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Shame and avoidance as barriers in midwives' communication about body weight with pregnant women: A qualitative interview study

Anne Christenson, Physiotherapist, Cognitive therapist, PhD student[a,*], Eva Johansson, Professor emeritus[b], Signy Reynisdottir, MD, PhD[a], Jarl Torgerson, Senior consultant, Associate Professor[c], Erik Hemmingsson, Lecturer, Associate Professor[d]

[a] Department of Medicine, Obesity Center, Karolinska University Hospital, Karolinska Institute, Norra Stationsgatan 93, 113 64 Stockholm, Sweden
[b] Department of Public Health Sciences (IHCAR), Karolinska Institute, Tomtebodavägen 18a, 171 77 Stockholm, Sweden
[c] Department of Molecular and Clinical Medicine, Institute of Medicine, Sahlgrenska Academy, University of Gothenburg, Medicinaregatan 3, 413 90 Göteborg, Sweden
[d] Swedish School of Sports and Health Sciences, GIH, Lidingövägen 1, 114 33 Stockholm, Sweden

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ABSTRACT

Introduction: Excessive gestational weight gain, regardless of initial BMI, is associated with perinatal risks for both mother and offspring and contributes to obesity in women. Studies report that healthcare professionals find it difficult to communicate about weight and pregnant women perceive healthcare professionals as unconcerned, leaving many women uninformed about weight recommendations and risks. We aimed to explore how midwives approach communication about gestational weight gain recommendations, and to characterize communication barriers and facilitators.

Methods: Seventeen midwives from different areas in Sweden were interviewed by a therapist using semi-structured interviews. Interviews were transcribed verbatim and analysed by three researchers using latent content analysis. Recurrent themes were identified and formulated.

Results: The main theme identified in the latent part of the analysis was "midwives use avoidant behaviours to cope with fear of inflicting worries, shame or feelings of guilt in pregnant women". Avoidant behaviours include: adjusting weight recommendations, toning down risks and avoid talking about weight. Subthemes identified were (I) Conflicting responsibilities in midwives' professional identity (II) Perceived deficiencies in the working situation.

Conclusion: Midwives' empathy and awareness of weight stigma strongly affects communication about weight with pregnant women, and midwives' use of avoidant behaviours constitutes salient information barriers. More research is needed on whether gestational weight guidelines and weighing routines for all women, resources for extra visits, training in specific communication skills and backup access to other professions can facilitate for midwives to initiate and communicate about healthy gestational weight development, enabling more pregnant women to make well-informed lifestyle choices.

Introduction

Excessive gestational weight gain, defined as weight gain exceeding the Institute of Medicines' guidelines from 2009 (Rasmussen and Yaktine, 2009), has been found to contribute substantially to postpartum weight retention and obesity in women (Amorim et al., 2007; Mannan et al., 2013; Nehring et al., 2011; Phillips et al., 2014). A growing amount of studies also show that regardless of initial Body Mass Index (BMI), excessive gestational weight gain increases the risk for gestational diabetes, pre-eclampsia, large for gestational age babies and caesarean delivery (Cedergren, 2006).

The recommended range for pregnancy weight gain, based on initial BMI, is 11–16 kg for normal weight (WHO definition), 7–11 kg for overweight and 5–9 kg for women with obesity (Rasmussen and Yaktine, 2009). The recommendations are based on observational studies and indicate the optimal gestational weight gain span to balance the risk of having a large for gestational age (LGA) or a small for gestational age (SGA) baby.

Midwives play an important and versatile role in promoting healthy behaviours in women during pregnancy, and with more than 47–70% of pregnant women exceeding weight gain recommendations (Akgun et al., 2017; Brownfoot et al., 2016a; Johnson et al., 2013) there is in-

* Corresponding author.
E-mail addresses: anne.christenson@ki.se (A. Christenson), eva.johansson@ki.se (E. Johansson), signy.reynisdottir@ki.se (S. Reynisdottir), jarl.torgerson@vgregion.se (J. Torgerson), erik.hemmingsson@gih.se (E. Hemmingsson).

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creased interest in helping women limit their gestational weight gain. However, among pregnant women who participate in intervention programs, about 40–60% still gain excessively (Brownfoot et al., 2016a; Lindholm et al., 2010; Phelan et al., 2011), indicating that there is room for improvement. Also, studies report that due to the sensitivity of the topic, healthcare professionals find it difficult to communicate about weight (Anderson et al., 2015; Duthie et al., 2013; Hasted et al., 2016; Heslehurst et al., 2013; Willcox et al., 2012), and correspondingly pregnant women perceive healthcare professionals as unconcerned when they tone down risks with excessive gestational weight gain or avoid addressing the issue at all (Callaway et al., 2009; Christenson et al., 2016; Duthie et al., 2013).

This is unfortunate since women who are aware of their own BMI and individual weight gain recommendations are more likely to gain adequate gestational weight (Shulman and Kottke, 2016; Whitaker et al., 2016). In some previous studies, pregnant women were positive to healthcare professionals bringing up weight (Atkinson et al., 2016; Dinsdale et al., 2016) and to being weighed (Brownfoot et al., 2016b; Heslehurst et al., 2017), while other studies showed that women with obesity wished that weight should not be in focus for caregivers, and perceived weight controls as uncomfortable (Nyman et al., 2010). These findings suggest a potential communication problem that is largely unexplored and may leave pregnant women unaware of risks with excessive gestational weight gain and thereby less able to make well-informed lifestyle choices (Christenson et al., 2016).

Aims

We aimed to explore how midwives approach communication about gestational weight recommendations with women of BMI ≥ 18.5, and to characterize communication barriers and facilitators and thereby identify areas where improvements of interventions can be made.

Methods

Study design

To explore and obtain in-depth data of a complex research area where knowledge was limited, we chose qualitative methodology, utilising semi-structured interviews with consenting midwives. Interviews were carried out by the first author, a cognitive therapist with prior experience from study interviews.

Antenatal care in Sweden

Standard care for pregnant women in Sweden includes about ten visits to a midwife at an antenatal clinic (Olovsson, 2016). If the pregnancy is considered uncomplicated there is no doctor's visit involved. The first visits around gestational week 8–12 are followed by an ultrasound in week 18–20 and then regular follow-up visits from week 25 until birth.

There is a national agreement in maternal health care to promote healthy gestational weight gain based on IOM guidelines. The actual implementation of the agreement varies between regions and antenatal clinics. In general, BMI is calculated at the first visit and additional weight is collected at 24 and 35 weeks. Some antenatal clinics have locally designed intervention programs, aimed to limit excessive gestational weight gain, focusing mainly on women who start their pregnancy with BMI ≥ 30 kg/m^2.

Many Swedish midwives have received some form of course in Motivational interviewing (MI). MI contains several components that can be used for conversations about weight, such as asking what the woman already knows about the subject, how she feels about her weight and asking for permission to provide further information.

Study participants and recruitment

To retrieve as many different angles and experiences as possible of the area of research interest, recruitment was purposeful as we wanted as diverse a sample as possible regarding working experience, year of graduation, experience of participating in a weight intervention program, geographical location and socio-demographic characteristics of the pregnant population where the antenatal clinic is situated.

Seventeen midwives, with experience of working with women during pregnancy, where recruited between November 2016 and February 2017 via emails and phone calls to antenatal clinics. The first author contacted the head of each clinic and they in turn asked their midwives if they wanted to participate after having been informed about the purpose of the study. Participants came from 12 different antenatal clinics from different parts of Sweden and from areas that varied in socio-demographic structure. Three clinics that were approached at the beginning of the study, declined participation due to lack of time. Nine of the clinics had been previously engaged in intervention programs.

All participants received oral and written information about the study purpose and procedure, and provided written informed consent. Since no patients participated in the study, no ethics approval was needed according to The Stockholm Research Ethics Vetting Boards decision nr: 2016/1278-31/5.

Data collection

A semi-structured interview guide was used to certify all pre-planned subject areas were covered (midwives' awareness of weight gain recommendations, their approach to promoting it and perceived hinders), while also allowing midwives to speak freely about whatever topic they associated with the subject:

- Tell me what you know about the association between weight gain and health during pregnancy?
- Where did you get your weight related knowledge from?
- What are your experiences of communicating about gestational weight gain?
- What are your experiences of weighing pregnant women?
- What do you do if you notice an unhealthy weight development?
- What do you think is the reason for excessive gestational weight gain?
- What do you think promotes healthy weight development during and after pregnancy?
- What are your beliefs and experiences around breastfeeding and weight change?
- What do you think (if anything) could help you improve your ability to promote healthy weight development in pregnant women?

To go deeper and clarify any uncertainties, the first author probed with more questions when necessary and midwives were encouraged to tell us about any factors they associated with the research topic. The midwife chose a convenient location, which was either in their clinic, at a hotel, or via Video call. The interviews comprised 10 face-to-face interviews and 7 video calls and lasted between 30 and 46 min, mean and median: 37 min. Interviews were audio-recorded and field notes were taken during the meeting.

After the interviews had been transcribed verbatim, the recordings were erased and participants were emailed a copy of the transcript to be able to correct or complement their statements. Three participants wanted to add or clarify their transcripts, one to provide information about the weight range of their scales, one to add information about the contents of their own website and one to specify the number of pregnant women she had met that had undergone bariatric surgery.

Data was analysed continuously and midwives were recruited and interviewed until no new data or topics occurred in the last three interviews and it was decided between the researchers that the data set was saturated and the diversity of the sample was sufficient.