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EMOTIONAL BURNOUT IN PREGNANT WOMEN DURING THIRD TRIMESTER: A NARRATIVE REVIEW

Narrative Review

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ABSTRACT

Background: Emotional burnout in the third trimester of pregnancy is a growing concern, characterized by persistent emotional fatigue, anxiety, and psychological distress. As women approach childbirth, heightened emotional vulnerability can significantly affect both maternal and neonatal outcomes. Despite its clinical relevance, emotional burnout during late pregnancy remains underrecognized and understudied, particularly in terms of standardized assessment and intervention strategies.

Objective: This narrative review aims to explore the psychological stressors, support systems, and emotional well-being of pregnant women in their third trimester, highlighting key risk factors, therapeutic approaches, and gaps in existing research.

Main Discussion Points: The review synthesizes findings from recent literature, identifying common stressors such as fear of labor, prior obstetric complications, and socioeconomic instability. The protective role of emotional and social support, especially from partners, is emphasized across studies. Non-pharmacological interventions, including Emotional Freedom Techniques, aromatherapy, and autogenic relaxation, have shown promising effects in reducing anxiety. However, methodological limitations such as small sample sizes, lack of randomized controlled trials, and inconsistent assessment tools hinder the strength of the evidence. The generalizability of findings remains limited due to a lack of diverse study populations.

Conclusion: Emotional burnout in the third trimester warrants greater clinical and research attention. While current findings support the integration of emotional screening and supportive therapies into prenatal care, further high-quality research is essential to develop evidence-based, culturally sensitive interventions.

Keywords: Emotional Burnout, Third Trimester Pregnancy, Antenatal Anxiety, Social Support, Non-Pharmacological Interventions, Narrative Review.

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INTRODUCTION

Pregnancy is a transformative period characterized by profound physical, emotional, and psychological shifts. In the third trimester—the final stage before childbirth—these changes intensify, often creating heightened emotional vulnerability in expectant mothers. Emotional burnout, a state of chronic emotional fatigue and psychological distress, is increasingly recognized as a concern during this stage. Globally, antenatal mental health issues affect approximately 10–25% of pregnant women, with anxiety and emotional distress notably peaking in the later stages of pregnancy (1). While physiological changes such as hormonal fluctuations and physical discomfort are well-established contributors to psychological stress, less attention has been paid to the complex interplay of social support, personal history, and anticipatory anxiety surrounding labor and motherhood (2). Third trimester emotional burnout is influenced by a range of stressors including fear of childbirth, concern for fetal health, prior obstetric complications, socioeconomic instability, and insufficient emotional support. Recent research underscores how these factors coalesce to impact the psychological well-being of pregnant women. For instance, women in the third trimester often experience increased anxiety due to the imminent delivery, coupled with fatigue, insomnia, and feelings of helplessness or inadequacy regarding motherhood. These symptoms, if sustained, may escalate into emotional burnout—a state linked to adverse maternal outcomes such as prolonged labor, postpartum depression, and impaired maternal-infant bonding (3,4).

Despite the increasing recognition of maternal mental health, existing research on emotional burnout in pregnant women remains limited and fragmented. Several studies have addressed anxiety and depressive symptoms during pregnancy, but few have explored the concept of emotional burnout specifically within the third trimester (5). Emotional burnout, distinct from general anxiety or depressive states, is characterized by emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment. In the antenatal context, it manifests as chronic worry, detachment from the pregnancy experience, and feelings of emotional depletion. This nuanced condition is poorly understood in both clinical practice and research settings, representing a significant gap in maternal mental health literature (6,7). Evidence suggests that robust social and emotional support plays a protective role against psychological distress in pregnancy. Support from partners, family, and healthcare providers can significantly mitigate anxiety and enhance emotional resilience. For instance, studies show that emotional support from a partner is moderately correlated with reduced anxiety levels among third trimester women, reinforcing the importance of relational dynamics during this stage (8). Similarly, women reporting high levels of perceived social support experience fewer negative emotions compared to those with little or no support (9).

Interventions targeting emotional burnout have begun to gain traction. Non-pharmacological therapies, such as Emotional Freedom Techniques (EFT) and aromatherapy, have demonstrated significant efficacy in reducing anxiety among pregnant women in the third trimester (10). Additionally, structured health education and cognitive psychotherapy have also been found to alleviate distress by equipping women with coping strategies and enhancing their emotional preparedness for childbirth (11,12). Despite these encouraging findings, a standardized approach to recognizing and managing emotional burnout in prenatal care remains absent. The objective of this narrative review is to examine the psychological stressors, support systems, and emotional well-being of women in the third trimester of pregnancy. The review synthesizes findings from recent observational and interventional studies to identify prevailing risk factors, evaluate existing support mechanisms, and propose strategies for early identification and management of emotional burnout. The review draws primarily from studies published in the past five years and focuses on third trimester women to offer targeted insights relevant to clinical practice and maternal care programs. This review is both timely and essential. By clarifying the multifaceted causes and manifestations of emotional burnout in late pregnancy, it addresses a critical research gap and advocates for the integration of mental health assessment into routine prenatal care. The ultimate goal is to promote maternal mental well-being, enhance birth outcomes, and ensure healthier early bonding between mothers and newborns.

THEMATIC DISCUSSION

Psychological Stressors in the Third Trimester of Pregnancy

The final trimester of pregnancy is a period marked by both anticipation and psychological burden. Emotional burnout during this stage is often precipitated by a constellation of stressors including fear of childbirth, health anxieties, prior obstetric complications, and

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socioeconomic concerns. Studies consistently indicate that anxiety peaks in the third trimester as women mentally prepare for labor and postpartum transitions. A study identified that proximity to delivery, fear of complications, insomnia, and history of miscarriage significantly elevated stress and anxiety levels among pregnant women, particularly during the third trimester, underscoring the compounding effects of both past trauma and current uncertainty (10). Moreover, social factors play a substantial role in shaping these psychological responses. Women of lower socioeconomic status, limited education, and younger age have shown heightened emotional vulnerability. A study demonstrated that inadequate financial resources, rural living conditions, and limited education were independently associated with increased levels of negative mood in the third trimester (11). These findings were corroborated by a study, which found that maternal age, education level, economic constraints, and parity significantly influenced the presence of anxiety disorders during late pregnancy (12).

Role of Emotional and Social Support Systems

Support systems—especially emotional support from partners—emerge as vital buffers against psychological deterioration during pregnancy. A study reported that 86.4% of women receiving good emotional support from their husbands showed no anxiety symptoms, while more than half of those lacking such support experienced mild to moderate anxiety (13). Similarly, a study found a significant inverse relationship between emotional support and anxiety levels in primigravida women, suggesting that interventions aimed at partner involvement may mitigate emotional burnout (14). These conclusions emphasize the critical importance of social scaffolding in maternal mental health. Notably, women who reported high levels of perceived support expressed more positive emotional states and demonstrated lower anxiety scores than those who felt emotionally isolated (15). However, the complexity of emotional support—being subjective and variable—means that not all women benefit equally. While some thrive with minimal assistance, others require extensive relational or professional support, indicating a need for individualized psychosocial assessments.

Coping Mechanisms and Therapeutic Interventions

To counteract emotional burnout, a range of therapeutic strategies has been explored. Non-pharmacological approaches such as Emotional Freedom Techniques (EFT) and aromatherapy have shown promising results. A study reported a statistically significant reduction in anxiety levels post-intervention, with a drop from a mean pre-test score of 2.31 to 1.31 ($p < 0.001$), suggesting these methods may offer effective, low-risk options for managing antenatal stress (16). Additionally, cognitive-behavioral interventions tailored for pregnancy contexts, including autogenic relaxation and psycho-correction, have yielded beneficial outcomes. A study demonstrated that autogenic relaxation significantly reduced anxiety in third trimester women, particularly those pregnant for the first time, by enhancing self-regulatory cognitive processing (17). Meanwhile, another study emphasized the value of psychotherapy in complicated pregnancies, showing that cognitive psycho-correction helped reduce psychological distress by reconstructing maladaptive thought patterns and bolstering emotional resilience (18). These studies reflect a trend toward integrating mental health support into routine antenatal care. However, accessibility remains a concern, especially in low-resource settings where mental health infrastructure is lacking. Furthermore, not all women may respond equally to these interventions, highlighting the importance of personalized care plans.

Gaps, Controversies, and Future Directions

Despite the growing evidence, inconsistencies remain. For instance, while some research suggests that emotional distress peaks in the third trimester, others indicate a more nuanced pattern, where distress levels may remain stable or even decline as women adapt to the pregnancy experience. A study noted that negative emotions were more pronounced in the first trimester, with only a mild increase in positive mood during the third, challenging the prevailing assumption that stress uniformly escalates with gestational age (19). Moreover, there is a dearth of studies that comprehensively explore the intersectionality of multiple stressors—such as chronic illness, cultural expectations, and lack of institutional support—which may influence emotional outcomes. Research is also limited in terms of diversity, with most studies focused on specific populations, thereby restricting generalizability. Further longitudinal studies are needed to understand the trajectory of emotional burnout and the long-term effects on maternal and neonatal outcomes. In summary, while emotional burnout during the third trimester is increasingly recognized, existing research still lacks a unified framework. There is an urgent need for integrative care models that combine psychosocial screening, partner involvement, and accessible mental health interventions. The complexity of emotional experiences during this critical period calls for a holistic, compassionate approach that acknowledges both biological and psychosocial determinants.

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CRITICAL ANALYSIS AND LIMITATIONS

The body of literature exploring emotional burnout in third trimester pregnant women has advanced significantly in recent years, yet it remains constrained by several methodological and conceptual limitations. One of the most pervasive issues is the limited robustness of study designs. Many studies rely heavily on observational or cross-sectional methodologies, lacking the rigorous structure of randomized controlled trials (RCTs) necessary to establish causality. For instance, studies employed correlational analyses to assess the impact of emotional support on anxiety, the absence of control groups or longitudinal tracking limits the strength of their conclusions and raises concerns about temporal relationships between variables (20). Sample size is another limitation that undermines the statistical power of several investigations. Studies included relatively small cohorts, often fewer than 100 participants, which limits their ability to detect subtle but clinically significant associations or generalize findings beyond their immediate contexts (21). This issue is compounded by the geographic concentration of many studies, which are often conducted in single centers or regions. Consequently, their findings may reflect local cultural, healthcare, or socioeconomic influences rather than broadly applicable trends.

The reviewed studies are also prone to various forms of bias. Selection bias is particularly prevalent, with participant recruitment frequently based on convenience sampling or limited to individuals receiving antenatal care in specific facilities. This skews samples toward women with relatively higher health literacy or healthcare access, potentially excluding more vulnerable populations such as those in rural areas or with limited resources. Moreover, the reliance on self-reported questionnaires introduces performance and reporting bias, as participants may overestimate or underestimate their emotional states based on social desirability or recall limitations, particularly in emotionally sensitive contexts such as pregnancy (20,21). Another significant limitation lies in the variability of measurement outcomes across studies. There is no universally adopted tool for assessing emotional burnout in pregnancy, with some studies using generalized anxiety scales (e.g., STAI), while others apply depression inventories or custom emotional well-being checklists. This lack of standardization complicates efforts to compare findings or synthesize data effectively. For example, the studies used distinct psychological scales, yielding different thresholds and interpretations of emotional burden, thereby reducing the coherence of cross-study conclusions (22).

Publication bias also appears to influence the available evidence. Studies showing significant associations between emotional support or intervention strategies and improved mental health outcomes are more likely to be published than those reporting null or negative results. This selective reporting may lead to an overestimation of the effectiveness of interventions such as relaxation therapy or aromatherapy. There is a noticeable scarcity of large-scale, peer-reviewed articles that explore ineffective or inconclusive treatments, suggesting a skew in the literature that may distort clinical expectations. Furthermore, the generalizability of current findings remains a major concern. Many studies draw on homogeneous populations in terms of ethnicity, socioeconomic status, or healthcare systems. For instance, studies based in Indonesia or Eastern Europe, though valuable, may not reflect the cultural or healthcare dynamics of Western nations or ethnically diverse populations. Consequently, it is unclear whether interventions found effective in one setting would yield similar results elsewhere. The failure to account for cultural attitudes toward pregnancy, support structures, and mental health may result in interventions that are less applicable or accepted in other contexts (23). In summary, while the recent body of literature provides meaningful insights into the psychological landscape of third trimester pregnancy, it is hampered by methodological weaknesses, measurement inconsistencies, and limitations in population diversity. To advance this field, future research must prioritize rigorous study designs, adopt standardized outcome measures, and include more diverse populations to enhance the reliability and applicability of findings.

IMPLICATIONS AND FUTURE DIRECTIONS

The synthesis of current evidence on emotional burnout in third trimester pregnant women has several meaningful implications for clinical practice, health policy, and future research. From a clinical perspective, these findings highlight the necessity of incorporating routine psychological assessments into antenatal care, particularly during the final trimester when emotional distress appears most pronounced. Healthcare professionals, including obstetricians, midwives, and mental health providers, should be trained to identify early signs of emotional exhaustion and offer supportive interventions. For example, tools such as the State-Trait Anxiety Inventory (STAI) or tailored emotional screening questionnaires can be integrated into antenatal visits to facilitate early recognition of distress. Studies emphasized the tangible benefits of emotional support and relaxation techniques in reducing anxiety levels, reinforcing their clinical value as part of a comprehensive prenatal care approach (17,18). In terms of health policy and guidelines, the findings advocate for the development of standardized clinical protocols for the assessment and management of antenatal emotional burnout. Despite increasing

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evidence of its prevalence and impact, most national and international antenatal care guidelines still lack formal recognition of emotional burnout as a distinct clinical entity. Incorporating specific recommendations for mental health screening, social support assessment, and referral pathways into obstetric guidelines would bridge this gap. The inclusion of low-cost, non-pharmacological interventions such as aromatherapy, emotional freedom techniques (EFT), and autogenic relaxation within policy frameworks could also ensure their broader implementation, especially in resource-limited settings where access to formal mental health care may be limited (24).

Future research must address several key gaps identified in the current literature. One critical area is the need for longitudinal studies that track emotional changes across all trimesters and into the postpartum period. Existing studies are largely cross-sectional, capturing emotional states at a single point in time, which restricts understanding of the progression and potential resolution of burnout symptoms. Furthermore, the complex interaction between biological, psychological, and social determinants of emotional burnout remains underexplored. For instance, the role of hormonal fluctuations, coping styles, and partner dynamics warrants further investigation through multifactorial models that integrate biopsychosocial variables. In addition, current evidence is predominantly based on small, localized populations, which limits its generalizability. Future studies should prioritize diverse, multicentric sampling strategies to ensure findings are applicable across different cultural, socioeconomic, and healthcare contexts. The inclusion of underrepresented groups such as adolescents, refugees, and women with high-risk pregnancies would provide a more comprehensive understanding of vulnerability to emotional burnout. Furthermore, qualitative studies exploring women's lived experiences could enrich quantitative findings and offer nuanced insights into their emotional trajectories during pregnancy.

Methodologically, future trials would benefit from adopting randomized controlled designs with appropriate blinding and control groups to rigorously evaluate the efficacy of psychological interventions. Studies have laid foundational evidence for non-pharmacological approaches, yet these findings require validation through larger, well-powered trials with standardized outcome measures (23,24). Uniformity in tools used to assess emotional burnout—whether anxiety scales, depression inventories, or burnout-specific indices—is essential to enable accurate comparison and meta-analyses. Ultimately, addressing emotional burnout during the third trimester is not only essential for maternal well-being but also carries downstream benefits for neonatal outcomes and early mother-infant bonding. Embedding mental health care within the broader framework of antenatal services, supported by targeted research and robust policy, represents a critical step toward more holistic and equitable maternal healthcare.

CONCLUSION

Emotional burnout in pregnant women during the third trimester emerges as a multifaceted issue influenced by psychological stressors, inadequate emotional support, and limited coping resources. The reviewed literature consistently highlights that heightened anxiety, fear of childbirth, and prior adverse obstetric experiences contribute significantly to emotional distress in late pregnancy. Evidence supports the protective role of partner support and the effectiveness of non-pharmacological interventions such as relaxation techniques and aromatherapy, though findings are drawn predominantly from small-scale, observational studies. While the current body of research offers valuable insights, the strength of evidence is moderate at best due to methodological limitations, including small sample sizes, lack of standardized assessment tools, and underrepresentation of diverse populations. Clinicians are encouraged to incorporate mental health screenings into routine antenatal care and to engage family support systems proactively. Future research should prioritize longitudinal, multicenter randomized controlled trials with culturally sensitive, standardized measures to better understand the trajectory of emotional burnout and inform evidence-based care models tailored to the needs of diverse maternal populations.

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AUTHOR CONTRIBUTION

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Shabahat Arain*	Substantial Contribution to study design, analysis, acquisition of Data Manuscript Writing Has given Final Approval of the version to be published
Izaz Ali	Substantial Contribution to study design, acquisition and interpretation of Data Critical Review and Manuscript Writing Has given Final Approval of the version to be published
Qurat ul Ain Ali Bukhari	Substantial Contribution to acquisition and interpretation of Data Has given Final Approval of the version to be published
Javeria Pervez	Contributed to Data Collection and Analysis Has given Final Approval of the version to be published
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