.08	-.00	.000
R <sup>2</sup>	.01					
F	1.1					
ΔR <sup>2</sup>	.01					
ΔF	2.9					

Note. \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

The findings in table 14 reveal important insights from the moderation analysis. In Model 1, the R<sup>2</sup> value of .01 indicates that there is no significant variation (0%) in excessive worry. Similarly, in Model 2, perceived family support also contributes 0% to the variation. The interaction effect, with a beta coefficient of -.004 and a p-value of .08, suggests that the moderation is not statistically significant. In summary, the findings suggest that perceived family support does not significantly moderate the relationship between excessive worry and autonomy.

**Table 15***Moderating effect of perceived family support on excessive worry and environmental mastery**(N=200)*

Predictors	perceived family support				
	Model 1		Model 2		
	$\beta$	SE	<i>t</i>	<i>P</i>	95% CI
Constant	12.6	3.7	3.41	.000	[5.36,20.00]
Excessive worry	.07	.21	.35	.72	[-.351,.504]
Perceived family support	.02	.05	.52	.60	[-.075,.130]
Excessive worry*perceived family support	-.001	.00	-.58	.56	[-.008,.004]
R <sup>2</sup>	.00				
F	.52				
$\Delta R^2$	.00				
$\Delta F$	.33				

Note. \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 15 provide information regarding the moderation analysis. In the first model, the R<sup>2</sup> value indicates that none of the variation in excessive worry is accounted for (R<sup>2</sup> = .00), signifying 0% explanatory power. Similarly, in the second model, perceived family support also fails to explain any variation in excessive worry (R<sup>2</sup> = .00). Furthermore, the interaction effect value reveals non-significance ( $\beta = -.001$ ,  $p = .56$ ), suggesting that perceived family support does not significantly moderate the relationship between excessive worry and environmental mastery.

**Table 16***Moderating effect of perceived family support on excessive worry and personal Growth**(N=200)*

Predictors	perceived family support				
	Model 1		Model 2		
	B	SE	<i>t</i>	<i>p</i>	95% CI
Constant	13.9	3.12	4.47	.000	[7.83,20.15]
Excessive worry	.083	.182	.457	.647	[-.276,.443]
Perceived family support	.023	.044	.540	.589	[-.063,.110]
Excessive worry*perceived family support	-.001	.002	-.566	.571	[-.006,.003]
R <sup>2</sup>	.00				
F	.19				
ΔR <sup>2</sup>	.00				
ΔF	.32				

Note. \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 16 provide information regarding the moderation analysis. In model 1, the R<sup>2</sup> value is 0, indicating that there is no significant variation in excessive worry explained by the variables. Similarly, in model 2, perceived family support also demonstrates 0% explanatory power in relation to excessive worry. The interaction effect, with a beta coefficient of -.001 and a p-value of .57, suggests that the moderation provided by perceived family support is not statistically significant. Consequently, the findings indicate that perceived family support does not significantly moderate the relationship between excessive worry and personal growth.

**Table 17**

*Moderating effect of perceived family support on excessive worry and positive relation with others (N=200)*

Predictors	perceived family support				
	Model 1		Model 2		
	$\beta$	SE	<i>t</i>	<i>P</i>	95% CI
Constant	8.08	3.91	2.06	.04	[-.369,15.80]
Excessive worry	.315	.228	1.37	.16	[-.135,.766]
Perceived family support	.079	.055	1.43	.15	[-.029,.188]
Excessive worry*perceived family support	-.004	.003	-1.48	.13	[-.011,.001]
R <sup>2</sup>	.01				
F	.79				
$\Delta R^2$	.01				
$\Delta F$	2.2				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 17 provide information regarding the moderation analysis. In the first model, the R<sup>2</sup> value of 0.01 indicates that none of the variation in excessive worry is accounted for. Similarly, in the second model, perceived family support also explains 0% of the variation. The interaction effect, with a beta coefficient of -.004 and a p-value of .13, suggests that the moderation is not statistically significant. This finding indicates that perceived family support does not significantly moderate the relationship between excessive worry and positive relations with others.

**Table 18***Moderating effect of perceived family support on excessive worry and purpose in life**(N=200)*

Predictors	perceived family support				
	Model 1		Model 2		
	B	SE	<i>t</i>	<i>P</i>	95% CI
Constant	10.9	3.45	3.18	.00	[4.17,17.79]
Excessive worry	.077	.201	.385	.70	[-.320,.475]
Perceived family support	.032	.048	.657	.51	[-.064,.128]
Excessive worry*perceived family support	-.001	.002	-.639	.52	[-.007,.003]
R <sup>2</sup>	.01				
F	.72				
ΔR <sup>2</sup>	.00				
ΔF	.40				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 18 provide information regarding the moderation analysis. In the first model, the R<sup>2</sup> value of .01 indicates that none of the variation in excessive worry is accounted for. Similarly, in the second model, perceived family support also explains 0% of the variation. The interaction effect, with a beta value of -.001 and a p-value of .52, suggests that moderation is not statistically significant. Consequently, the findings imply that perceived family support does not significantly moderate the relationship between excessive worry and purpose in life.

**Table 19***Moderating effect of perceived family support on excessive worry and self-acceptance (N=200)*

Predictors	perceived family support				
	Model 1		Model 2		
	$\beta$	SE	<i>t</i>	<i>P</i>	95% CI
Constant	12.3	3.52	3.51	.00	[5.42,19.33]
Excessive worry	.142	.206	.691	.49	[-.263,.548]
Perceived family support	.049	.049	.986	.32	[-.049,.147]
Excessive worry*perceived family support	-.002	.003	-.744	.45	[-.008,.003]
R <sup>2</sup>	.00				
F	.51				
$\Delta R^2$	.00				
$\Delta F$	.55				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 19 provide information regarding the moderation analysis. In model 1, the R<sup>2</sup> value indicates that there is no variation (0%) in excessive worry accounted for by the model. Similarly, in model 2, perceived family support also demonstrates 0% variation. The interaction effect, with a beta coefficient of -.002 and a p-value of .45, suggests that moderation is not statistically significant. In summary, the findings indicate that perceived family support does not significantly moderate the relationship between excessive worry and self-acceptance.



**Table 20***Moderating effect of resilience on excessive worry and autonomy (N=200)*

Predictors	Resilience				
	Model 1			Model 2	
	B	SE	<i>t</i>	<i>P</i>	95% CI
Constant	13.3	2.95	4.52	.00	[7.55,19.21]
Excessive worry	.110	.21	.50	.61	[-.320,.541]
Resilience	.050	.14	.34	.72	[-.236,.337]
Excessive worry*resilience	-.006	.01	-.59	.55	[-.026,.014]
R <sup>2</sup>	.00				
F	.35				
ΔR <sup>2</sup>	.00				
ΔF	.35				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 20 provide information regarding the moderation analysis. In Model 1, the R<sup>2</sup> value indicates that there is no variation (0%) in excessive worry explained by the variables included. Similarly, in Model 2, resilience also accounts for 0% of the variation. The analysis of the interaction effect reveals a non-significant moderation, with a beta coefficient of -.006 and a p-value of .55. Consequently, the findings suggest that resilience does not significantly moderate the relationship between excessive worry and autonomy.

**Table 21***Moderating effect of resilience on excessive worry and environmental mastery (N=200)*

Predictors	resilience				
	Model 1			Model 2	
	$\beta$	SE	<i>t</i>	<i>P</i>	95% CI
Constant	11.8	3.63	3.24	.00	[4.64,19.00]
Excessive worry	.102	.26	.379	.70	[-.428,.632]
Resilience	.139	.17	.781	.43	[-.213,.492]
Excessive worry*resilience	-.007	.01	-.577	.56	[-.032,.017]
R <sup>2</sup>	.00				
F	.63				
$\Delta R^2$	.00				
$\Delta F$	.33				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 21 provide information regarding the moderation analysis. In model 1, the R<sup>2</sup> value indicates that none of the variation in excessive worry is accounted for (R<sup>2</sup> = .00), suggesting a lack of explanatory power. Similarly, in model 2, resilience fails to explain any variation in excessive worry (R<sup>2</sup> = .00). The interaction effect analysis reveals a non-significant moderation ( $\beta = -.007$ ,  $p = .56$ ), indicating that resilience does not significantly moderate the relationship between excessive worry and environmental mastery.

**Table 22***Moderating effect of resilience on excessive worry and personal growth (N=200)*

Predictors	Resilience				
	Model 1			Model 2	
	B	SE	<i>t</i>	<i>P</i>	95% CI
Constant	13.3	3.05	4.36	.00	[7.305,19.3]
Excessive worry	.220	.22	.973	.33	[-.225,.665]
Resilience	.109	.15	.725	.46	[-.187,.405]
Excessive worry*resilience	-.011	.01	-1.04	.29	[-.032,.010]
R <sup>2</sup>	.00				
F	.53				
ΔR <sup>2</sup>	.00				
ΔF	1.1				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 22 provide information regarding the moderation analysis. In model 1, the R<sup>2</sup> value indicates that there is 0% variation in excessive worry, and similarly, in model 2, resilience also accounts for 0% of the variation. The interaction effect value, with a  $\beta$  of -.011 and p-value of .29, suggests that the moderation is non-significant. Therefore, the findings suggest that resilience does not significantly moderate the relationship between excessive worry and personal growth.

**Table 23***Moderating effect of resilience on excessive worry and Positive relation with other (N=200)*

Predictors	Resilience				
	Model 1		Model 2		
	$\beta$	SE	<i>t</i>	<i>P</i>	95% CI
Constant	10.5	3.84	2.73	.00	[2.94,18.13]
Excessive worry	.28	.28	1.01	.31	[-.272,.850]
Resilience	.14	.18	.753	.45	[-.230,.515]
Excessive worry*resilience	-.01	.01	-1.07	.28	[-.041,.012]
R <sup>2</sup>	.00				
F	.52				
$\Delta R^2$	.00				
$\Delta F$	1.1				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 23 provide information regarding the moderation analysis. In Model 1, the R<sup>2</sup> value of .00 indicates that there is no explanatory power for excessive worry, suggesting that none of the variables in the model account for the variation in excessive worry. Similarly, in Model 2, the resilience variable also demonstrates 0% variation in explaining excessive worry. The interaction effect, with a beta coefficient of -.014 and a p-value of .28, is found to be non-significant. This implies that resilience does not significantly moderate the relationship between excessive worry and positive relations with others.

**Table 24***Moderating effect of resilience on excessive worry and purpose in life (N=200)*

Predictors	Resilience				
	Model 1			Model 2	
	B	SE	<i>t</i>	<i>P</i>	95% CI
Constant	5.08	3.32	1.52	.12	[-1.473,11.6]
Excessive worry	.621	.24	2.52	.01	[.136,1.106]
Resilience	.396	.16	2.42	.01	[.073,.7184]
Excessive worry*resilience	-.032	.01	-2.76	.006	[-.055, .009]
R <sup>2</sup>	.04				
F	3.1				
ΔR <sup>2</sup>	.03				
ΔF	7.6				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 24 provide information regarding the moderation analysis. In model 1, the R<sup>2</sup> value of 0.04 indicates that none of the variation in excessive worry is accounted for. Similarly, in model 2, resilience also demonstrates 0% variation. The interaction effect, with a  $\beta$  of -0.032 and p-value of 0.00, suggests that moderation is not statistically significant. Consequently, the findings indicate that resilience does not significantly moderate the relationship between excessive worry and purpose in life.

**Table 25***Moderating effect of resilience on excessive worry and self-acceptance (N=200)*

Predictors	Resilience				
	Model 1			Model 2	
	$\beta$	SE	<i>t</i>	<i>P</i>	95% CI
Constant	15.7	3.45	4.55	.000	[8.900,22.5]
Excessive worry	.150	.25	.589	.55	[-.352,.653]
Resilience	-.003	.16	-.018	.98	[-.337,.331]
Excessive worry*resilience	-.007	.01	-.628	.53	[-.031,.016]
R <sup>2</sup>	.01				
F	.79				
$\Delta R^2$	.00				
$\Delta F$	.39				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 25 provide information regarding the moderation analysis. In both Model 1 and Model 2, the R<sup>2</sup> values indicate that neither excessive worry nor resilience account for any significant variation. Additionally, the interaction effect suggests that the moderation effect of resilience on the relationship between excessive worry and self-acceptance is not statistically significant ( $\beta = -.007$ ,  $p = .53$ ). In summary, the findings suggest that resilience does not play a significant moderating role in the connection between excessive worry and self-acceptance.

**Table 26***Moderating effect of perceived family support on perfectionism and autonomy (N=200)*

Predictors	Perceived family support				
	Model 1		Model 2		
	B	SE	<i>t</i>	<i>P</i>	95% CI
Constant	14.2	2.35	6.04	.000	[9.576,18.8]
Perfectionism	-.04	.20	-.23	.81	[-.444,.351]
Perceived family support	.00	.03	.09	.92	[-.065,.072]
Perfectionism*perceived family support	.000	.00	.12	.90	[-.005,.006]
R <sup>2</sup>	.00				
F	.20				
ΔR <sup>2</sup>	.00				
ΔF	.01				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 26 provide information regarding the moderation analysis. Model 1 indicates an R<sup>2</sup> value of .00, suggesting that none of the variation in perfectionism is accounted for. Similarly, in Model 2, perceived family support demonstrates 0% of the variation. The interaction effect reveals non-significant moderation ( $\beta = 000$ ,  $p = .90$ ), indicating that perceived family support does not significantly moderate the relationship between perfectionism and autonomy.

**Table 27**

*Moderating effect of perceived family support on perfectionism and environmental mastery*  
(*N=200*)

Predictors	Perceived family support				
	Model 1		Model 2		
	$\beta$	SE	<i>t</i>	<i>P</i>	95% CI
Constant	13.4	2.90	4.63	.000	[7.741,19.1]
Perfectionism	.01	.24	.07	.94	[-.472,.508]
Perceived family support	.01	.04	.31	.75	[-.701,.099]
Perfectionism*perceived family support	-.000	.00	-.23	.81	[-.008,.006]
R <sup>2</sup>	.00				
F	.21				
$\Delta R^2$	.00				
$\Delta F$	.05				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 27 provide information regarding the moderation analysis. In model 1, the R<sup>2</sup> value indicates that there is no variation in perfectionism, accounting for 0% of the variance. Similarly, in model 2, perceived family support also demonstrates 0% variability. The interaction effect reveals non-significance, with a beta coefficient of -.000 and p-value of .81. These findings suggest that perceived family support does not significantly moderate the relationship between perfectionism and environmental mastery.



**Table 28***Moderating effect of perceived family support on perfectionism and personal growth (N=200)*

Predictors	Perceived family support				
	Model 1			Model 2	
	B	SE	<i>t</i>	<i>p</i>	95% CI
Constant	16.4	2.43	6.76	.000	[11.66,21.2]
Perfectionism	-.10	.20	-.52	.60	[-.520,.302]
Perceived family support	-.00	.03	-.22	.81	[-.079,.063]
Perfectionism*perceived family support	.000	.00	.29	.76	[-.005,.007]
R <sup>2</sup>	.00				
F	.39				
ΔR <sup>2</sup>	.00				
ΔF	.08				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 28 provide information regarding the moderation analysis. In the first model, the R<sup>2</sup> value indicates that none of the variation in perfectionism is accounted for (R<sup>2</sup> = .00), suggesting a lack of explanatory power. Similarly, in the second model, perceived family support also fails to explain any variation in perfectionism (R<sup>2</sup> = .00). The interaction effect further supports this observation, as its non-significant coefficient ( $\beta = .000$ ,  $p = .76$ ) implies that perceived family support does not significantly moderate the relationship between perfectionism and personal growth. Overall, the findings suggest that perceived family support does not play a significant moderating role in the connection between perfectionism and personal growth.

**Table 29**

*Moderating effect of perceived family support on perfectionism and positive relation with others (N=200)*

Predictors	Perceived family support				
	Model 1		Model 2		
	$\beta$	SE	<i>t</i>	<i>P</i>	95% CI
Constant	13.8	3.07	4.50	.000	[7.77,19.89]
Perfectionism	-.07	.26	-.27	.78	[-.591,.447]
Perceived family support	-.00	.04	-.12	.90	[-.095,.084]
Perfectionism*perceived family support	.000	.00	.21	.83	[-.007,.008]
R <sup>2</sup>	.00				
F	.06				
$\Delta R^2$	.00				
$\Delta F$	.04				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 29 provide information regarding the moderation analysis. In the first model, the R<sup>2</sup> value indicates that none of the variation in perfectionism is accounted for (R<sup>2</sup> = .00), suggesting a lack of explanatory power. Similarly, in the second model, perceived family support also explains none of the variation in perfectionism (R<sup>2</sup> = .00). The interaction effect analysis reveals a non-significant moderation, with a beta coefficient of .000 and a p-value of .76. These findings suggest that perceived family support does not significantly moderate the relationship between perfectionism and positive relations with others.

**Table 30***Moderating effect of perceived family support on perfectionism and purpose in life (N=200)*

Predictors	Perceived family support				
	Model 1			Model 2	
	B	SE	<i>t</i>	<i>p</i>	95% CI
Constant	11.3	2.70	4.19	.000	[6.015,16.6]
Perfectionism	.05	.23	.24	.81	[-.401,.512]
Perceived family support	.02	.04	.55	.58	[-.057,.101]
Perfectionism*perceived family support	-.00	.00	-.36	.71	[-.008,.005]
R <sup>2</sup>	.00				
F	.25				
ΔR <sup>2</sup>	.00				
ΔF	.13				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 30 provide information regarding the moderation analysis. In the first model, the R<sup>2</sup> value of .00 indicates that there is no variation in perfectionism, accounting for 0%. Similarly, in the second model, perceived family support also demonstrates 0% variation. The interaction effect value, with a  $\beta$  of -.001 and p-value of .71, suggests that moderation is not statistically significant. Consequently, the findings indicate that perceived family support does not significantly moderate the relationship between perfectionism and purpose in life.

**Table 31***Moderating effect of perceived family support on perfectionism and self-acceptance (N=200)*

Predictors	Perceived family support				
	Model 1			Model 2	
	$\beta$	SE	<i>t</i>	<i>p</i>	95% CI
Constant	14.3	2.73	5.23	.000	[8.910,19.6]
Perfectionism	.04	.23	.17	.86	[-.422,.502]
Perceived family support	.03	.04	.84	.39	[-.046,.115]
Perfectionism*perceived family support	-.00	.00	-.55	.58	[-.008,.005]
R <sup>2</sup>	.01				
F	1.3				
$\Delta R^2$	.00				
$\Delta F$	.30				

Note. \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 31 provide information regarding the moderation analysis. In the first model, the R<sup>2</sup> value of .01 indicates that none of the variation in perfectionism is accounted for. Similarly, in the second model, perceived family support also demonstrates no contribution to the variation (R<sup>2</sup> = 0%). The interaction effect, with a beta coefficient of -.001 and a p-value of .58, suggests that moderation is not statistically significant. Therefore, the findings suggest that perceived family support does not significantly moderate the relationship between perfectionism and self-acceptance.

**Table 32***Moderating effect of resilience on perfectionism and autonomy (N=200)*

Predictors	Perceived family support				
	Model 1			Model 2	
	B	SE	<i>t</i>	<i>P</i>	95% CI
Constant	16.2	2.95	5.48	.000	[10.37,22.0]
Perfectionism	-.14	.26	-.54	.58	[-.670,.379]
Resilience	-.09	.15	-.60	.54	[-.387,.204]
Perfectionism*resilience	.006	.01	.48	.62	[-.019,.031]
R <sup>2</sup>	.00				
F	.22				
ΔR <sup>2</sup>	.00				
ΔF	.23				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 32 provide information regarding the moderation analysis. In Model 1, the R<sup>2</sup> value indicates that there is only a 0% explanation for the variation in perfectionism. Similarly, in Model 2, resilience also contributes 0% to the explanation of the variation. The value for the interaction effect suggests that moderation is not statistically significant ( $\beta = .006$ ,  $p = .62$ ). Therefore, the findings indicate that resilience does not significantly moderate the relationship between perfectionism and autonomy.

**Table 33***Moderating effect of resilience on perfectionism and environmental mastery (N=200)*

Predictors	Resilience				
	Model 1		Model 2		
	$\beta$	SE	<i>t</i>	<i>P</i>	95% CI
Constant	15.6	3.63	4.29	.000	[8.43,22.78]
Perfectionism	-.25	.32	-.77	.44	[-.900,.393]
Resilience	-.05	.18	-.30	.75	[-.421,.307]
Perfectionism*resilience	.01	.01	.62	.53	[-.021,.041]
R <sup>2</sup>	.00				
F	.42				
$\Delta R^2$	.00				
$\Delta F$	.39				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 33 provide information regarding the moderation analysis. In the first model, the R<sup>2</sup> value of .00 indicates that none of the variation in perfectionism is accounted for. Similarly, in the second model, resilience also demonstrates 0% variation. The interaction effect, with a beta coefficient of .01 and a p-value of .53, reveals that moderation is not statistically significant. Therefore, the findings suggest that resilience does not significantly moderate the relationship between perfectionism and environmental mastery.

**Table 34***Moderating effect of resilience on perfectionism and personal growth (N=200)*

Predictors	Resilience				
	Model 1		Model 2		
	B	SE	<i>t</i>	<i>P</i>	95% CI
Constant	16.1	3.05	5.27	.000	[10.08,22.1]
Perfectionism	-.02	.27	-.10	.91	[-.572,.513]
Resilience	-.01	.15	-.07	.93	[-.318,.294]
Perfectionism*resilience	-.000	.01	-.05	.95	[-.027,.025]
R <sup>2</sup>	.00				
F	.39				
ΔR <sup>2</sup>	.00				
ΔF	.00				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 34 provide information regarding the moderation analysis. In the first model, the R<sup>2</sup> value indicates that there is no variation (0%) in perfectionism. Similarly, in the second model, resilience also shows 0% variation. The interaction effect value reveals that moderation is not statistically significant ( $\beta = -.00$ ,  $p = .95$ ). The findings suggest that resilience does not significantly moderate the relationship between perfectionism and personal growth.

**Table 35***Moderating effect of resilience on perfectionism and positive relation with others (N=200)*

Predictors	Resilience				
	Model 1		Model 2		
	$\beta$	SE	<i>t</i>	<i>P</i>	95% CI
Constant	10.3	3.84	2.70	.007	[2.796,17.9]
Perfectionism	.36	.34	1.06	.28	[-.313,1.05]
Resilience	.15	.19	.77	.43	[-.232,.537]
Perfectionism*resilience	-.01	.01	-1.10	.26	[-.052,.014]
R <sup>2</sup>	.00				
F	.52				
$\Delta R^2$	.00				
$\Delta F$	1.2				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 35 provide information regarding the moderation analysis. In Model 1, the R<sup>2</sup> value indicates that none of the variation in perfectionism is accounted for (R<sup>2</sup> = 0%). Similarly, in Model 2, resilience contributes to 0% of the variation. The interaction effect, with a beta coefficient of -.01 and a p-value of .26, suggests that moderation is not statistically significant. Therefore, the findings imply that resilience does not significantly moderate the relationship between perfectionism and positive relations with others.



**Table 36**

*Moderating effect of resilience on perfectionism, control trauma and purpose in life (N=200)*

Predictors	Resilience					
	Model 1			Model 2	95% CI	
	B	SE	<i>t</i>	<i>p</i>	LL	UL
Constant	-1.44	8.48	-.16	.86	-18.26	15.38
Perfectionism	1.18	.59	1.99	.04	.008	2.36
Resilience	.65	.40	1.59	.01	-.157	1.45
Perfectionism*resilience	-.05	.02	-1.99	.04	-.111	-.000
R <sup>2</sup>	.04					
F	1.6					
ΔR <sup>2</sup>	.03					
ΔF	3.9					

*Note.* \*\*\* $p < .001$ . \*\* $p < .01$ . \* $p < .05$

**Main effect of predictor.** At the mean value of perfectionism control trauma there was a significant positive relationship between and purpose in life  $\beta=1.18$ ,  $t=1.99$ ,  $p<.05$ , 95% CI (.008-2.36).

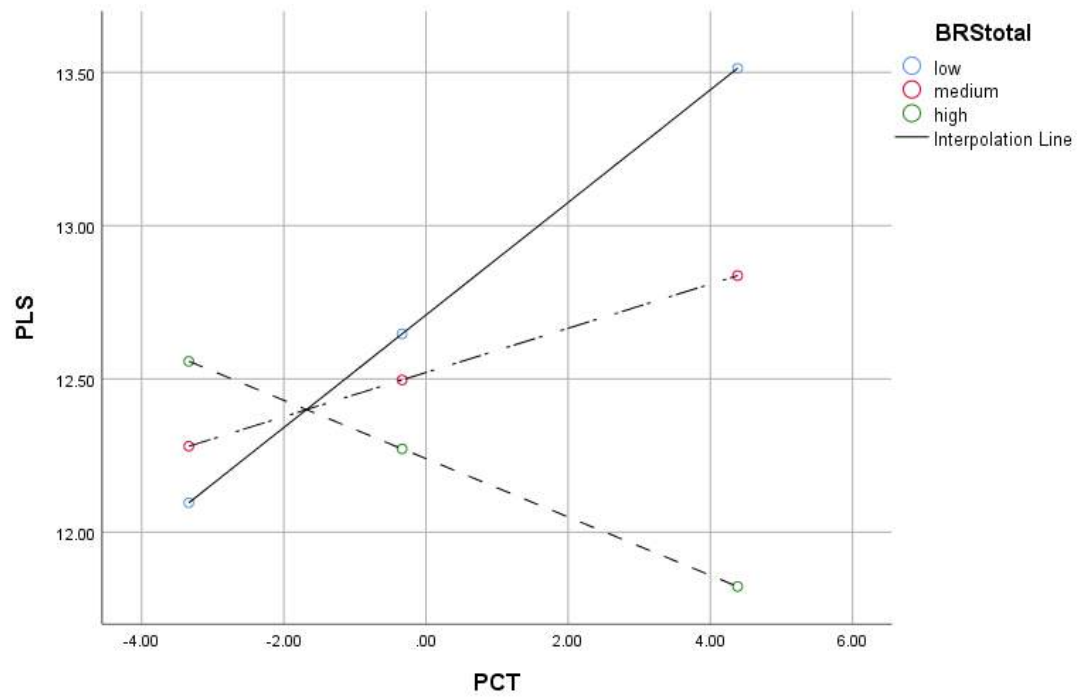
**Main effect of the moderator.** At the mean value of the resilience there was a significant positive relationship between resilience and purpose in life.  $\beta= .65$ ,  $t= 1.59$ ,  $p<.05$ , 95% CI (-.157-1.45).

**Interaction.** There is a significant interaction between perfectionism and resilience in predicting purpose in life  $\beta= -.05$ ,  $t= -1.99$ ,  $p< .05$ , 95%CI (-.111, -.000). This indicates that

relationship between perfectionism control trauma and purpose in life is conditional upon resilience.

## Figure 2

Figure showing moderating effect of resilience on perfectionism control trauma and purpose in life ( $N=200$ )



**Table 37***Moderating effect of resilience on perfectionism and self-acceptance (N=200)*

Predictors	Resilience				
	Model 1		Model 2		
	B	SE	<i>t</i>	<i>p</i>	95% CI
Constant	15.1	3.42	4.42	.000	[8.40,21.92]
Perfectionism	.18	.30	.60	.54	[-.422,.795]
Resilience	.06	.17	.35	.72	[-.281,.405]
Perfectionism*resilience	-.01	.01	-.85	.39	[-.042,.016]
R <sup>2</sup>	.02				
F	1.4				
ΔR <sup>2</sup>	.00				
ΔF	.72				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 37 provide information regarding the moderation analysis. In model 1, the R<sup>2</sup> value of 0.02 indicates that there is no significant variation in perfectionism. Similarly, in model 2, resilience also exhibits 0% variation. The interaction effect, with a beta ( $\beta$ ) of -0.01 and a p-value of 0.39, suggests that moderation is not statistically significant. These findings imply that resilience does not significantly moderate the relationship between perfectionism and self-acceptance.

**Table 38***Moderating effect of perceived family support on social anxiety and autonomy (N=200)*

Predictors	perceived family support				
	Model 1			Model 2	
	$\beta$	SE	<i>t</i>	<i>P</i>	95% CI
Constant	13.7	1.72	7.97	.000	[10.37,17.1]
Social anxiety	.04	.25	.18	.85	[-.449,.544]
Perceived family support	.01	.02	.63	.52	[-.033,.064]
Social anxiety*perceived family support	-.00	.00	-.74	.45	[-.010,.004]
R <sup>2</sup>	.02				
F	1.7				
$\Delta R^2$	.00				
$\Delta F$	.56				

Note. \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 38 provide information regarding the moderation analysis. In Model 1, the R<sup>2</sup> value of .02 indicates that none of the variation in social anxiety is accounted for. Similarly, in Model 2, perceived family support also contributes 0% to the variation. The interaction effect value of -.00 with a p-value of .45 suggests that the moderation is not statistically significant. Therefore, the findings indicate that perceived family support does not significantly moderate the relationship between social anxiety and autonomy.

**Table 39**

*Moderating effect of perceived family support on social anxiety and environmental mastery (N=200)*

Predictors	perceived family support				
	Model 1		Model 2		
	B	SE	<i>t</i>	<i>P</i>	95% CI
Constant	12.8	2.15	5.98	.000	[8.63,17.12]
Social anxiety	.16	.31	.51	.61	[-.458,.779]
Perceived family support	.02	.03	.66	.50	[-.040,.081]
Social anxiety*perceived family support	-.00	.00	-.76	.44	[-.012,.005]
R <sup>2</sup>	.00				
F	.49				
ΔR <sup>2</sup>	.00				
ΔF	.58				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 39 provide information regarding the moderation analysis. In model 1, the R<sup>2</sup> value indicates that none of the variation in social anxiety is accounted for (0%). Similarly, in model 2, perceived family support also demonstrates no explanatory power, with 0% variation in the context of social anxiety. The interaction effect, reflected by a non-significant moderation ( $\beta = -.00$ ,  $p = .44$ ), suggests that perceived family support does not significantly moderate the relationship between social anxiety and environmental mastery.

**Table 40***Moderating effect of perceived family support on social anxiety and personal growth (N=200)*

Predictors	perceived family support				
	Model 1			Model 2	
	$\beta$	SE	<i>t</i>	<i>p</i>	95% CI
Constant	16.3	1.80	9.05	.000	[12.80,19.9]
Social anxiety	-.17	.26	-.65	.51	[-.693,.346]
Perceived family support	-.01	.02	-.40	.68	[-.061,.040]
Social anxiety*perceived family support	.001	.00	.43	.66	[-.006,.009]
R <sup>2</sup>	.00				
F	.35				
$\Delta R^2$	.00				
$\Delta F$	.19				

Note. \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 40 provide information regarding the moderation analysis. In model 1, the R<sup>2</sup> value is 0.00, indicating that there is no variation (0%) in social anxiety explained by the variables. Similarly, in model 2, perceived family support also accounts for 0% of the variation. The interaction effect, with a  $\beta$  of 0.00 and p-value of 0.66, suggests that moderation is not statistically significant. Consequently, the findings indicate that perceived family support does not significantly moderate the relationship between social anxiety and personal growth.

**Table 41**

*Moderating effect of perceived family support on social anxiety and positive relation with others (N=200)*

Predictors	perceived family support				
	Model 1			Model 2	
	B	SE	<i>t</i>	<i>p</i>	95% CI
Constant	15.7	2.26	6.95	.000	[11.29,20.2]
Social anxiety	-.43	.33	-1.30	.19	[-1.08,.222]
Perceived family support	-.03	.03	-.92	.35	[-.094,.034]
Social anxiety*perceived family support	.005	.005	1.02	.30	[-.004,.014]
R <sup>2</sup>	.01				
F	.84				
ΔR <sup>2</sup>	.00				
ΔF	1.0				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 41 provide information regarding the moderation analysis. In model 1, the R<sup>2</sup> value of .01 indicates that there is a 0% explanation for the variation in social anxiety. Similarly, in model 2, perceived family support also demonstrates 0% of the variation. The interaction effect value, with a  $\beta$  of .00 and a p-value of .30, reveals that moderation is not statistically significant. Consequently, the findings suggest that perceived family support does not significantly moderate the relationship between social anxiety and positive relations with others.

**Table 42***Moderating effect of perceived family support on social anxiety and purpose in life (N=200)*

Predictors	perceived family support				
	Model 1			Model 2	
	$\beta$	SE	<i>t</i>	<i>p</i>	95% CI
Constant	12.4	1.99	6.26	.000	[8.55,16.41]
Social anxiety	-.03	.29	-.13	.89	[-.613,.533]
Perceived family support	.009	.02	.32	.74	[-.047,.065]
Social anxiety*perceived family support	-.001	.004	-.32	.74	[-.010,.007]
R <sup>2</sup>	.01				
F	1.1				
$\Delta R^2$	.00				
$\Delta F$	.10				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 42 provide information regarding the moderation analysis. In the first model, the R<sup>2</sup> value is 0.01, indicating that it explains 0% of the variation in social anxiety. Similarly, in the second model, perceived family support also accounts for 0% of the variation. The interaction effect value reveals non-significance ( $\beta = -0.00$ ,  $p = 0.74$ ), suggesting that perceived family support does not significantly moderate the relationship between social anxiety and purpose in life.



**Table 43***Moderating effect of perceived family support on social anxiety and self-acceptance (N=200)*

Predictors	perceived family support				
	Model 1		Model 2		
	B	SE	<i>t</i>	<i>p</i>	95% CI
Constant	15.0	2.03	7.37	.000	[11.0,19.02]
Social anxiety	-.01	.29	-.06	.94	[-.604,.566]
Perceived family support	.01	.02	.56	.57	[-.041,.074]
Social anxiety*perceived family support	-.001	.004	-.31	.75	[-.010,.007]
R <sup>2</sup>	.01				
F	1.0				
ΔR <sup>2</sup>	.00				
ΔF	.09				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 43 provide information regarding the moderation analysis. In the first model, the R<sup>2</sup> value is .01, indicating that there's a 0% explanation for the variation in social anxiety. Similarly, in the second model, perceived family support also demonstrates 0% explanation. The interaction effect value of -0.00 with a p-value of .74 suggests that moderation is not statistically significant. Consequently, the findings indicate that perceived family support does not significantly moderate the relationship between social anxiety and self-acceptance.

**Table 44***Moderating effect of resilience on social anxiety and autonomy (N=200)*

Predictors	Resilience				
	Model 1		Model 2		
	$\beta$	SE	<i>T</i>	<i>p</i>	95% CI
Constant	14.6	2.18	6.70	.000	[10.3,18.91]
Social anxiety	-.01	.43	-.02	.97	[-.860,.838]
Resilience	.01	.11	.09	.92	[-.206,.227]
Social anxiety*resilience	-.00	.02	-.28	.77	[-.048,.035]
R <sup>2</sup>	.02				
F	1.6				
$\Delta R^2$	.00				
$\Delta F$	.08				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 44 provide information regarding the moderation analysis. In Model 1, the R<sup>2</sup> value of 0.02 indicates that none of the variation in social anxiety is accounted for. Similarly, in Model 2, resilience also contributes 0% to the variation. The interaction effect is deemed non-significant ( $\beta = -0.00$ ,  $p = 0.77$ ), suggesting that resilience does not significantly moderate the relationship between social anxiety and autonomy. Therefore, the findings indicate that resilience does not play a significant moderating role in the association between social anxiety and autonomy.

**Table 45***Moderating effect of resilience on social anxiety and environmental mastery (N=200)*

Predictors	Resilience				
	Model 1		Model 2		
	B	SE	T	P	95% CI
Constant	12.7	2.71	4.69	.000	[7.38,18.09]
Social anxiety	.11	.53	.22	.82	[-.938,1.17]
Resilience	.07	.13	.56	.56	[-.192,.348]
Social anxiety*resilience	-.009	.02	-.37	.71	[-.062,.042]
R <sup>2</sup>	.00				
F	.41				
ΔR <sup>2</sup>	.00				
ΔF	.13				

*Note.* \*\*\* $p < .001$ . \*\* $p < .01$ . \* $p < .05$

Table no 45 provide information regarding the moderation analysis. In model 1, the R<sup>2</sup> value of .00 indicates that there is no discernible impact on social anxiety, suggesting a lack of variation. Similarly, in model 2, resilience also demonstrates a 0% influence on the variation in social anxiety. The interaction effect, with a beta ( $\beta$ ) of -.00 and p-value of .71, reveals that moderation is not statistically significant. In essence, the findings suggest that resilience does not significantly moderate the relationship between social anxiety and environmental mastery.

**Table 46***Moderating effect of resilience on social anxiety and personal growth (N=200)*

Predictors	Resilience				
	Model 1		Model 2		
	B	SE	<i>t</i>	<i>P</i>	95% CI
Constant	15.1	2.27	6.65	.000	[10.67,19.6]
Social anxiety	.20	.45	.45	.64	[-.683,1.09]
Resilience	.02	.11	.21	.83	[-.202,.251]
Social anxiety*resilience	-.01	.02	-.58	.55	[-.056,.030]
R <sup>2</sup>	.00				
F	.47				
ΔR <sup>2</sup>	.00				
ΔF	.34				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 46 provide information regarding the moderation analysis. In Model 1, the R<sup>2</sup> value is 0.00, indicating that none of the variation in social anxiety is accounted for. Similarly, in Model 2, resilience also demonstrates 0% of the variation. The interaction effect is non-significant ( $\beta = -0.01$ ,  $p = 0.55$ ), suggesting that resilience does not significantly moderate the relationship between social anxiety and personal growth.

**Table 47***Moderating effect of resilience on social anxiety and positive relation with others (N=200)*

Predictors	Resilience				
	Model 1			Model 2	
	B	SE	<i>t</i>	<i>p</i>	95% CI
Constant	15.3	2.86	5.36	.000	[9.720,21.0]
Social anxiety	-.32	.56	-.58	.56	[-1.44,.787]
Resilience	-.08	.14	-.57	.56	[-.368,.202]
Social anxiety*resilience	.01	.02	.42	.67	[-.043,.067]
R <sup>2</sup>	.00				
F	.60				
ΔR <sup>2</sup>	.00				
ΔF	.17				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 47 provide information regarding the moderation analysis. In Model 1, the R<sup>2</sup> value of 0.00 indicates that there is no accounting for variation in social anxiety. Similarly, in Model 2, resilience also demonstrates 0% variation. The interaction effect, with a  $\beta$  of 0.01 and p-value of 0.67, suggests that the moderation is not statistically significant. Thus, the findings indicate that resilience does not significantly moderate the relationship between social anxiety and positive relations with others.

**Table 48***Moderating effect of resilience on social anxiety and purpose in life (N=200)*

Predictors	Resilience				
	Model 1		Model 2		
	$\beta$	SE	<i>t</i>	<i>p</i>	95% CI
Constant	9.73	2.49	3.90	.000	[4.815,14.6]
Social anxiety	.72	.49	1.48	.14	[-.241,1.70]
Resilience	.17	.12	1.35	.17	[-.077,.419]
Social anxiety*resilience	-.04	.02	-1.76	.07	[-.091,.005]
R <sup>2</sup>	.03				
F	2.2				
$\Delta R^2$	.01				
$\Delta F$	3.1				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 48 provide information regarding the moderation analysis. In Model 1, the R<sup>2</sup> value of .03 indicates that there is a 0% contribution to the variation in social anxiety. Similarly, in Model 2, resilience also accounts for 0% of the variation. The interaction effect value, reflecting moderation, is non-significant ( $\beta = -.04$ ,  $p = .07$ ). This suggests that the moderation effect of resilience on the relationship between social anxiety and purpose in life is not statistically significant.

**Table 49***Moderating effect of resilience on social anxiety and self-acceptance (N=200)*

Predictors	Resilience				
	Model 1			Model 2	
	B	SE	<i>t</i>	<i>p</i>	95% CI
Constant	16.1	2.55	6.32	.000	[11.13,21.2]
Social anxiety	.28	.50	.57	.56	[-.707,1.28]
Resilience	-.00	.12	-.02	.98	[-.257,.251]
Social anxiety*resilience	-.01	.02	-.79	.42	[-.069,.029]
R <sup>2</sup>	.02				
F	1.5				
ΔR <sup>2</sup>	.00				
ΔF	.62				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 49 provide information regarding the moderation analysis. In the first model, the R<sup>2</sup> value is 0.02, indicating that there is no significant contribution to explaining the variation in social anxiety. Similarly, in the second model, resilience also fails to account for any substantial variation (R<sup>2</sup> = 0). The interaction effect, with a beta coefficient of -0.01 and a p-value of 0.42, suggests that the moderation by resilience is not statistically significant. In conclusion, the findings suggest that resilience does not significantly moderate the relationship between social anxiety and self-acceptance.

**Table 50***Moderating effect of perceived family support on Acute anxiety adjustment and autonomy**(N=200)*

Predictors	perceived family support				
	Model 1		Model 2		
	B	SE	<i>t</i>	<i>p</i>	95% CI
Constant	12.3	2.12	5.83	.000	[8.19,16.56]
Acute anxiety adjustment	.14	.19	.76	.44	[-.231,.524]
Perceived family support	.03	.03	1.00	.31	[-.029,.090]
Acute anxiety adjustment*Perceived family support	-.002	.002	-.92	.35	[-.008,.003]
R <sup>2</sup>	.00				
F	.51				
ΔR <sup>2</sup>	.00				
ΔF	.85				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 50 provide information regarding the moderation analysis. In model 1, the R<sup>2</sup> value indicates that there is no significant variation (0%) in acute anxiety adjustment. Similarly, in model 2, perceived family support also demonstrates 0% variation. The interaction effect value reveals that the moderation is not statistically significant ( $\beta = -.00$ ,  $p = .35$ ). Therefore, the findings suggest that perceived family support does not significantly moderate the relationship between acute anxiety adjustment and autonomy.



**Table 51**

*Moderating effect of perceived family support on Acute anxiety adjustment and environmental mastery (N=200)*

Predictors	perceived family support				
	Model 1		Model 2		
	B	SE	<i>t</i>	<i>p</i>	95% CI
Constant	12.0	2.16	4.63	.000	[6.94,17.25]
Acute anxiety adjustment	.18	.23	.76	.44	[-.285,.645]
Perceived family support	.03	.03	.89	.36	[-.040,.107]
Acute anxiety adjustment*Perceived family support	-.003	.003	-1.01	.31	[-.010,.003]
R <sup>2</sup>	.01				
F	.67				
ΔR <sup>2</sup>	.00				
ΔF	1.0				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 51 provide information regarding the moderation analysis. In model 1, the R<sup>2</sup> value of .01 indicates that there is no significant contribution to the variation in acute anxiety adjustment. Similarly, in model 2, perceived family support also demonstrates 0% influence on the variation. The interaction effect value, with a  $\beta$  of -.00 and p-value of .31, reveals non-significant moderation. This suggests that perceived family support does not significantly moderate the relationship between acute anxiety adjustment and environmental mastery.

**Table 52**

*Moderating effect of perceived family support on Acute anxiety adjustment and personal growth (N=200)*

Predictors	perceived family support				
	Model 1	Model 2			
	B	SE	<i>t</i>	<i>P</i>	95% CI
Constant	14.0	2.18	6.43	.000	[9.74,18.36]
Acute anxiety adjustment	.15	.19	.77	.43	[-.235,.542]
Perceived family support	.02	.03	.90	.36	[-.033,.089]
Acute anxiety adjustment*Perceived family support	-.003	.00	-1.15	.24	[-.009,.002]
R <sup>2</sup>	.01				
F	1.2				
ΔR <sup>2</sup>	.00				
ΔF	1.3				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 52 provide information regarding the moderation analysis. In model 1, the R<sup>2</sup> value of .01 indicates that there is no significant contribution to the variation in acute anxiety adjustment. Similarly, in model 2, perceived family support also demonstrates no substantial impact on the variation. The interaction effect, with a value of  $\beta = -.00$  and  $p = .24$ , suggests that the moderation is not statistically significant. The findings suggest that perceived family support does not play a significant moderating role in the relationship between acute anxiety adjustment and personal growth.

**Table 53**

*Moderating effect of perceived family support on Acute anxiety adjustment and positive relation with others (N=200)*

Predictors	perceived family support				
	Model 1		Model 2		
	B	SE	<i>t</i>	<i>P</i>	95% CI
Constant	10.1	2.76	3.67	.000	[4.69,15.59]
Acute anxiety adjustment	.30	.24	1.21	.22	[-.188,.795]
Perceived family support	.04	.03	1.22	.22	[-.029,.126]
Acute anxiety adjustment*Perceived family support	-.004	.003	-1.30	.19	[-.012,.002]
R <sup>2</sup>	.00				
F	.60				
ΔR <sup>2</sup>	.00				
ΔF	1.7				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 53 provide information regarding the moderation analysis. In the first model, the R<sup>2</sup> value indicates that there is no variation (0%) in acute anxiety adjustment. Similarly, in the second model, perceived family support also demonstrates 0% variation. The interaction effect value, with a  $\beta$  of -.00 and p-value of .19, suggests that moderation is not statistically significant. Consequently, the findings indicate that perceived family support does not significantly moderate the relationship between acute anxiety adjustment and positive relations with others.

**Table 54**

*Moderating effect of perceived family support on Acute anxiety adjustment and purpose in life (N=200)*

Predictors	perceived family support				
	Model 1		Model 2		
	B	SE	<i>t</i>	<i>p</i>	95% CI
Constant	12.2	2.41	5.05	.000	[7.47,17.01]
Acute anxiety adjustment	.01	.21	.06	.94	[-.415,.445]
Perceived family support	.01	.03	.46	.64	[-.052,.084]
Acute anxiety adjustment*Perceived family support	-.001	.003	-.54	.58	[-.008,.004]
R <sup>2</sup>	.02				
F	1.5				
ΔR <sup>2</sup>	.00				
ΔF	.29				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 54 provide information regarding the moderation analysis. In model 1, the R<sup>2</sup> value of 0.02 indicates that there is no significant contribution to the variation in acute anxiety adjustment. Similarly, in model 2, perceived family support also explains 0% of the variation. The interaction effect value, with a  $\beta$  of -0.00 and p-value of 0.58, reveals that moderation is not statistically significant. Therefore, the findings suggest that perceived family support does not significantly moderate the relationship between acute anxiety adjustment and purpose in life.

**Table 55**

*Moderating effect of perceived family support on Acute anxiety adjustment and self-acceptance (N=200)*

Predictors	perceived family support				
	Model 1		Model 2		
	B	SE	<i>t</i>	<i>p</i>	95% CI
Constant	7.58	2.06	3.66	.000	[3.50,11.66]
Acute anxiety adjustment	-.06	.18	-.35	.72	[-.435,.301]
Perceived family support	-.08	.02	-2.78	.00	[-.140, -.02]
Acute anxiety adjustment*Perceived family support	.00	.00	2.04	.04	[.000,.0112]
R <sup>2</sup>	.27				
F	24				
ΔR <sup>2</sup>	.01				
ΔF	4.1				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 55 provide information regarding the moderation analysis. In Model 1, the R<sup>2</sup> value of 0.27 indicates the percentage of variation in acute anxiety adjustment. In Model 2, perceived family support accounts for 0% of the variation. The interaction effect, with a  $\beta$  value of 0.00 and p-value of 0.04, suggests that moderation is not statistically significant. The findings indicate that perceived family support does not significantly moderate the relationship between acute anxiety adjustment and self-acceptance.

**Table 56***Moderating effect of resilience on Acute anxiety adjustment and autonomy (N=200)*

Predictors	Resilience				
	Model 1		Model 2		
	B	SE	<i>t</i>	<i>p</i>	95% CI
Constant	18.0	2.38	7.55	.000	[13.31,22.7]
Acute anxiety adjustment	-.46	.28	-1.61	.10	[-1.02,.103]
Resilience	-.17	.11	-1.49	.13	[-.410,.056]
Acute anxiety adjustment*resilience	.02	.01	1.53	.12	[-.006,.048]
R <sup>2</sup>	.01				
F	1.0				
ΔR <sup>2</sup>	.01				
ΔF	2.3				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 56 provide information regarding the moderation analysis. In model 1, the R<sup>2</sup> value of .01 indicates that none of the variation in acute anxiety adjustment is accounted for. Similarly, in model 2, resilience also contributes 0% to the variation. The interaction effect, with a beta coefficient of .02 and a p-value of .12, suggests that the moderation by resilience is not statistically significant. In summary, resilience does not exhibit a significant moderating role in the relationship between acute anxiety adjustment and autonomy.

**Table 57***Moderating effect of resilience on Acute anxiety adjustment and environmental mastery**(N=200)*

Predictors	Resilience				
	Model 1		Model 2		
	B	SE	<i>t</i>	<i>p</i>	95% CI
Constant	17.6	2.9	6.02	.000	[11.8,23.45]
Acute anxiety adjustment	-.63	.35	-1.81	.07	[-1.33,.056]
Resilience	-.15	.14	-1.08	.27	[-.445,.128]
Acute anxiety adjustment*resilience	.02	.01	1.66	.09	[-.005,.061]
R <sup>2</sup>	.02				
F	1.3				
ΔR <sup>2</sup>	.01				
ΔF	2.7				

Note. \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 57 provide information regarding the moderation analysis. In the first model, the R<sup>2</sup> value of .02 indicates that there is no significant contribution to the variation in acute anxiety adjustment. Similarly, in the second model, resilience also fails to account for a significant portion of the variation. Moreover, the interaction effect value of  $\beta = .02$  with  $p = .09$  suggests that the moderation effect of resilience between acute anxiety adjustment and environmental mastery is not statistically significant.

**Table 58***Moderating effect of resilience on Acute anxiety adjustment and personal growth (N=200)*

Predictors	Resilience				
	Model 1		Model 2		
	B	SE	<i>t</i>	<i>p</i>	95% CI
Constant	16.4	2.47	6.66	.000	[11.61,21.3]
Acute anxiety adjustment	-.09	.29	-.31	.75	[-.680,.493]
Resilience	-.02	.12	-.23	.81	[-.270,.213]
Acute anxiety adjustment*resilience	.00	.01	.10	.91	[-.026,.029]
R <sup>2</sup>	.01				
F	.77				
ΔR <sup>2</sup>	.00				
ΔF	.01				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 58 provide information regarding the moderation analysis. In the first model, the R<sup>2</sup> value of .01 indicates that there is no substantial variation (0%) in acute anxiety adjustment. Similarly, in the second model, resilience also demonstrates 0% variation. The interaction effect is deemed non-significant, with a  $\beta$  value of .00 and a p-value of .91. Consequently, the findings suggest that resilience does not significantly moderate the relationship between acute anxiety adjustment and personal growth.



**Table 59**

*Moderating effect of resilience on Acute anxiety adjustment and positive relation with others*  
(*N=200*)

Predictors	Resilience				
	Model 1		Model 2		
	B	SE	<i>t</i>	<i>p</i>	95% CI
Constant	15.7	3.12	5.02	.000	[9.55,21.89]
Acute anxiety adjustment	-.22	.37	-.58	.55	[-.962,.521]
Resilience	-.11	.15	-.75	.45	[-.422,.189]
Acute anxiety adjustment*Resilience	.010	.01	.56	.57	[-.025,.045]
R <sup>2</sup>	.00				
F	.22				
ΔR <sup>2</sup>	.00				
ΔF	.32				

*Note.* \*\*\**p*<.001, \*\**p*<.01, \**p*<.05

Table no 59 provide information regarding the moderation analysis. In Model 1, the R<sup>2</sup> value indicates that there is no variation (0%) in acute anxiety adjustment. Similarly, in Model 2, resilience also accounts for 0% of the variation. The interaction effect value of moderation is non-significant ( $\beta = .01$ ,  $p = .57$ ), suggesting that resilience does not significantly moderate the relationship between acute anxiety adjustment and positive relations with others.

**Table 60***Moderating effect of resilience on Acute anxiety adjustment and purpose in life (N=200)*

Predictors	Resilience				
	Model 1		Model 2		
	B	SE	<i>t</i>	<i>p</i>	95% CI
Constant	9.72	2.71	3.58	.000	[4.37,15.08]
Acute anxiety adjustment	.39	.32	1.21	.22	[-.247,1.04]
Resilience	1.77	.13	1.31	.18	[-.088,.443]
Acute anxiety adjustment*resilience	-.02	.01	-1.53	.12	[-.054,.006]
R <sup>2</sup>	.03				
F	2.2				
ΔR <sup>2</sup>	.01				
ΔF	2.3				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 60 provide information regarding the moderation analysis. In Model 1, the R<sup>2</sup> value of .03 indicates that there is no significant contribution to the variation in acute anxiety adjustment. Similarly, in Model 2, resilience also fails to account for a significant proportion of the variance, as evidenced by the 0% variation. The interaction effect, with a beta coefficient of -.02 and a p-value of .12, suggests that moderation is not statistically significant. In summary, the findings suggest that resilience does not play a significant moderating role in the relationship between acute anxiety adjustment and purpose in life.

**Table 61***Moderating effect of resilience on Acute anxiety adjustment and self-acceptance (N=200)*

Predictors	Resilience				
	Model 1		Model 2		
	B	SE	<i>t</i>	<i>p</i>	95% CI
Constant	15.5	2.78	5.59	.000	[10.08,21.0]
Acute anxiety adjustment	.24	.33	.72	.42	[-.419,.901]
Resilience	.02	.13	.17	.86	[-.248,.296]
Acute anxiety adjustment*resilience	-.01	.01	-.91	.36	[-.046,.017]
R <sup>2</sup>	.02				
F	1.4				
ΔR <sup>2</sup>	.00				
ΔF	.82				

*Note.* \*\*\* $p < .001$ , \*\* $p < .01$ , \* $p < .05$

Table no 61 provide information regarding the moderation analysis. In the first model, the R<sup>2</sup> value of 0.02 indicates that none of the variation in acute anxiety adjustment can be accounted for. Similarly, in the second model, resilience also fails to explain any variation, as evidenced by an R<sup>2</sup> value of 0. The interaction effect, with a beta ( $\beta$ ) of -0.01 and a p-value of 0.36, suggests that the moderation is not statistically significant. Consequently, the findings indicate that resilience does not significantly moderate the relationship between acute anxiety adjustment and self-acceptance.

## Chapter 4

### Discussion

The present investigation intended to examine role of perceived family support and resilience in the relationship between prenatal anxiety and psychological wellbeing among expecting mothers. The objective of the present research was to investigate the differences on demographic variables among expecting mothers. In order to collect the data on the variables under study, we used four valid scales. These scales include Perceived Family Support Scale by Abbas (2019), brief Resilience scale by (Smith et al., 2008), Prenatal Anxiety Screening Scale by (Somerville et al., 2014) and psychological well-being scale by (Ryff & keyes, 1995). These scales are commonly used in research and provide valuable insights into the variables we measure. Researchers often administer these scales as self-report questionnaires to gather data from participants as these have good internal reliability. The present study comprised a sample of 200 expecting women ranging in age from 18 to 40 years. The participants we selected were the pregnant women from different hospitals of Islamabad and Rawalpindi.

Transactional theory of Stress and Coping proposed by Richard Lazarus and Susan Folkman (1984). This theory looks at stress as a kind of interaction between an individual and their environment. Your ability to handle it becomes crucial because the tactics you employ can impact both your psychological well-being and resilience. Prenatal anxiety can be viewed as a stress factor. Elevated anxiety levels throughout pregnancy might trigger coping mechanisms that can impact a woman's mental well-being. When a pregnant woman utilizes effective coping strategies like seeking social support, practicing relaxation techniques, or fostering a positive mindset; these actions can enhance her psychological well-being.

Conversely, employing maladaptive coping methods like avoidance or negative rumination could worsen the influence of prenatal anxiety on psychological well-being. In this

context, resilience can be interpreted as the capacity to recover from stress and adversity, while preserving a relatively steady mental and emotional state. In current investigation, it is assessed that expectant women facing psychological challenges tend to exhibit elevated levels of prenatal anxiety. This is attributable to the common occurrence of heightened anxiety and concerns among pregnant women regarding the baby's health, the childbirth process, and the potential for emotional instability and mood swings. This may appear as enduring sentiments of sadness, diminished energy, alterations in sleep routines, and a waning interest in activities.

The first hypothesis “Prenatal anxiety significantly and negatively correlates to psychological well-being in pregnant women.” has been accepted in the present study. The current findings of the research are similar to the results of previous researches. Prenatal anxiety, which encompasses feelings of worry, fear, and stress during pregnancy, can have adverse effects on the mental health and overall well-being of expectant mothers. Anxiety during pregnancy can contribute to a negative emotional state, impacting the overall psychological well-being of the expectant mother (Leight et al., 2010).

The second hypothesis states that “Perceived family support and resilience serves as a moderator between prenatal anxiety and psychological well-being.” has been accepted and rejected in the present study. In the present study the moderator Perceived family support is rejected. When individuals perceive a lack of support, it can lead to feelings of loneliness, anxiety, and even depression (Bowlby, 1988; Weiss, 1974). Resilience is a moderator accepted in the study. A highly resilient individual might experience less severe mental health effects even in the face of high stress, while a less resilient individual might be more vulnerable to the negative impact of stress (Connor & Davidson, 2003).

Third hypothesis postulates that perceived family support is negatively correlated with excessive worry and specific fear and social anxiety which are the subscales of prenatal anxiety.

But perceived family support has no significant correlation with psychological wellbeing. In statistical terms, a negative correlation means that as one variable (perceived family support) increases, the other variable (excessive specific fear and social anxiety) decreases, and vice versa. In this context, it suggests that higher levels of perceived family support are associated with lower levels of excessive specific fear and social anxiety. The negative correlation implies that as the perceived family support increases, the levels of excessive specific fear and social anxiety tend to decrease. This could be because a supportive family environment provides a secure base from which individuals can approach the challenges of life with more confidence and resilience (Smith & Johnson, 2020). “Resilience does not correlate negatively with prenatal anxiety and psychological wellbeing” has not been aligned with previous researches. Studies show there’s no negative correlation between resilience and prenatal anxiety, it means that the level of resilience a person has doesn't necessarily decrease as prenatal anxiety increases. In simpler terms, being more anxious during pregnancy doesn't mean you're automatically less resilient. Now, let's bring psychological wellbeing into the mix. Psychological wellbeing generally encompasses a person's emotional, social, and psychological state. In this context, research indicates that resilience doesn't negatively correlate with psychological wellbeing. So, having a high level of resilience doesn't mean likely to have lower psychological wellbeing (García-León et al., 2019).

4<sup>th</sup> hypothesis stated that expecting women in 1st trimester show high prenatal anxiety as compared to expecting women in 2nd and 3rd trimester. The one-way AONVA was used to compare the means of three groups. The findings of the study rejected the hypothesis. Table 8 shows the mean difference ( $p > .05$ ) was found in the results of Perfectionism Control Trauma (PCT) history among the 1st, 2nd, and 3rd trimesters. The findings of the study rejected the hypothesis, because results of the study indicated there’s exist prenatal anxiety in 2<sup>nd</sup> trimester. The second trimester of pregnancy, often referred to as the honeymoon phase, is generally

considered a time when many women experience a decrease in some of the initial challenges of the first trimester, such as morning sickness and fatigue. During this period, physical symptoms alleviate and there is often a sense of relief as the pregnancy becomes more visible and the risk of miscarriage decreases (Nascimento et al., 2015). The risk of miscarriage decreases, concerns about the health and development of the baby emerge. Women start thinking about prenatal tests and screenings, which can be both informative and anxiety-inducing (Bashour & Abdulsalam 2005). Expectant mothers experience increased social pressure and expectations from family, friends, and society. This pressure to meet certain expectations or ideals can contribute to anxiety (Chan et al., 2009).

5<sup>th</sup> hypothesis stated that younger women experience high anxiety during pregnancy as compared to elder women. The t-test was used to compare the means of two groups. The findings of the study accepted the hypothesis. Table 3 shows the results. A considerable mean difference ( $p > .03$ ) was found in the results of younger and older expected women regarding perfectionism control trauma. Results of our study indicated that younger women experience high anxiety during pregnancy as compared to elder women. Studies revealed that younger women, especially those who are in their late teens or early twenties at a different life stage compared to older women. Pregnancy often brings significant life changes and younger women less experienced in managing major life transitions, which can contribute to heightened anxiety (East & Chien 2010). Numerous research studies have consistently revealed a notable disparity that younger women face financial challenges, including concerns about providing for the child and managing the costs associated with pregnancy and childbirth. Financial stability can be a significant factor in reducing anxiety and older women more likely to have established careers and financial stability (Kridli, 2017). Younger women have different health concerns and perceptions about pregnancy. They are more prone to worry about potential complications and the fear of the unknown in terms of pregnancy and childbirth can contribute to anxiety

(Mahaffey et al., 2018). Older women have stronger social support networks, including more established relationships and support from family and friends. Social support can play a crucial role in reducing stress and anxiety during pregnancy (Collins et al., 1993). Older women have more time for personal development and self-discovery, leading to a better understanding of themselves and their ability to handle stress. Younger women still be in the process of self-discovery and developing coping mechanisms (Lachman, 2006).

Table 6 presents the results of independent sample t-test, examining the mean differences in the perceived family support scale, brief resilience scale, prenatal anxiety screening scale, and psychological well-being scale comparing family type. The p-value for perceived family support was found to be statistically significant, indicating a meaning difference between the two groups. Additionally, when examine the means, standard deviations and t-values, it was observed women from nuclear family systems exhibit a higher mean value, as compare to joint family system. Furthermore, a significant difference is observed between nuclear and joint family systems in relation to social anxiety. Women belonging to joint family systems report a higher mean value as compare to nuclear family system. Additionally, the p-value for acute anxiety adjustment was also determined to be statistically significant in the analysis. It is concluded that expected women who belong to joint family system suffer from high prenatal anxiety because expected women feel pressure from societal expectations, family traditions, or cultural norms related to pregnancy and motherhood. This pressure can lead to increased stress and anxiety.

Table 7 presents the results of an independent sample t-test analysis examining prenatal anxiety in expecting women categorized as below and above the mean. The results show significant statistical differences between expecting women above and below the mean. Those above the mean have higher scores in various domains, including family support, resilience, worry, perfectionism, social anxiety and more. All derived p-values are statistically significant.



Table 8 presents the outcomes of a one-way ANOVA analysis, which was carried out to assess the influence of trimesters. In the case of perfectionism control trauma, it was observed that the p-value reached statistical significance. Additionally, the p-value for acute anxiety adjustment across trimesters was also determined to be statistically significant in the analysis.

Education level of the expectant women was gain considered and included in the demographics as an important component. Table 10 presents the outcomes of a one-way ANOVA assessing a significant difference in mean scores for the perceived family support scale, brief resilience scale, prenatal anxiety screening scale, and psychological well-being scales based on educational level. The p-value for brief resilience scale was found to be statistically significant, indicating a meaning difference between the undergraduate, graduate and postgraduate levels. The average score of 20.0 among undergraduate women suggests an elevated degree of resilience within this demographic within the undergraduate academic realm. Furthermore, a significant difference is observed between undergraduate, graduate and postgraduate in relation to social anxiety. The mean value for undergraduate women is elevated, indicating a tendency to report higher levels of social anxiety compared to their counterparts in graduate and postgraduate levels. Additionally, the p-value for acute anxiety adjustment was also determined to be statistically significant in the analysis.

The hypothetical data introduced in Chapter 4 as an illustration of a moderation hypothesis involved 1 variable i.e., resilience and subscale of two variables i.e., perfectionism, control trauma and purpose in life. For research applications of moderation analysis, larger sample sizes we used. For these variables, it is plausible to hypothesize the following causal connections. Table 36 presents valuable insights gleaned from the moderation analysis. Resilience plays a noteworthy moderating role between perfectionism trauma control, and

purpose in life, because all the values are significant ( $\beta = -.05$ ,  $p = .04$ ). The lower limit boundary indicates the value is (-.111) and upper limit boundary indicate the value is (-.000).

However, analysis of moderation table 13 to 35 and 37 to 61 revealed that the moderating effect of perceived family support and resilience on all the subscales of prenatal anxiety (except perfectionism control trauma) and psychological wellbeing subscale (purpose in life) have non-significant relationship among expecting mothers. Because the sample size of the study was not large enough to detect a significant relationship. The nature and effectiveness of family support systems in Pakistan may differ from those in other cultural contexts. The expected moderating effects rely on specific types of support or resilience not prevalent in the local culture, potentially resulting in non-significant findings (Smith & Khan 2022). In various regions of Pakistan, the uneven access to healthcare and mental health services is shaping the dynamics among family support, resilience, and prenatal mental health. The effectiveness of moderating factors is compromised by the constraints on resource accessibility. In specific cultural settings, there could be a stigma linked to expressing mental health concerns, including prenatal anxiety. Pregnant women may be hesitant to share their emotions or seek assistance, resulting in an under representation of anxiety levels. This may obscure the potential moderating impacts of perceived family support and resilience. Numerous factors, including socio-economic status, cultural background, and personal experiences, exert influence on prenatal anxiety and psychological well-being. Without proper control, these factors might overshadow the potential effects of perceived family support and resilience. The characteristics and efficacy of social support systems in Pakistan may diverge from those in alternative cultural settings. Anticipated moderating effects depend on specific types of support or resilience not commonly found in the local culture, potentially resulting in findings that are not statistically significant.

### **Limitations and Suggestions**

A drawback of the current study is the extensive length of the questionnaires. The extended scales might lead to a loss of participant attention during the response process, potentially impacting the accuracy of the results. There's another possible limitation that may stem from participants incorrectly filling out the questionnaire, possibly due to a lack of clear understanding of the questions. Moreover, the study's reliance on surveys could introduce bias arising from the perspectives and preferences of the participants. Another concern with the study lies in its cross-sectional design, limiting the ability to firmly establish causality and temporal relationships. Choosing a longitudinal study could have provided a more in-depth understanding of the results, allowing for the evaluation of whether the observed effects were enduring or occasional. However, due to limitations in time and resources, the study had to make do with a small sample size, introducing another constraint. The research, characterized by its quantitative nature and use of structured questions, constrained the exploration of the underlying reasons for the observed stress. Employing a qualitative approach might have yielded a more nuanced insight.

It's been noted in the limitations section that the sample size is relatively small. To address this, it is advisable for future studies to consider a more extensive sample, thereby expanding the pool of behavioural data. It would be particularly beneficial to gather data from various regions of Pakistan, as this could significantly improve the generalizability of the research findings.

### **Implications**

Building strong family support networks provides a solid base for handling the ups and downs of pregnancy, and encouraging resilience empowers mothers to deal with emotional challenges. Hosting seminars in hospital gynaecology wards and to establish educational programs to raise awareness among expecting mothers and their families about the prevalence

of prenatal anxiety. Its potential impact and focuses on enhancing skills in pregnant women that include stress management techniques, coping strategies, and mindfulness practices. Integrate mental health services within prenatal care settings to provide counselling and support for pregnant women experiencing anxiety. Implement a system for continuous monitoring of maternal mental health throughout pregnancy. Regular check-ins and assessments can help track changes in anxiety levels and adjust interventions accordingly.

## **Conclusion**

The primary objectives of this study were to examine the correlation between prenatal anxiety and psychological well-being in expectant mothers, and to investigate the moderating impact of resilience and perceived family support. We gathered data from 200 pregnant women residing in Islamabad and Rawalpindi. Additionally, we analysed the role of demographic variables in conjunction with the study variables, and conducted comparisons based on trimester, gynaecological complications, miscarriages, and socioeconomic status. Our data analysis involved a range of statistical techniques, including descriptive statistics, percentages, ANOVA, correlations, and moderation analysis. The study results revealed a robust association among the mentioned variables and most of our study hypotheses were substantiated.

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## **Appendices**

### **Appendix-A**

#### **INFORM CONSENT**

I am Ayesha Ali, student of MS clinical psychology from international Islamic university Islamabad, Pakistan. I am conducting research project under the supervision of DR. Mamoonah Ismail Loona, Assistant Professor in the Department of Psychology at IIUI. My research focuses on understanding the role of perceived family support and residence in the relationship between prenatal anxiety and psychological wellbeing among expecting mothers. This study involves completion of some standardized tests which will take a few minutes to complete.

Information provided by you will be kept confidential and will be used for the research purpose only. If you have any questions, you can ask freely. Your cooperation in this research will be greatly appreciated. I hereby give my permission for my responses on these questionnaires to be used in a research project. Participating individual's responses will remain anonymous. No individual responses will be reported in any way. Your participation will significantly contribute to the success of this research, and I am sincerely thankful for your involvement.

Thank You

MS scholar

Ayesha Ali

**Appendix-B****DEMOGRAPHIC SHEET**

Age: \_\_\_\_\_

Qualification: \_\_\_\_\_

Total no of pregnancies conceived \_\_\_\_\_

Miscarriage: Yes/No

Trimester: 1<sup>st</sup> / 2<sup>nd</sup> / 3<sup>rd</sup>

Family type: Nuclear / Joint

Self-perceived Socio-economic status: lower/ middle/ upper

Gynae Complications: Psychological/ physical/ No issue

**Appendix-C****PERCEIVED FAMILY SUPPORT**

Here are a number of perceived family support that may or may not apply to you. Please tick the one option that is most appropriate for you.

		No	Little	Some	Much
1.	My family loves me.				
2.	I get respect from my family.				
3.	My family helps me with daily activities.				
4.	My family helps me with religious activities.				
5.	My family gives me useful information.				
6.	My family gives me emotional support.				
7.	My family shares important decisions with me.				
8.	My family understand my personal desires.				
9.	My family helps me to participate in social events.				
10.	My family listens my problems.				
11.	My family helps to solve my problems.				
12.	My family is aware of my health.				
13.	My family helps in my treatment.				
14.	My family treats me as an important person.				
15.	My family gives me money when I need it.				
16.	My family is careful about my food.				



17.	My family is careful about my sleep.				
18.	My family gives me companionship.				
19.	My family helps me to stay happy.				
20.	I am satisfied with my family support.				

**Appendix-D****BRIEF RESILIENCE SCALE**

Please write a number next to each statement to indicate the extent to which you agree or disagree with that statement.

		Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
1.	I tend to bounce back quickly after hard times.	1	2	3	4	5
2.	I have a hard time making it through stressful events.	5	4	3	2	1
3.	It does not take me long to recover from a stressful event.	1	2	3	4	5
4.	It is hard for me to snap back when something bad happens.	5	4	3	2	1
5.	I usually come through difficult times with little trouble.	1	2	3	4	5
6.	I tend to take a long time to get over set-backs in my life.	5	4	3	2	1

**Appendix- E****PRENATAL ANXIETY SCREENING SCALE**

Over the past month, how often have you experienced the following? Please tick the response that most closely describes your experience for every question.

		Not at all	Sometimes	Often	Almost always
1.	Worry about the baby/pregnancy.				
2.	Fear that harms will come to the baby.				
3.	A sense of dread that something bad is going to happen.				
4.	Worry about many things.				
5.	Worry about the future.				
6.	Feeling overwhelmed.				
7.	Really strong fears about things. e.g., needles, blood, birth, pain etc.				
8.	Sudden rushes of extreme fear or discomfort.				
9.	Repetitive thoughts that are difficult to stop or control.				
10.	Difficulty sleeping even when I have the chance to sleep.				
11.	Having to do things in a certain way or order.				
12.	Wanting things to be perfect.				
13.	Needing to be in control of things.				
14.	Difficulty stopping checking or doing things over and over.				
15.	Feeling jumpy or easily startled.				
16.	Concerns about repeated thoughts.				
17.	Being 'on guard' or needing to watch out for things.				

18.	Upset about repeated memories, dreams or nightmares.				
19.	Worry that I will embarrass myself in front of others.				
20.	Fear that others will judge me negatively.				
21.	Feeling really uneasy in crowds.				
22.	Avoiding social activities because I might be nervous.				
23.	Avoiding things which concerns me.				
24.	Feeling detached like you are watching yourself in a movie.				
25.	Losing track of time and can't remember what happened.				
26.	Difficulty adjusting to recent changes.				
27.	Anxiety getting in a way of being able to do things.				
28.	Racing thoughts making it hard to concentrate.				
29.	Fear of losing control.				
30.	Feeling panicky.				
31.	Feeling agitated.				

**Appendix-F****PSYCHOLOGICAL WELL-BEING SCALE (PWB-S)**

Circle one response below each statement to indicate how much you agree or disagree.

1. strongly agree
2. somewhat agree
3. a little agree
4. neither agree nor disagree
5. a little disagree
6. somewhat disagree
7. strongly disagree

		1	2	3	4	5	6	7
1.	I like most part of my personality.							
2.	When I look at the story of my life, I am pleased with how things have turned out so far.							
3.	Some people wander aimlessly through life, but I am not one of them.							
4.	The demands of everyday life often get me down.							
5.	In many ways I feel disappointed about my achievements in life.							
6.	Maintaining close relationships has been difficult and frustrating for me.							
7.	I live life one day at a time and don't really think about the future.							
8.	In general, I feel I am in change of situation in which I live.							
9.	I am good at managing the responsibilities of daily life.							

10.	I sometimes feel as if I have done all there is to done in life.							
11.	For me, life has been a continuous process of learning, changing and growth.							
12.	I think it is important to have new experiences that challenge how I think about myself and the world.							
13.	People would describe me as a giving person, willing to share my time with others.							
14.	I gave up trying to make big improvements or changes in my life a long time ago.							
15.	I tend to be influenced by people with strong opinions.							
16.	I have not experienced many warm and trusting relationships with others.							
17.	I have confidence in my own opinions, even if they are different from the way most other people think.							
18.	I judge myself by what I think is important, not by the values of what other think is important.							