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Original Research

The Subjective Impact of a Diagnosis of Gestational Diabetes Among Ethnically Diverse Pregnant Women: A Qualitative Study

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A B S T R A C T

Objective: Women diagnosed with gestational diabetes mellitus (GDM) require enhanced medical care, social support and health behaviour changes to reduce the complications of pregnancy and future adverse health outcomes. Little is known about how a GDM diagnosis positively and negatively impacts women, especially those of diverse ethnic backgrounds. This qualitative study sought to gain insight into the reactions and experiences of multiethnic women diagnosed with GDM.
Methods: A qualitative descriptive approach was used to analyze semistructured telephone interviews conducted with 19 pregnant women of diverse backgrounds who were diagnosed with GDM. Interviews were recorded and transcribed and then coded and analyzed using content analysis.
Results: This study identified 2 main themes and several subthemes. First, women reported many negative effects of a GDM diagnosis, including heightened pressure to fulfill multiple roles, financial impact, and a disconnect between diabetes-prevention recommendations and their cultural practices. Second, a GDM diagnosis also had positive effects on many women. Women indicated being motivated to make health behaviour changes after a GDM diagnosis and viewed it as a wake-up call to modify their lifestyles.
Conclusions: To help pregnant women with self-management of gestational diabetes, healthcare providers should pay greater attention to the adverse effects of GDM on women, including role expectations, cultural issues and financial barriers. Healthcare providers also need to focus on the positive effects and capitalize on women's motivation to make lifestyle changes to reduce their future risk for diabetes.

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R É S U M É

Objectif : Les femmes ayant reçu un diagnostic de diabète gestationnel (DG) nécessitent de meilleurs soins médicaux, un soutien social et des modifications à leur comportement en matière de santé afin de réduire les complications de grossesse et les résultats néfastes sur l'évolution future de leur état de santé. On en connaît peu sur les conséquences positives ou négatives du diagnostic de DG chez les femmes, particulièrement chez celles de diverses origines ethniques. Cette étude qualitative cherche à offrir un aperçu sur les réactions et les expériences des femmes de multiples origines ethniques ayant reçu un diagnostic de DG.
Méthodes : Une approche qualitative descriptive a été utilisée pour analyser les entretiens téléphoniques semi-structurés réalisés auprès de 19 femmes enceintes de diverses origines qui avaient reçu un diagnostic de DG. Les entretiens ont été enregistrés et transcrits, puis codés et analysés au moyen de l'analyse de contenu.
Résultats : Cette étude a déterminé 2 thèmes principaux et plusieurs sous-thèmes. Premièrement, les femmes ont rapporté plusieurs effets négatifs liés au diagnostic du DG, y compris l'accroissement de la

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pression pour remplir de multiples rôles, la répercussion financière, et la déconnexion entre les recommandations sur la prévention du diabète et leurs pratiques culturelles. Deuxièmement, le diagnostic du DG a également eu des effets positifs chez de nombreuses femmes. Les femmes ont indiqué éprouver la motivation d'apporter des modifications à leur comportement en matière de santé après avoir reçu le diagnostic de DG et ont perçu cette annonce du diagnostic comme le signal de la nécessité à modifier leur mode de vie.
Conclusions : Pour aider les femmes enceintes à prendre en charge de manière autonome leur DG, les prestataires de soins de santé devraient offrir une plus grande attention aux effets indésirables du DG sur les femmes, y compris les attentes liées à leurs rôles, les problèmes culturels et les obstacles financiers. Les prestataires de soins de santé ont également besoin de mettre l'accent sur les effets positifs et de mettre à profit la motivation des femmes à apporter des modifications à leur mode de vie pour réduire le risque futur de diabète.

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Introduction

Gestational diabetes mellitus (GDM) occurs in 1% to 14% of all pregnancies (1), and its prevalence has increased in ethnic minority groups (2–4). Known risk factors for GDM are maternal age, race/ethnicity, parity, body mass index, hypertension and smoking status (5). Although GDM resolves after delivery in at least 70% of cases (6,7), women with histories of GDM have a 7-fold increase in future risk for developing diabetes compared to women without GDM (8). Current clinical practice guidelines recommend universal screening and treatment of GDM during pregnancy to reduce fetal macrosomia and its associated risks (5,9,10).

GDM introduces health challenges that significantly affect the usual trajectory of a woman's pregnancy. Clinical guidelines recommend that healthcare providers refer all women with GDM to specialized diabetes programs, which encourage health behaviour changes to reduce the risk for obstetrical and fetal complications (5,9,11). These changes include dietary adjustments, glucose monitoring, enhancing physical activity and, in many cases, administering insulin injections (5,9,11). Although there is widespread evidence showing improved outcomes with intensive management of GDM (12,13), there has been limited research on the psychosocial and lifestyle impacts of a GDM diagnosis.

Previous qualitative studies have shown that diabetes management during pregnancy is particularly challenging and stressful for women and their families (14–16), given the heightened concern for the well-being of their unborn children (17). Therefore, women may struggle to perceive a diagnosis of GDM as a positive health-promoting occasion if their pregnancies are characterized mostly by stress. However, some women report that knowing their risk for diabetes in the future may prompt healthy lifestyle changes postpartum (18). Past studies indicate that women's perceptions of at-risk pregnancies are related to their present health status, past experiences, personal beliefs and values (19). Women's perceptions of at-risk pregnancy are not always congruent with the views of health professionals. Although pregnant women want to be informed of risks, they may not always follow all treatments recommended by health professionals (20,21), and such recommendations may influence their engagement in healthful behaviours (22–24). Women's abilities to make lifestyle changes are also influenced by mental well-being and perceived stress and by broader sociocultural factors, such as role expectations, social support networks and cultural beliefs (25–27). These factors may be particularly salient in women of diverse ethnic backgrounds seeking care in a Western healthcare setting.

Given that the prevalence of GDM is higher in many ethnic minority populations (3,28), it is important to understand how GDM is experienced within a more ethnically diverse group (29). A diagnosis of GDM also provides an opportunity to identify women with an increased risk for future diabetes and to offer counselling aimed at promoting long-term health behaviour changes. However, 1 survey study showed that lifestyle counselling during pregnancy was largely ineffective in producing postpartum lifestyle changes (30). Moreover, relatively few studies have assessed the extent to which women understand their risk and recognize the need to make lifestyle modifications in the setting of active GDM management. To better optimize the window of opportunity of a pregnancy involving GDM to promote health behaviour changes, we must have a better understanding of the subjective experiences of women in managing a pregnancy involving GDM.

The purpose of this qualitative study of women with GDM was to gain insight into the experiences of ethnically diverse pregnant women with GDM, including the advantages and disadvantages of self-care management and their perceptions regarding their health status, risk for diabetes and need for lifestyle modification.

Methods

This qualitative study is part of a longitudinal cohort study that examined readiness for lifestyle changes in an ethnically diverse population of women with GDM (31). Ethnicity status was based on self-report of ethnic background (e.g. Caucasian, South Asian, etc.). Pregnant women who were medically diagnosed with GDM after 24 weeks' gestation were eligible to enter the cohort if they were >18 years of age, currently pregnant and could communicate in English. During scheduled visits at diabetes-in-pregnancy clinics, we invited eligible women to participate in the longitudinal cohort study. A consecutive subset of women was also invited to participate in a qualitative telephone interview during pregnancy to discuss their experiences of being diagnosed with GDM. We conducted interviews with a purposive sample of 19 pregnant women from 2 diabetes-in-pregnancy clinics located in Toronto, Ontario. Recruitment and interviewing continued until we reached saturation of themes and subthemes. Final sample size was determined according to the richness of the data obtained through the interviews (32).

Data collection and analysis

We used a qualitative descriptive approach according to Sandelowski's definition (33,34) and a semistructured interview guide based on Andersen's model of health behaviour (35), which outlines potential clinical, demographic and psychosocial factors associated with a person's readiness and capacity to engage in health behaviour change. Andersen's model posits that health behaviours are influenced by a combination of predisposing (e.g. motivation); enabling (e.g. time, resources) and need (e.g. high glucose levels) factors (35). Our interview guide was designed to elicit women's perceptions of their health and diabetes risk and factors that influenced their health behaviours during pregnancy (Table 1). All interviews were conducted by telephone and lasted between 30 and 60 minutes. The 2 interviewers (SK, SM) used

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