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'They'll be judging us' a qualitative study of pregnant women's experience of being offered participation in a supportive intervention

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ABSTRACT

Objective: to explore pregnant women's experience of being offered participation in a supportive intervention and how their experience influenced the outcome of the intervention.

Design and setting: a qualitative, phenomenological hermeneutic study based on semi-structured interviews with eight Danish first-time mothers.

Findings: the study revealed a divergence between the professional's and the women's perception of their vulnerability. The women typically felt the offer of participation as a stigma, which they met with anxiety and confusion. Insufficient information led to uncertainty and a feeling of being evaluated as inadequate mothers or parents. The information offered failed to provide the basis of informed choice. However, the development of a trusting, supportive and non-judgemental relationship with the health professionals ensured most women a positive outcome of the intervention.

Key conclusion: being invited to participate in an intervention targeting vulnerable women may induce unintended feelings in relation to stigmatization and judgement, leading to doubt about own ability to cope with motherhood. Inadequate information and explication about aims and contents of the intervention are likely to cause confusion and anxiety and a feeling of being judged as parents. Information combined with establishing a trusting and non-judgemental relationship between women and professionals appears to have significant impact on outcomes.

Implications for practice: care providers should be aware of the induced negative feelings and sense of judgement and stigmatization as a result of being categorized as vulnerable and perceived in need of help to cope with motherhood, and that they may play a key role in helping women cope with this. Furthermore, detailed information about the intervention and the background of the offer should be ensured as well as an informed choice of participation.

Introduction

Vulnerable pregnant women experience serious inequities in health due to higher incidences of physical, mental and social risk factors, which may adversely affect pregnancy, maternal and prenatal outcomes as well as the child's health and well-being in both childhood and adulthood (Kramer et al., 2000; Lewis, 2007; Talge et al., 2007; Daoud et al., 2014). Efforts to reduce these inequities are attracting increasing attention. In Denmark, the general service level described in the national antenatal care programme for pregnant women (Brot and Poulsen, 2013) has been significantly reduced to allow for a greater focus on individually adapted services and interventions for risk groups (Diderichsen et al., 2011). The tailoring of services to the needs of vulnerable pregnant women has been recommended by the National Institute for Health and Care Excellence (2010). Definitions of vulnerability vary between countries and between interventions, but typically include young mothers, women affected by mental health problems or a troubled social background, and women exposed to physical or sexual abuse or violence. Substance abuse may be included in some (National Institute for Health and Care Excellence, 2010), but not all definitions (Brot and Poulsen, 2013).

The Danish government has allocated funds to strengthen efforts in antenatal care for vulnerable women (Ministry of Health, 2011a). A 2011 systematic review concluded that many of the available studies on the effect of the intervention had serious methodological limitations (Hollowell et al., 2011). Also few comprehensive studies of women's experiences and perspectives of participation in such interventions are available (Kirkpatrick et al., 2007; Birtwell et al., 2015).

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Many interventions may therefore be ineffective or, even worse, have unintended negative consequences for already vulnerable women. In general, evaluations of unintended negative consequences, such as stigmatization, anxiety and social discrimination associated with public health interventions are often absent or incomplete, leading to a fundamental pitfall of effectiveness evidence (Allen-Scott et al., 2014) As pointed out by Benoit, pregnant women risk experiencing stigma due to the environment's expectations of women as the primary caregiver. Health behaviours considered undesirable by society may cause them to be perceived as unfit for motherhood (Benoit et al., 2010). Pregnant women from socially disadvantaged or ethnic minority groups may furthermore experience discrimination and prejudice (Ertel et al., 2012). Identifying vulnerable pregnant women for participation in interventions is thus challenging for health professionals.

A friendly, attentive and individual approach has been documented to enhance women's experience of antenatal care (Downe et al., 2009). Carolan and Hodnett (2007) has showed that a safe and supportive relationship between the vulnerable woman and the health professionals is essential. It is therefore of crucial importance to learn from insights into the users' perceptions and experiences when they are offered participation in such interventions.

In the setting of Danish maternity services, a recent report evaluating interventions for vulnerable pregnant women documented the participants' positive perceptions (The Danish Health Authority, 2017). However, potential unintended consequences were little explored. The elicitation of women's perspectives may help policymakers and health professionals improve their understanding of benefits, harms and pitfalls in relation to interventions designed to meet the women's needs.

This study explores first-time mothers' experience of being offered participation during pregnancy in a supportive intervention and how their experiences influenced the outcome of the intervention.

Methodology

Design

A qualitative study of data collected through semi-structured interviews was undertaken. The methodology applied was phenomenological hermeneutic (Dahlberg et al., 2001; Denzin and Lincoln, 2011), in keeping with much health research, including midwifery (Jirojwong et al., 2014). We were inspired by Dahlberg et al. (2001)'s reflective lifeworld approach, which integrates phenomenological and hermeneutic philosophy to gain insight into people's lived experiences, their lifeworld. In phenomenology the researcher must let the phenomenon come forward as it is. We found this approach appropriate in exploring the experiences and perspectives of vulnerable women whose voices are rarely heard. It informed our interviewing and ensured a strong empirical foundation of the initial data analysis (Dahlager and Fredslund, 2008). In the last step of the analysis, Gadamer (1998)'s philosophical hermeneutic approach was dominant, as further described below.

Setting

The setting was an intervention for vulnerable pregnant women offered as part of the public antenatal care programme in a mixed rural and urban region of Denmark. As part of the first consultation with a midwife (17th week of pregnancy) all women were screened for vulnerability factors. All midwives were trained to use the same semi-structured interview guide with questions focused around the woman's and her partner's upbringing and life situation, their health, well-being, relationship, network and resources, and thoughts about pregnancy and parenthood (Buhelt, 2014). If vulnerability factors were identified the woman/couple were offered participation in an intervention aiming to strengthening the women and their partners' coping abilities and parenting skills by providing social and professional support from a dedicated midwife and health visitor assigned to each woman/couple. Four antenatal and one to two postpartum sessions of 90 minutes were generally offered, during which individual themes relating to the identified vulnerability factors were discussed. If considered relevant, other supportive initiatives could be offered, also the social services could be involved. The intervention started in September 2013 and continues. Data were collected between April 2016 and August 2016.

Recruitment and participants

Eighty-eight women who had ended their participation in the intervention and given birth at least 3 months ago were identified as potential participants. The women formed a relatively homogeneous group in the sense that they were Danish speaking, offered the intervention due to psycho-social vulnerability factors and most between the ages of 20–30 years. Considering our methodological approach, focused research question and this homogeneity (Dahlberg et al., 2001; Guest et al., 2006), we aimed to recruit 6–10 participants. According to Danish legislation, recruitment of patients for research must take place through the health institution/center providing their care. Furthermore, recruiting vulnerable individuals is a well-known challenge (Marsh et al., 2017) as they may be hard to reach on conventional means and have life experiences that may have left them with distrust of unknown others. We therefore agreed with the intervention manager to use a gatekeeper strategy, where potential participants were contacted by the intervention staff and informed about the study by phone. To minimize problems related to use of gatekeepers including e.g. blocking or promoting access to particular groups (Marsh et al., 2017) a sample of 15 women were randomly selected. This oversample considered potential reluctance of women towards participation. Twelve women accepted further contact and were called by a member of the research team offering further information and scheduling an interview. One woman cancelled due to sickness while three failed to respond to repeated phone calls. The remaining eight women gave informed consent to participate in an individual interview, conducted 12–18 months after birth. Fig. 1 gives an overview of the recruitment process.

The study participants' characteristics are presented in Table 1.

Data collection

Eight in-depth interviews of approximately one-hour duration were conducted in a location chosen by the interviewee: either the home, the antenatal clinic or in the local public library, where a semi-private space was available. The phenomenological approach is reflected in a semi-structured interview guide with a thematic focus and open-ended questions allowing the interviewer to explore the women's experiences. The interview guide focused on four themes: the woman's social situation and vulnerability factors, her experience of being offered participation in the intervention, her experience of participating in the intervention and the interaction with professionals, and the perceived outcome of participation. Follow-up questions were asked to support the participant's reflections and expression of their experiences. Briefing and debriefing about study aims, informed consent, withdrawal, confidentiality and anonymity took place before and after the interview. The participants were invited to review the transcripts, none of them wanted this.

Four of the interviews were conducted by two researchers (one interviewed while the other observed) to allow for later review of the interview technique. Following recommendations by Christensen et al. (2008), the first interview was perceived as pilot interview, but as no need for major changes to the interview guide was identified, it was included. The remaining four interviews were conducted by one

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