



Threatened preterm labour: Women's experiences of risk and care management: A qualitative study

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ABSTRACT

Background: Preterm birth is a major cause of neonatal death and severe morbidity, so pregnant women experiencing symptoms of threatened preterm labour may be very anxious. The risk assessment and management that follows recognition of threatened preterm labour has the potential to either increase or decrease this anxiety. The aim of this study was to explore women's experience of threatened preterm labour, risk assessment and management in order to identify potential improvements in practice.

Design: One-to-one semi-structured interviews with 19 women who experienced assessment for threatened preterm labour took place between March 2015 and January 2017. A purposive sample approach was employed to ensure participants from different risk and demographic backgrounds were recruited at an inner city UK NHS hospital. Interviews were recorded and transcribed. Data was managed with NVivo software and analysed using the Framework Approach. A public and patient involvement panel contributed to the design, analysis and interpretation of the findings.

Findings: Data saturation was achieved after 19 interviews. 11 women were low risk and 8 were high risk for preterm birth. All high risk women had experience of being supported by a specialist preterm team. Four main themes emerged: (i) coping with uncertainty; (ii) dealing with conflicts; (iii) aspects of care and (iv) interactions with professionals. Both low and high risk women experiencing TPTL struggle to cope with the uncertainty of this unpredictable state. The healthcare management they receive can both help and hinder their ability to cope with this extremely stressful experience. High risk women were less likely to receive conflicting advice.

Key conclusions and implications for practice: Clinicians should acknowledge uncertainty, minimize conflicting information and advice, and promote continuity of care models for all women, including those attending high risk clinics and in the ward environment.

Introduction

Preterm birth is a major cause of neonatal death and severe morbidity (Marlow et al., 2014), so the development of symptoms or problems that may indicate premature labour can cause considerable stress and anxiety. Many women experiencing symptoms of threatened preterm labour (TPTL) will not subsequently deliver early, so clinical assessment and test results that can reassure as quickly as possible are likely to be beneficial. For those women whose symptoms develop into preterm labour and birth, accurate risk assessment is vital to ensure interventions, such as the administration of antenatal corticosteroids for fetal lung maturation, can be instigated quickly.

Aims

The overall aim of the PETRA study was to provide data that would lead to improvements in the management and experience of women with

symptoms of TPTL. In the first part, a prospective cohort study, data was collected for the development of a risk assessment tool for calculating individual likelihood of preterm birth. The tool combines background risk factors, gestation and test results (fetal fibronectin and cervical length) and calculates a simple percentage risk of delivery within certain clinically important time points (Watson et al., 2017). Knowledge of this individualised risk may enhance clinical decision making and increase confidence that management is offered to those most at risk while reducing unnecessary intervention and providing reassurance to those who are not. We also aimed to explore the experience and views of women with TPTL symptoms and the factors that could both positively and negatively affect that experience. This paper presents findings from this second, qualitative, part of the PETRA study.

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Literature review

Literature on women's experience of preterm labour or being at risk of preterm birth is limited with most published studies being qualitative in nature with few participants. A picture emerges, however, of a challenging experience where women with symptoms of preterm labour try to cope with anxiety and uncertainty. They are called upon to make decisions on when to seek help, dealing with fears for the health of the baby, and often having to cope with a loss of control as they try to balance other responsibilities such those to other children or work commitments (Barlow et al., 2007; Coster-Schulz and Mackey, 1998; Mackey and Coster-Schulz, 1992; Palmer and Carty, 2006; Patterson et al., 1992; Weiss et al., 2002). The experience of hospitalisation or home bedrest for preterm labour has been described by a number of authors (Adler and Zarchin, 2002; Hoglund and Dykes, 2013; Lowenkron, 1999; Mackinnon, 2006) where similar themes describe women's anxiety, loss of control and conflicting responsibilities.

There is a greater paucity of evidence around women's experience and views on specific tests used as part of TPTL assessment or common interventions. Only one study was found that explored the experiences of women who had had fetal fibronectin testing as part of their assessment for TPTL symptoms (Peterson et al., 2014). The authors concluded that this test is acceptable to women but also described how participants felt increased anxiety as they waited for the results. Vis et al. (2011) undertook a systematic review of papers assessing the additional effects (such as reassurance) of cervical length measurement in threatened preterm labour but did not find a single study that had measured the psychosocial effects. One study described women's experiences of *in utero* transfer (IUT) and how, despite little knowledge of IUT and feelings of unpreparedness, most women were resigned to the intervention (Porcellato et al., 2015). No studies were found on women's experience of antenatal corticosteroid use, one of the most common interventions for women with TPTL symptoms (Roberts et al., 2017).

Methods

This study was part of the "Threatened preterm labour: risk and care management", the PETRA study, which was approved by South London Research Ethics Committee (REC Ref. 14/LO/1988).

Participant selection and recruitment

A number of participants who agreed to take part in the prospective cohort study were invited to participate in the qualitative component. In an effort to capture the experience of a wide variety of women, a purposive sample strategy was used (Ritchie et al., 2013). Willing participants were given written information to consider before an interview was arranged. The information provided included reassurance that additional support would be available should the participant find talking about their experience upsetting. Written consent was obtained before commencement of the interview.

Setting

Participants received care at a large inner city teaching hospital which provides a specialist service for women at risk of preterm birth. The team offers clinical care through their preterm surveillance clinic and provides information and advice for both women and clinicians, locally and nationally.

Data collection

Data was collected through semi-structured, one-to-one interviews which were carried out between March 2015 and January 2017. Following informed consent, participants were asked to talk about their experience and views on their care and any interventions they may have

received. The interview schedule was designed following literature review, consultation with clinical colleagues and in collaboration with the local preterm birth studies public and patient involvement (PPI) panel. Interviews took place in a private room in the hospital or at home, at a time convenient to the participant as soon as possible after the initial assessment for TPTL. The interviews lasted approximately one hour and were recorded, with participants consent, on digital audio equipment. The interviews were then transcribed and prepared for analysis.

Data analysis

The Framework approach (Ritchie and Spencer, 2002) was used to analyse the data, which is a systematic method of qualitative data analysis designed to generate findings that can inform practice and policy. The steps used within this approach lend themselves well to the data generated in this study as the primary aim was the description and interpretation of a pre-defined sample in a specific setting (women who have experienced TPTL symptoms and their care) with the *a priori* issue of women's experience of risk assessment procedures and management. In order to increase validity, a proportion of transcripts and identification of themes was reviewed by an academic supervisor. Data was managed using NVivo Pro (version 11) qualitative data software. The preterm birth studies PPI panel contributed to the interpretation of results.

Findings

Participants

Data saturation was achieved after 19 women had been interviewed. Eleven had no risk factors for preterm birth, while eight were high risk. Seven of the eight high risk women had experienced previous preterm birth or late miscarriage, and one had a twin pregnancy. Eleven women were admitted because of their symptoms and test results.

Themes

Four main themes were identified, two of which captured the women's experience of threatened preterm labour, "Coping with uncertainty" and "Dealing with conflicts" and two which elucidated elements of care which had an important effect on the experience, "Aspects of care" and "Interactions with the Professionals" (Fig. 1).

Theme 1: coping with uncertainty

Threatened preterm labour is a state of uncertainty, where women experience symptoms that may, or may not be early preterm labour. Data from this study suggests that women, both worried first time mothers and women with a history of preterm birth, will initially try to make sense of the symptoms they are experiencing, go on seek reassurance and then try to maintain a sense of control over this unpredictable state as they "try to hold it together".

Trying to make sense of the symptoms. Many women appeared to have spent some time trying to rationalise their symptoms as something other than preterm labour, although this was less likely in women with a history of PTB. Some women worried that their symptoms had been caused by something they had done, for example, activity, sex or not resting enough, and they felt responsible.

*"Maybe because I was walking a lot more than usual ... I don't know."
[12_6239]*

Where symptoms remained unexplained, some accepted this and were reassured, although often initially described feeling "confused". Others were unhappy, and felt "shrugged off" by the healthcare professionals, which could diminish their trust in the doctors.

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