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Jakobsen, Sara Pihl; Overgaard, Charlotte

Published in:
Midwifery

DOI (link to publication from Publisher):
[10.1016/j.midw.2018.02.017](https://doi.org/10.1016/j.midw.2018.02.017)

Publication date:
2018

Document Version
Version created as part of publication process; publisher's layout; not normally made publicly available

[Link to publication from Aalborg University](#)

Citation for published version (APA):
Jakobsen, S. P., & Overgaard, C. (2018). “They’ll be judging us”: A qualitative study of pregnant women’s experience of being offered participation in a supportive intervention. *Midwifery*, 61, 81-87.
<https://doi.org/10.1016/j.midw.2018.02.017>

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Author's Accepted Manuscript

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PII: S0266-6138(18)30059-7
DOI: <https://doi.org/10.1016/j.midw.2018.02.017>
Reference: YMIDW2205

To appear in: *Midwifery*

Received date: 1 September 2017
Revised date: 12 February 2018
Accepted date: 18 February 2018

Cite this article as: Sara Pihl Jakobsen and Charlotte Overgaard, *"They'll be judging us"* A qualitative study of pregnant women's experience of being offered participation in a supportive intervention, *Midwifery*, <https://doi.org/10.1016/j.midw.2018.02.017>

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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**

Sara Pihl Jakobsen MSc (Research Assistant)^{1*}, Charlotte Overgaard RM, MSc, PhD (Associate Professor, Women’s, Child & Family Health)¹

Department of Health Science and Technology, Public Health and Epidemiology Group, Aalborg University, Niels Jernes Vej 14, 9220 Aalborg Øst, Denmark

sarapjacob@hotmail.com

co@hst.aau.dk

***Corresponding author:** Sara Pihl Jakobsen

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.

Keywords: vulnerable women; antenatal care; qualitative methods; pregnancy; intervention; experiences

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 (Daoud et al., 2014; Kramer et al., 2000; Lewis, 2007; Talge et al., 2007). 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 (Birtwell et al., 2015; Kirkpatrick et al., 2007).

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 has showed that a safe and supportive relationship between the vulnerable woman and the health professionals is essential (2007). It is therefore of crucial im-

portance 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.'s reflective lifeworld approach, which integrates phenomenological and hermeneutic philosophy (2001) 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's philosophical hermeneutic approach (1998) 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

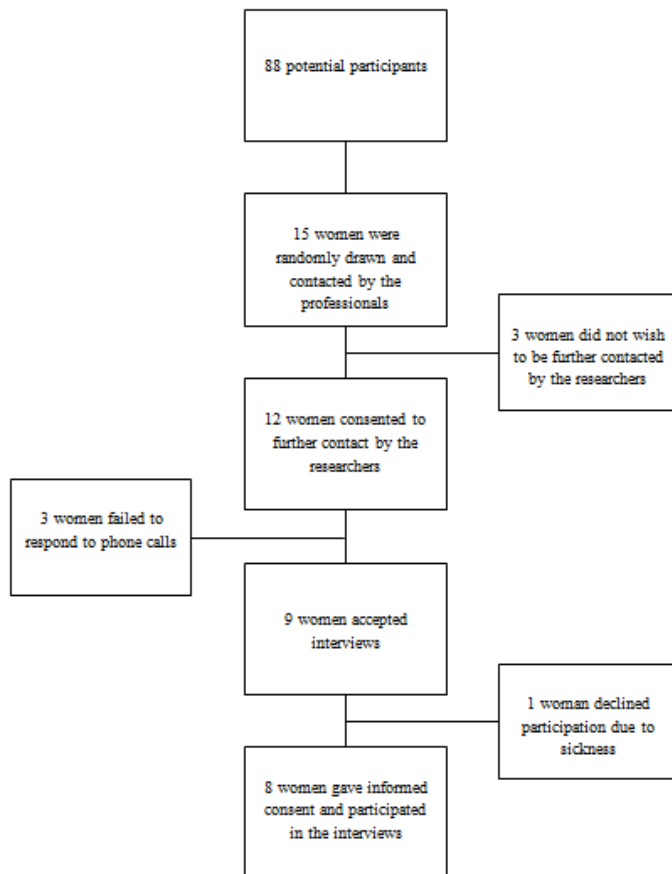
(17th week of pregnancy) all women were screened for vulnerability factors. All midwives were trained to use the same semi-structured interview guide with questions focused around the woman's and her partner's upbringing and life situation, their health, well-being, relationship, network and resources, 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 over-sample 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. Figure 1 gives an overview of the recruitment process.

Figure 1 The recruitment process



The study participants' characteristics are presented in Table 1.

Table 1 Participant's characteristics (fictitious names)

Women	Age	Employment/ Education	Civil status	Vulnerability factors	Additional support/ Involvement
Alison	29	Teacher	Cohabiting**	Unintended pregnancy	None

Amber	21	Social benefits claimant	Cohabiting**	Young mother; partner has mental illness	Involvement by social service
Gabrielle	27	Factory worker	Cohabiting**	Unintended pregnancy	None
Marissa	22	Student	Cohabiting**	Young mother; both partners with history of substance abuse	None
Shannon	21	Student	In relationship**	Partner's childhood marked by violence and abuse	None
Lynn	24	Social and health worker	In relationship**	Unstable relationship with partner	None
Holly	22	Student	No longer in relationship	Childhood marked by violence and abuse; partner has mental illness	Postpartum stay at mother-baby home
Danielle	21	Stay-at-home mother	Cohabiting**	Young mother; complex social background	Involvement by social service. Postpartum withdrawal from the intervention

** Cohabiting/in relationship with father of child during pregnancy and now

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 experi-

ence 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., the first interview was perceived as pilot interview, but as no need for major changes to the interview guide was identified, it was included (2008). The remaining four interviews were conducted by one researcher. All interviews were audio-taped and transcribed verbatim by the interviewer, while another research team member collated the transcription and the audio tape to ensure consistency. Data analysis was undertaken using NVivo Pro 11.

Data analysis

Following Dahlager and Fredslund's approach aiming to integrate phenomenological and hermeneutical methodological perspectives, a four-step analysis was undertaken (2008). The first three steps were inspired by phenomenology and Giorgi's (1994) recommendation that the researchers strive to "bracket" their own preunderstanding of the phenomena to ensure a strong empirical foundation of the analysis. A first impression of the interviews was formed through reading and listening. Meaning units were then identified and coded according to themes, which were subsequently reviewed for further operationalization. The fourth hermeneutical step followed Gadamer (1998) in consciously applying the researcher's preunderstandings to a "fusion of horizons". During this last step, the themes were recontextualized and combined in relation to the broader study context. All interviews were encoded by more than one member of the research team. The individual researcher's preunderstandings, identified themes and interpretations were compared and discussed as well as theory and results from other studies to ensure a validated and integrated analysis and reflective interpretations of meaning, which resulted in a joint analysis.

Ethics

According to Danish legislation, interview studies are based on written consent and require no ethical approval (Ministry of Health, 2011b). Throughout the study, the principles outlined in the Act on Research Ethics Review of Health Research Projects (2011) regarding informed consent, withdrawal, confidentiality and anonymity were followed. All participants were informed orally about the study at recruitment and prior to the interviews, and their written consent was obtained.

Findings

Four major themes and four subthemes were identified: A feeling of being labelled (subthemes: “Not that kind of woman”, Provoking self-doubt about parenting skills); Not knowing what to expect (subthemes: Insufficient information, Unclear expectations); Going along with the midwife’s suggestion and Establishing a trusting relationship.

A feeling of being labelled

“Not that kind of woman”

Most of the women in our study were overwhelmed by being categorized as vulnerable and offered participation in the intervention and struggled with seeing themselves as someone in need of help and support to succeed with motherhood. Gabrielle, a 27-year-old factory worker, and her cohabiting partner participated in the intervention because her pregnancy was unintended. In this typical quote she shared her thoughts on the target group for the intervention:

“I thought that this [intervention] was offered to someone who is not in control of anything – that they are trying to help those who are not suitable for parenthood.” (Gabrielle)

The women’s perceptions of the intended target group provoked negative thoughts related to the women’s own identity and a feeling of being judged as an inadequate mother. The professionals’ and the women’s perception of their level of vulnerability often appeared to be at odds. In the process of coming to terms with the situation, the women reflected on their social position and the motivations behind the invitation.

As part of their reflections, the women self-negotiated the reasons for the invitation to participate, and some of them found what appeared to be ways of distancing themselves from “the kind of women” that they believed to be the core target group for the intervention and thus also from the fear of being cast into a marginalized group. Alison, who was a school teacher for instance said:

“When I thought it over ... well, it’s not because I’m socially marginalized, socially deprived or anything like that. It’s simply because I put too high demands on myself. That’s where they [the professionals] said this could actually help you. It was super cool. But I didn’t fit into the normal box.” (Alison)

In coming to terms with the categorization, some of the women were helped by the professionals in explicating and accommodating their difficult feelings, as expressed by Gabrielle:

They told me that many women fear having their child taken away and things like that [...]. That’s what a lot of girls are thinking when they’re asked to join. But they talked me out of my thoughts and made me relax more.” (Gabrielle)

It appears from the interviews that the professionals were aware of the women’s negative associations and supported them in articulating their apprehensions and distancing themselves from their negative perceptions of the target group, thus making participation acceptable.

Provoking self-doubt about parenting skills

While social categorization and stigmatization was a general concern, many of the women also felt that their parenting skills were being questioned and that they were perceived as women who needed professional help to succeed with motherhood. This left them with a very hurtful sense of inadequacy. In addition, some of them feared that their child would be removed by the social services as they believed that the professionals had a role in evaluating their parenting skills. In general, such feelings gradually subsided. However, for Holly, a young mother with a troubled background, the feeling of being seen as an unfit mother with poor

parenting skills was paramount throughout the intervention. This appeared to have a major influence on her experience of participation:

“I was afraid to say no. I was afraid what would happen if they informed the council and then the council would come and take my son away from me because I was uncooperative –but I wasn’t, it was only that I wanted things to be done properly.” (Holly)

Not knowing what to expect

Insufficient information

The theme discussed above was closely linked with the theme called “Not knowing what to expect”, which encapsulated the women’s uncertainty about the aims and content of the intervention. Amber, a young mother, spoke for most of the women in saying:

“They didn’t explain to us what it would be like or what it actually was about ... only that we would be sitting down and talk about a lot of things.” (Amber)

The women were told that the intervention consisted of conversations with a midwife and a health visitor, while no specific information about aim and content, or the basis of the women’s selection for participation was provided. All information was given orally by a midwife from the general antenatal team performing the routine screening for vulnerability. Overall, their feeling that they had been inadequately informed led to confusion as to the reason for their invitation, and the women struggled to see the point of participation at the same time as they felt that their ability to cope with motherhood was being questioned and that their parenting skills were under evaluation. Gabrielle’s reflections are typical:

“They might have formulated it in another way when they suggested I join [...] they kind of made me feel that I would be insufficient as a mother.” (Gabrielle)

Gabrielle’s troublesome feelings of being short-traded on information and caught off guard are contrasted by those of Marissa, a mother with a history of substance misuse. She had a clear understanding that her and her

partner's participation in the intervention aimed at helping them cope with their challenges rather than evaluating them:

“He [her partner] felt that it was a criticism against us and that we'd be monitored and stuff like that, but they [the midwife and health visitor] carefully explained that it wasn't about that at all.” (Marissa)

For many of the women the feeling that they had been insufficiently informed, in particular about the primary screening for vulnerability, was critical. The subsequent clarification of the aim and content of the intervention given by the professionals was seen as very helpful by the women and their partners and generally relieved their apprehensions concerning participation.

Unclear expectations

The information deficit also meant that many of the women had very unclear or mismatching expectations of the intervention. Danielle, a young mother with a complex social background, expressed her disappointment with the intervention:

“Well, I had expected we would be given some facts and practical information about becoming parents, but that wasn't the case at all!” (Danielle)

Danielle's perspective on her degree of vulnerability and antenatal care needs deviated markedly from the professionals' view. The poor alignment and perceived lack of information made her feel that her needs were not met.

Going along with the midwife's suggestion

Despite their unclear ideas about what they were agreeing to, most of the women followed the midwife's suggestion for participation in the intervention. They expressed a range of reasons for going along with the midwife's suggestion. Three of the women did not feel that participation had been presented as a real offer as

explained by Holly, who felt that the midwife performing the screening had forced the intervention upon her:

“It was presented as an offer, but I did not feel that it was – it was more that she [the midwife] thought that it would be a good idea that we accepted this – otherwise she’d have to tell the council that we were uncooperative on a project that could help us.” (Holly)

The coercion felt by Holly made her very cautious about what she said for fear that the social services remove her child. Holly was eventually asked to stay in a mother-and-baby home for the first months after birth; a stay she found helpful and supportive.

Having accepted participation, two women spoke of a wish to “prove the professionals wrong”. Other women seemed to trust the professionals' judgement that participation would be beneficial, despite occasional ambivalence and confusion as to how the intervention could help them. Lynn explained:

After we had talked a bit about my childhood she [the midwife] thought it would be a good idea [to participate], and I thought, well, it might be a good idea. I just trusted her when she said that it was a good idea. (Lynn)

Establishing a trusting relationship

Although most women initially experienced negative or ambivalent feelings when introduced to the intervention, they generally spoke positively about the outcome of the intervention. The key to this change appeared to be the establishment of a safe, trusting and non-judgemental relationship with the professionals. Especially for Alison and Gabrielle, who had experienced the introduction to the intervention as particularly hurtful, this development was crucial. Alison described how, despite her initial feeling of being stigmatized, the professionals made her and her partner comfortable enough to speak openly about their challenges:

“We could talk about everything. Absolutely everything. My feeling was that they saw us as who we were [...]. It was so liberating to be able to sit with two strangers, yet they were just so professional and so humane – it was really nice.” (Alison)

In contrast, neither Holly nor Danielle experienced the development of trusting relationship with the professionals. Unlike Danielle, Holly continued her participation, although her relation with the professionals was distanced and distrustful. It appears that the introduction to participation as an “offer she could not refuse” influenced both her inclination and ability to open up to the professionals and severely restricted the outcome of her participation.

Another key factor in the change in the participants’ attitudes to the intervention relates to the professionals’ ability to explain its aims and content and to empathize with the women's feelings at being singled out as vulnerable mothers. The professionals were able to help some but not all participants overcome their initial worries about being “under surveillance” as explained by Emilie:

“I thought now they will judge us on how we were going to be parents and all, but they didn’t. It was just to talk to us, and they said that from the first conversation; we will not judge you as parents or anything; it is basically just an offer to talk. [...]. Already from the first conversation we learned what it really was.” (Emilie)

Discussion

In this study we explored eight first-time mothers’ experience of being offered participation in a supportive intervention and how their experiences influenced the outcome of the intervention. The categorization as vulnerable generally elicited feelings of stigmatization in the women. Many reacted with anxiety and a sense of inadequacy. A lack of information about the aim and content of the intervention led to confusion, unclear expectations and worries about being evaluated as parents. The women had various reasons for accepting the midwife’s suggestion about participation, although they had no sense that an informed choice was being offered. Despite this, the negative feelings subsided for the majority of the women, and positive outcomes were achieved. The professionals’ ability to establish a trusting and non-judgemental relationship with the women or the couple was a key factor in this.

The women generally revealed negative preconceptions of interventions for vulnerable pregnant women and struggled to identify themselves with the perceived target group. This corroborates earlier findings of a dis-

crepancy between women's and professionals' perceptions of women's vulnerability and need for support. As was the case in our study, the women had no clear perception of the grounds for the invitation to participate in the intervention (Barlow et al., 2005).

The women's initial reaction with incomprehension and anxiety at the invitation may partly be a result of the systematic screening of all pregnant women for vulnerability factors and furthermore the wide definition of vulnerability applied. This may be why, some women who did not themselves regard e.g. their life circumstances as particularly challenging, were included.

The women's perception of the professionals' stigmatizing view of them as unfit mothers was an important unintended consequence of the intervention. This issue has previously been raised by participants in other studies, who reported that they felt judged on their lifestyle, or, if they disregarded the midwife's recommendation, even bullied (Downe et al., 2009; Ebert et al., 2014). There is nothing in our data to suggest that the participants were bullied, but it appears that unequal power relations were at play as many accepted participation despite reservations. Many did so before having a clear idea about the aim and scope of the intervention. While the women's acceptance may have reflected their trust in the midwife's advice and her ability to safeguard their interests, it may also have been caused by anxieties about being judged as irresponsible or "bad mothers", making them prone to avoid contravening the professionals' recommendations (Ebert et al., 2014). In professional circles, it is generally acknowledged that a woman's views, beliefs and values must be respected and that she should have the opportunity to make informed decisions about her maternity care and treatment in collaboration with the health professionals (National Institute for Health and Care Excellence, 2010). This approach is in line with Danish legislation to ensure that the patient's decision about treatment is based on adequate information (Ministry of Health, 2016). It is concerning to find that the women studied here were poorly informed about the intervention and thus unable to make an informed choice about their participation. This curtailment of women's autonomy and engagement in decisions about their own maternity care may be seen as an unintended consequence of the identification and recruitment procedure. Our findings support Ebert et al.'s conclusion that insufficient or inadequate information prevents women from engaging in their maternity care choices (Ebert et al., 2014). A thorough effort to provide ade-

quate information and secure good communication between professionals and vulnerable women is a prerequisite for women's opportunity to engage in their own care. The experience or fear of stigmatisation and prejudice may play a role in the well-documented inequality in the use of maternity care, where vulnerable women are found less likely to attend maternity care services (Feijen-de Jong et al., 2012; Raleigh et al., 2010).

Our results suggest that the introduction to the intervention and the lack of explanation of the reasons for encouraging their participation affected the women's self-images and perception of their own parenting skills negatively. This may be interpreted as a loss of self-efficacy, defined as the individual's belief in their own ability to perform certain actions. Self-efficacy affects how people think, feel and acts and is a result of a number of factors such as personal experiences, support and encouragement from others (Bandura, 1986). Although in hindsight most women felt they had benefitted greatly from the intervention and were happy they had accepted participation, the initial feeling of being labelling as unfit mothers left an indelible mark on some of the women's reflections on their pregnancies and lives as mothers.

We have documented that the described information and communication problems occurred primarily in the initial screening and referral to the intervention. The professionals' ability to establish a trusting, supportive and non-judgemental relationship with the women was a key factor in helping them overcome their initial concerns, and eventually secured positive outcomes of the intervention. This finding echoes those of other studies, which have shown that successful interventions are grounded in empowering, collaborative and non-judgemental relationships (Kirkpatrick et al., 2007; McLeish and Redshaw, 2017). An examination of barriers to participation has shown that women's main reason for non-attendance was suspicion and mistrust of health care providers. A feeling of being judged by their lifestyle and labeled by the health professionals also discouraged women from attending maternity care (Downe et al., 2009).

Although our sample was small and homogeneous, and the findings should be generalised with caution, we find indication that the failure to create safe and trusting relationships prevents women from engaging in an intervention and may disincline them from speaking openly about their challenges. Ebert et al. (2014) like-

wise found that a safe relationship with the midwife was instrumental for the woman's ability to engage in or take control of her maternity care as she worried about being judged as an irresponsible mother. Other studies have also shown that vulnerable women find it difficult to trust professionals (Barlow et al., 2005; Bloom et al., 2013; McLeish and Redshaw, 2017).

Methodological considerations and study limitations

A limitation of this study is the relatively small number of women participating in one, specific intervention. Other opinions and nuances may have been offered by enlarging the number of participants or especially by including non-Danish speaking women or women with prior experiences with pregnancy and motherhood. Still, we were able to generate rich data from women with varied life circumstances and perspectives. To make the women feel safe and in control they were free to choose the place for the interview. All appeared comfortable with their choice and the location did not seem to affect their confidence to speak openly. The analysis showed some saturation of data. Saturation can be reached quite early if "*the goal is to describe a shared perception, belief or behavior among a relatively homogeneous group*" (Guest et al., 2006 p. 76). As argued in the methodology sections, we believe this applies to our study.

Recruitment was based on random selection and facilitated by use of gatekeepers. We believe this approach proved relevant, leading to a high number of the women contacted by gatekeepers accepting being contacted by the research team. The later withdrawal of some of the women underline, that recruitment of vulnerable individuals for research is challenging. Participants may be suspicious or concerned about why they are being studied and may also have had negative experiences with authorities in the past. Furthermore they may not want to put themselves in a situation leaving them feeling ashamed or exposed (Marsh et al., 2017). It was a key issue for the research team, that women should be clearly informed about the study purpose and participation entirely voluntary. Thus, women were informed both by the gatekeeper and before being asked to sign the written consent form, that we would protect their anonymity and that their answers would not be known to the intervention staff. Distrust may however still have played a role in women's decisions on participation. If the women withdrawing were more vulnerable or had more severe problems compared to the eight interviewees, this may have influenced our results. Based on these and earlier studies (Barlow et al.,

2005; Ebert et al., 2014), we do however find it unlikely that more vulnerable women would have had more positive experiences of the initial screening and recruitment for the intervention than the women interviewed. While observation of the interaction between the women/couples and the health professionals in antenatal consultations and dialogic sessions was outside our scope, it may have contributed with additional insights and could be considered in future research.

What this study adds

This study adds to the limited knowledge on the users' perceptions and experiences on interventions for vulnerable pregnant women and has indicated unintended consequences including stigmatization and social categorization as well as feelings of uncertainty, anxiety and judgement, here related to the method of introduction to participation. This highlights the importance of a trusting and non-judgemental relationship and thorough information about the aim and content of interventions aiming at this group. The chances of positive outcomes would be enhanced by offering real informed choice and stressing the benefits of participation in terms of thorough information about aim and content.

Implications for practice

Our findings demonstrate the need for awareness of the women's sensitivity to categorization as vulnerable and belonging to the target group for support. Furthermore, professionals recruiting women for such interventions should offer women detailed information, an informed choice of participation as well as help to articulate and accommodate difficult feelings, which may be provoked. The study findings may further the development of antenatal care for vulnerable women by raising care providers' general awareness of the women's perspectives.

Conclusion

This study has shown that an invitation to participate in an intervention targeting vulnerable pregnant women may induce unintended feelings in relation to stigmatization and judgement and may provoke a feeling of doubt about own ability to cope with motherhood. A lack of information about the aims and contents of the

intervention is likely to create confusion and anxiety and cause the participants to feel they are being judged as parents. A thorough introduction to the intervention and the grounds for offering participation may help women overcome initial scepticism. The establishment of a trusting relationship between women and professionals appears to have a significant impact on the outcome of the intervention.

Acknowledgements

We are grateful to all women who participated in the study and generously shared their experiences and to the health professionals facilitating our contact to former participants in the intervention. Furthermore, we thank Ajla Dzubur and Pernille Frøstrup for their important contribution to the data collection and project.

Conflicts of interest

None.

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Ethical Statement

Ethical Approval

According to Danish legislation, interview studies are based on written consent and does not require ethical approval. The principles outlined in Act on Research Ethics Review of Health Research Projects regarding informed consent, withdrawal, confidentiality and anonymity were adhered to throughout the study. All participants were informed orally about the study at recruitment and prior to the interviews, and their written consent was obtained.

Funding Sources

Aalborg University. No specific grant from funding agencies in the public, commercial, or not-for-profit sectors was received for this research.

Clinical trial

Not applicable

Author Contributions

SPJ and CO developed the concept for this study. Data collection and analysis was carried out by SPJ together with Ajla Dzubur and Pernille Frøstrup and supervised by CO. SPJ wrote the first draft of the manuscript. Interpretation of data and critical revisions of the manuscript are the joint work of SPJ and CO and both approved the final version of the manuscript.