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Midwives' strategies in challenging dietary and weight counselling situations

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ABSTRACT

Objective: By enhancing maternal nutritional status, midwives can help women lower the risks of pregnancy complications and adverse birth outcomes as well as improve maternal health during pregnancy and in the long run. Dietary counselling is, on the other hand, not reported to be effective. Poor communication and conflicting messages are identified as possible barriers to adherence with recommendations. Midwives' experiences of providing dietary advice and counselling during pregnancy are sparsely reported. The aim of this study was therefore to explore midwives' strategies when faced with challenging dietary counselling situations.
Methods: Seventeen midwives from different parts of Sweden and working within antenatal health care were interviewed by telephone. The interviews were analysed using qualitative content analysis.
Results: Challenges were commonly experienced when counselling women who were overweight, obese, had eating disorders or were from different cultures. The midwives talked in terms of "the problematic women" when addressing counselling problems. Strategies used in challenging counselling situations were Getting acquainted; Trying to support and motivate; Pressure to choose "correctly"; Controlling and mastering; and Resigning responsibility.
Conclusions: The results indicate that Swedish midwives' counselling strategies are quite ambiguous and need to be questioned and that counselling of vulnerable groups of women should be highlighted. We could identify a need for education of practicing midwives to develop person-centred counselling skills.

Introduction

Dietary advice during pregnancy has changed over time and differs between countries. In general, avoidance of toxins, contaminants, drugs, and other food safety issues are important for pregnant women and the foetus and recommended by midwives in antenatal care. Furthermore, according to the Nordic Nutrition recommendations from 2012, energy requirements increase slightly during pregnancy by approximately 100 kcal in the first trimester to about 500 in the last [1]. The aim of dietary counselling in pregnancy is a nutritionally balanced and "healthy" diet [1,2] and a restricted weight gain to reduce the risks of obstetric complications [3–5]. Avoiding unnecessary weight gain is especially important since, according to the Swedish Medical Birth Register [6], overweight (BMI >25) among women in early pregnancy increased from 25% in 1992 to 38% in 2011.

Dietary counselling in pregnancy has benefits. By enhancing maternal nutritional status pregnant women lower their risks of pregnancy complications and adverse birth outcomes while improving their own health in the long run [7]. A Dutch study showed that pregnant women were reported to have higher nutrition awareness than non-pregnant women, especially concerning food items to avoid [8]. A meta-analysis including 44 trials (7278 women) found that dietary and lifestyle interventions during pregnancy reduced maternal gestational weight gain and improved outcomes for both the mother and child. Interventions based on diet were the most effective and were associated with reductions in gestational weight gain and improved obstetric outcomes [9].

Dietary counselling is, on the other hand, reported to be less than effective. In a Swedish focus group study pregnant women noted they received insufficient information and counselling about diet. Feelings of fear and guilt as well as feelings of being controlled by the midwives and by their own families and friends were described [10]. A study from the US revealed that less than half of the participating pregnant women reported receiving dietary advice from a health care provider and younger women with low income and multiparous women were least likely to get sufficient dietary advice [11]. In an international review, reporting adherence to dietary recommendations, pregnant women with low income, obesity and poor food habits prior to the pregnancy were reported as having

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Table 1
Midwives' working areas and work experiences.

Midwife code	Geographical working area (N = North M = Mid-Sweden S = South)	Working rural/central (Rural = R/Central = C)	Work experience as midwife (years)	Work experience in antenatal care (years)
M1	N	C	5	4
M2	N	R	2	1.5
M3	N	C	1	0.5
M4	S	C	31	22
M5	M	C	19	16
M6	N	C	23	17
M7	N	C + R	29	3
M8	M	R	26	24
M9	M	C	32	25
M10	S	C	26	16
M11	M	C	35	25
M12	N	C	38	31
M13	N	R	15	15
M14	M	C + R	2	2
M15	S	R	38	17
M16	M	R	28	13
M17	M	C	17	15
Total	7 N 7 M 3 S	5 Rural/10 central 2 both rural and central	Mean 19 (median 26)	Mean 12 (median 16)

problems adhering to dietary recommendations [12]. The effect of dietary counselling in a group of pregnant women in UK was reported to increase if they were given food vouchers [13].

Problems in counselling and associated poor adherence have been reported in the scientific literature. Poor communication of advice and conflicting messages have been identified as possible barriers to adherence [14,15]. Furthermore, inability among midwives to provide person-centred advice is reported as another barrier to effective dietary counselling [7,11,16]. Differences in what is seen as culturally accepted food, individual dietary preferences, and low levels of food literacy also play a role in non-adherence [14,15]. All these aspects constitute challenges for midwives working in antenatal care but to the best of our knowledge, studies of midwives' experiences and ways of acting in challenging counselling situations are sparse.

The aim of this study was, therefore, to explore midwives' strategies in challenging dietary counselling situations, that is, in situations where they experienced problems communicating with pregnant women about the benefit of changing dietary habits.

Materials and methods

Context

Antenatal health care in Sweden is provided free of charge by the public sector. The standard care program includes 8–10 check-ups by a midwife during non-complicated pregnancies. According to the guidelines for midwives, these check-ups should include health counselling in various areas including information about the negative effects of smoking and alcohol and providing advice about a healthy diet.

Participants and settings

Seventeen female midwives working within Swedish antenatal healthcare participated in the study. The midwives were selected by strategic geographic sampling and recruited with help from local coordinating midwives, local managers, and through "snowball sampling" implying that one participating midwife suggested names of other midwives who could be contacted. In total, 22 participants were suggested, contacted and informed by telephone and letter about the study. Five midwives declined participation. The participants' came from eight different counties in Sweden, from the north to the south, and their work experiences in primary health care clinics varied between 6 months and 31 years with a median of 15 years. The midwives are de-identified with codes in the text and quotations, but in Table 1, the working area and work experience of each participant are described.

Interviews

An interview guide with the following three question areas was used: When and what kind of dietary advice is given to pregnant women; Examples of successful and challenging counselling situations; Own experiences of difficult and challenging dietary counselling. The first author conducted the semi-structured telephone interviews, lasting 20–40 minutes, in the spring of 2012.

Analysis

The audio-recorded interviews were transcribed verbatim. Qualitative content analysis was used to highlight similarities and differences between and within codes and categories [17]. The method addresses the manifest and latent content in the text. After thorough reading, meaning units corresponding to the aim were identified. When required, the meaning units were condensed and shortened but core content was retained. The meaning units were then compared, coded into categories organised at different levels and in a particular order with each three to four underlying subcategories.. During all steps of the analysis, the members of the research group discussed the interpretations until agreements about the content and labelling of categories were resolved in order to enhance the trustworthiness of the findings.

Ethical considerations

We have not identified any risks for the midwives related to their voluntary participation in the interview study. The study has been approved by the Regional Ethics Board in Umeå, Sweden (Dno 2011-426-31 Ö).

Table 2
Overview of categories and sub-categories.

Strategies used in challenging situations	
Getting acquainted	Relating to and offering the women help and guidance
	Adapting to the women
	Treading carefully when addressing the problems
Trying to support and motivate	Listening actively
	Facilitating reflections about habits
	Supporting goal setting
Convincing about choosing "correctly"	Transferring general medical knowledge
	Clarifying the message
	Repeating the message
Controlling and mastering	Confronting the women with their poor lifestyles
	Forming an alliance with the women's partners
	Frightening them with medicals risks and complications
	Moralising about "good motherhood" obligations and "normal" family life
Resigning responsibility	Referring the women to other health care professionals
	Transferring responsibility to the women
	Distancing from the women
	Giving up – letting go.

Results

The midwives described their general dietary information focus was on prevention and the risks associated with unhealthy eating. Specific advice included eating cooked meals on a regular basis, avoiding alcohol, toxins, and contaminants, and following the Swedish National Food Administration's (NFA) recommendations. Information was given in early pregnancy and in connection with routine oral glucose tolerance tests in mid-pregnancy. Counselling strategies used in challenging situations could be separated into five categories with three to four subcategories each, which are presented in Table 2 and in text with quotations as examples.

Strategies used in challenging situations

Challenges in dietary counselling were a common experience for the midwives, particularly with women diagnosed as overweight, obese or with eating disorders. Immigrant women, vegans, and women living in socio-economic deprivation were also mentioned as being challenging to counsel. The midwives often talked in terms of "the problematic women". In such counselling, the midwives described various strategies, which we have sorted into the following five categories: *Getting acquainted*; *Trying to support and motivate*; *Convincing about choosing "correctly"*; *Controlling and mastering*; and *Resigning responsibility* (Table 2). These strategies were sometimes used as part of a process, i.e. the more difficulty the midwife experienced connecting with the woman, and more authoritative the midwives became. On the other hand there were midwives who used only one or two strategies. Overall, the use of counselling strategies differed greatly among midwives. The subcategories are written in ***bold italics*** and are exemplified by original quotations in the text.

Getting acquainted

In this strategy, which could be the first step of a counselling process, the midwives were striving to understand the women in their contexts and life circumstances. When women did not seem concerned or bothered about their habits, the midwives tried to understand them and their problems better. The midwives also described trying to evaluate the pregnant women's interests and motivation by ***relating to them and offering them help and guidance*** based on individual needs. Being curious about the women's own ideas and experience regarding how to solve problems was described as important.

> *I think you must be very curious, or curious about their experiences and their own ideas . . . and telling them that if they want help, they can get it . . . When you are too pushy . . . then it will not work out well irrespective of what you are saying. You lead the way and they are left behind.* (M 5)

When the midwives felt that they had problems reaching the pregnant women, they commonly tried to ***adapt to the women*** by changing counselling style to fit with an individual woman's needs.

> *I feel I have to meet her in the position she is in. I have to start there . . . and maybe not talking only about their diet because they often know this very well. Instead it is more about lifestyle patterns.* (M 10)

The participants were careful when asking about and discussing lifestyle issues, particularly with women who were either overweight or underweight. The midwives described how they would ***tread carefully when addressing the problems*** so as not to violate the women's trust. Counselling in weight issues was mentioned as even more difficult than addressing tobacco use or alcohol consumption.

> *You don't really know [how to counsel women with weight problems]. It's like walking in a minefield. You do not really know what might trigger them. But on the other hand, it's nothing you have to be frightened of. Because it's the only thing they think of themselves, FOOD. By talking about it you might de-dramatize it.* (M 5)

Trying to support and motivate

In the second step of the process the midwives described how they tried to ***listen actively*** in order to support women's motivation for change. By this they meant that they listened, gave feedback, asked for further explanations and also confirmed their views of their problems.

> *I listen actively and ask them how long it has been like this and how long they want to keep it like this.* (M 5)

To support inner motivation for change, the midwives also tried to ***facilitate reflection about habits*** and to problematise them. Several midwives described how they discussed the costs and benefits of making lifestyle changes.

> *Her BMI was 44 at the first visit so it was really large. I asked her if she used to walk outdoors and reflected about physical activities and about the costs related to her Coca-Cola consumption and sugar intake.* (M 6)

Supporting goal setting was another strategy to facilitate change. Setting goals that were too high and not realistic would not work. Dividing main goals into smaller ones and reaching them one at a time was seen as positive for self-efficacy and inner motivation. The midwives said that then women felt they had succeeded with at least some part of the goal.

> *It is realistic goals we are setting. We don't set 25 kg as a first goal because this is not achievable. Instead we have smaller goals because if you take it stepwise it goes easier . . . In this case we decided together that she should simply not gain any weight during the pregnancy.* (M 6)

Convincing about choosing "correctly"

Some midwives used this strategy exclusively, but most only resorted to it in situations when they felt that dialogue and counselling did not work and they could not connect. They then tried to convince and persuade pregnant women about making the "correct choices" in lifestyle and daily habits. One common method used was to ***transfer general medical knowledge*** about risks, such as diabetes and hypertension, and potential consequences of an unhealthy

diet for the pregnancy, the delivery, the child, and also for the expecting mother's future health.

> *To convince them to change, you tell them that it is important that the child avoids high blood sugars so as not to become obese in the future. I asked her, "What do you believe is the reason for your high blood sugars? Can it be that you eat a high amount of carbohydrates that are wearing down your insulin receptors?"* (M 10)

Trying to ***clarify the message*** to reach a better understanding among the women of the problem and how to solve it was also described as a common way to convince the women about the "right choice". Using pedagogical approaches such as visualising and comparing foods and nutritional issues were examples of this:

> *It is easier to use a brochure to point things out in, somewhat like teaching . . . the patients might not always want to keep the brochures and take them home, but at least we have looked at them and read them and pointed things out and so on. Therefore, I can see that they understand what I am talking about.* (M 9)

A few participants spoke of ***repeating the message*** over and over again throughout the pregnancy when they sensed no response from women, and doing this even if the midwives thought their message was falling on deaf ears.

> *She [the pregnant woman] doesn't want me to butt into her eating habits . . . but maybe it is something that will develop . . . My hope is that if you meet several times, maybe sometime during the pregnancy you will reach her and she will possibly listen to what you are saying.* (M 14)

Even if the midwife felt that her message continued to be ignored repeating it calmed her own worries about doing what was demanded from her as midwife.

Controlling and mastering

In order to influence women who did not adhere to dietary advice, some midwives described how they tried to control and master the women's behaviour, for example by telling them exactly how much and how often they were allowed to eat "unhealthy food". Alternatively they might ask women to keep diaries on food intake, including kinds, amounts, and frequencies, to present at the next visit. They would then ***confront the women with their bad habits and poor lifestyle***. The midwives also spoke of situations when pregnant women claimed that they had changed their dietary habits and routines, although the midwives doubted if this was true.

> *At the end of the pregnancy we were making a kind of summary and at that meeting she said, "I am usually outdoors walking." Then I touched her gently on her arm and asked, "Are you really honest now?" "No," she answered, "I have not been exercising at all."* (M 12)

As a way to insist on adherence to recommendations, the midwives sometimes attempted ***getting into an alliance with the partner of the expecting woman*** to get help in controlling and mastering her dietary habits.

> *Then I turned to the guy and said, "Perhaps you then are interested in food issues and can take this brochure and then we'll see if there is something you would like to talk about, something you don't really understand."* (M 5)

Some of the midwives also thought that to catch the women's attention they had to ***frighten them with medicals risks and complications.*** Women's insufficient dietary habits were presented as a direct threat to the health and life of the foetus and also an obvious risk for complications in delivery.

> *I talk about and address some of the complications that occur if you gain 25–30 kg. [I tell them that] many times this ends up in vacuum extraction and Caesarean section and prolonged labour.* (M 12)

Another patronising strategy to control the expecting women was to ***moralise*** about the woman's behaviour and relate that to norms about ***"good motherhood" obligations*** such as cooking and gathering the family around the dinner table. If women were not succeeding in their struggle to change to healthy dietary habits during pregnancy, the midwives appeared to sometimes question their success as mothers:

> *I usually ask about which lifestyle they have thought of when becoming a mother, about what kind of role model they want to become for the child. What is okay and not okay? It is not only about eating, it is about other parts too.* (M 6)

Many of the midwives stated that the pregnancy is a period when expecting mothers have to adapt to new circumstances and a new role with new responsibilities and that the midwife could influence this process through counselling. In the following quotation the midwife's perception of what constitutes "***normal" family life*** also becomes heteronormative and moralising.

> *If I think forward in time and about the social importance that surrounds sitting down together as father, mother, and children to eat, you have the social aspects that are so meaningful and important.* (M 8)

Resigning responsibility

In difficult situations when neither the communication nor the relation between midwife and pregnant woman worked, and the midwife comprehended the woman as non-adherent, resigning responsibility could be a last step. One way to handle non-adherent women who were seen as problematic, was to ***refer her to other health care professionals*** such as dieticians, physicians, or psychologists.

> *Furthermore, I find it difficult with vegetarians and vegans or those who have had different surgeries. But in these cases they get a doctor whom they can contact so you as a midwife can get away from the problem.* (M 14)

When the midwives felt that they could not reach the women with any strategy, or if they lacked knowledge or tools to motivate or persuade them to change, they could ***transfer the responsibility to the women*** themselves.

> *It ends up with me saying, "But you chose yourself what to do. I am not going to force anyone or say that it is absolute that one must keep to low-fat foods."* (M 11)

Under these circumstances the midwives described how they sometimes were ***distancing themselves from the women*** and their dietary problems. This occurred for example when midwives found that they did not have sufficient knowledge or when they had nothing more to add and therefore chose to focus on anything other than diet in their counselling.

> *I explained that we would simply discontinue this, and it didn't feel good. It certainly did not, but it felt like there were so many other aspects around her that focusing on her diet was totally wrong at that time. At the same time you know it's so important. But no, I could not take it anymore. No!* (M 17)

Finally, some midwives described how they also resigned responsibility in counselling of women with many problems and particularly when counselling immigrants from various cultures with unfamiliar dietary habits. The midwives expressed helplessness in counselling these women and used the strategy we have labelled as ***giving up – letting go***.

These ones [immigrants] are really, really hard. You just have to leave them to eat as usual. They don't eat this and they don't eat that and they eat this and that. Well, what should I do about it then? (M 6)

Discussion

The interviewed midwives talked about "problematic women" when describing those who were seen as challenging to counsel. In so doing midwives defined the problem as arising from the individual woman rather than her behaviour, the interaction or from themselves and their limited understanding or counselling skill.

When using the strategy *Getting acquainted* and *Trying to support and motivate* the pregnant women, the midwives described how listening, relating, adapting, and tiptoeing also facilitated reflections, problematising, and goal setting. We have interpreted these strategies as expressions of person-centred care (PCC), which is more than just a method of communication, and the midwives seemed to be considering the women's preferences, experiences, needs, and values when using this approach. Ekman and co-authors [18] pointed out the partnership as an important expression of PCC and suggest three simple routines to facilitate and also safeguard the transition to PCC, which are (1) letting the patient's/woman's narratives become the first step in establishing a partnership with the professional, (2) shared decision-making, which is built on this partnership, and (3) documentation in the patient's record to contribute to the continuity and transparency of the partnership. Another of the goals of PCC is to build an alliance between patients and health care professionals [19,20]. Such alliances were sought by the midwives using the get acquainted approach, as they tried to identify the expectant mother's barriers and attitudes towards dietary changes [21].

In line with our findings, Abrahamsson et al. [22] showed that midwives who tried to support pregnant women to quit smoking used strategies that they labelled "Friend-making" and "Co-operating" in which it was important to use the woman's view as a starting point for the intervention. Corcoran [21] stated that efficient and satisfying communication plays an important role in any efforts to improve health. Furthermore, she stated that the communication process is a multi-dimensional transaction influenced by a variety of factors in which both "content" and "relationship" are prominent. The content is about how the message is transmitted, and this is influenced by the relationship between the midwife and the woman.

We interpret the following strategies (Table 2) as less person-centred. When using the strategy *Convincing about choosing "correctly"*, the midwives described a quite traditional patient education approach, including transferring general medical knowledge and clarifying and repeating messages, but also insisting on adherence. Historically, patient education in health care has been built on expectations of compliance, which might be one reason for using this strategy. In this approach, health care professionals define the problems and solutions and patients are expected to accept the given advice. Vlasnik et al. [23] stated that adherence represents a broader interpretation and understanding than compliance because adherence includes more components of shared decision-making. The term adherence has been argued to have a larger focus on the provider–patient relationship and the patient's involvement in care, and adherence has been seen as a somewhat more contemporary concept than compliance. However supporting women's choice and control fits well into person-centred care approaches and more and more studies are reporting positive outcomes from such interventions, compared with the relative ineffectiveness of trying to convince women [24].

When using the strategy *Controlling and mastering women*, the midwives described that they were labelling and confronting pregnant women with their bad habits and lifestyles, frightening them with medical risks and complications, and moralising about motherhood related to these habits. Another aspect of control was to seek support from the women's partners in persuading women to make changes. The wordings of the subcategories – confronting, frightening, and moralising – tell us that counselling about diet can include power relations. In gestational diabetes, Persson et al. [25] found that the midwife acted as a medical guardian and explained that the mother-to-be had a moral obligation towards the foetus to make healthy choices such as not gaining excessive weight. As a health issue and a matter for policies and interventions, overweight and obesity have frequently been presented in the public discourse within an existing moral framework that links these characteristics with moral failure [26]. Both midwives and mothers are actors in this discourse. A study about diet during pregnancy reported that pregnant women constructed their identities as good mothers through their monitored prenatal diets [27]. In counselling about diet, midwives must be aware of how they might impose guilt. If the focus of a counselling session is on risk reduction then this strategy might be useful. However, because the outcome can be precarious, *control* should be used with caution. Although risk reduction is often the main focus for dietary counsellors who believe that insights into risks will change diet practices, knowledge of risks might not be the most important determinant of food choices for individuals. Knowledge of the benefits of healthy eating alone might also be insufficient to motivate dietary change. Factors such as culture and social norms, including taste preferences, attitudes and beliefs, availability, and accessibility influence people's food choices and should be targeted to achieve changes in behaviour [28].

The last strategy, *resigning responsibility*, involves the midwives distancing themselves from the women, transferring responsibility to them, and referring them to other health care professionals. This strategy suggests that the midwives are giving up – letting go. Similar findings labelled "avoiding" were reported in a study about smoking cessation during pregnancy. Lack of competence with smoking issues was expressed as a reason to abstaining from such a discussion [22]. Counselling women from other cultures with deeply rooted dietary habits were also found to be difficult. A study of pregnant immigrant women in Norway revealed that dietary information offered was very general, weight management was never discussed, and information was incongruent with the woman's culture [29]. Persson et al. [25] also described that when midwives found women with gestational diabetes failed to follow their advice, they returned the responsibility to the women.

Our results concur with those of a current systematic review [30] of qualitative evidence concerning weight management during pregnancy reporting that health professionals are reluctant to discuss weight management with obese women. According to the authors, this might be related to a fear of offending overweight women with but also could be related to a lack of knowledge and/or time for counselling challenging cases. The review concludes that midwives require specialised knowledge about nutrition and physical activity during pregnancy, and appropriate referral information, but also that some midwives may lack communication skills. Counselling around dietary habits that does not consider the multiple dimensions of decision-making associated with food and eating has limited effectiveness [30].

Telephone interviewing is an efficient method for data acquisition. It provides an opportunity for a good dialogue and procurement of personal experiences despite the lack of face-to-face contact. We performed and analysed 17 interviews with midwives but we experienced a kind of data saturation after analysing about 12 interviews. However, we had already interviewed 17 based on previous experiences of qualitative content analysis and included all interviews in the results. Our sample of midwives from the whole country from north to south, and from different antenatal

settings, rural and central, was beneficial. Because there is cultural diversity and difference in meaning about diet across Sweden the sample should and did this variety. The interviewer in this study is also a midwife, which could be a strength in that the interviewer was knowledgeable about midwives' work and working conditions, but, simultaneously, could pose a risk that latent meaning and content might get lost due to collegial agreement. The interviewed midwives seemed to be especially interested in dietary counselling, and this might have influenced the findings. Despite these potential limitations, we have interpreted our results as suggesting that several aspects of dietary counselling might need improvements. We also find the method of telephone interviewing beneficial as midwives seemed able to express their opinions and narrate about positive and negative experiences openly. This may relate to the fact that the researcher and the participants were not known to each other beforehand.

Conclusion

In conclusion, weight-related counselling and counselling of women on special diets, non-adherent women, and immigrants or women from different cultures was described as particularly challenging. Midwives may need cooperation with dieticians to manage such challenges. Midwives also need improved education and training to develop counselling skills such as motivational interviewing for person-centred care during pregnancy. Despite their education, Swedish midwives may benefit from opportunities to train, reflect and be observed when counselling. This study indicates that Swedish midwives' counselling strategies' can be ambiguous, controlling and coercive although also can be person-centred and that midwives struggle providing care to vulnerable pregnant women.

Conflict of interest

None.

Statement of authorship

ALW, KH and ÅH designed the study. ALW recruited and interviewed the participants. ALW analysed the data under supervision of KH and ÅH. ALW drafted the manuscript but all authors contributed to and approved the final version of the manuscript.

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