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Now is the Chance: Patient-Provider Communication about Unplanned Pregnancy During the First Prenatal Visit

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Abstract

OBJECTIVE—Unplanned pregnancy is associated with psychosocial stress, post-partum depression, and future unplanned pregnancies. Our study describes how topics related to unplanned pregnancy were addressed with patients during the first prenatal visit.

METHODS—We audio-recorded and transcribed initial prenatal visits between 48 patients and 16 providers from a clinic serving racially diverse, lower-socio-economic patients. We conducted a fine-grained thematic analysis of cases in which the patient's pregnancy was unplanned.

RESULTS—Of the 48 patients, 35 (73%) had unplanned pregnancies. Twenty-nine visits for unplanned pregnancies (83%) included discussion of the patient's feelings about the pregnancy. Approximately half (51%) of the visits touched on partner or other types of social support. Six patients (17%) were offered referrals to counseling or social services. Only four visits (11%) touched on future birth control options.

CONCLUSION—Most initial prenatal visits for unplanned pregnancies included discussion of patient feelings about the pregnancy. However, opportunities to discuss future birth control and for more in-depth follow-up regarding social support and psychological risks associated with unplanned pregnancy were typically missed.

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PRACTICE IMPLICATIONS—Obstetrics care providers should be cautious about making assumptions and should consider discussing pregnancy circumstances and psychosocial issues in more depth when treating patients facing unplanned pregnancy.

Keywords

patient-provider relationship; communication; prenatal care; pregnancy, unplanned

1. Introduction

Nearly half of the pregnancies in the United States each year are unplanned, being either unwanted or mistimed [1,2]. Forty-four percent of unplanned pregnancies end in birth, 42% in abortion, and 14% in fetal loss. [1]

Research indicates that unplanned pregnancy (UPP) is a risk factor for a range of psychosocial problems. Studies have found an association between UPP and depression and depressive symptoms both during and after pregnancy, including post-partum depression. [3,4,5,6,7,8,9] UPP is also associated with an increased risk of maternal anxiety during pregnancy and after birth. [8] Women with UPPs report more exposure to stressors and lower overall life satisfaction than women with planned pregnancies, and they tend to have less support from the father of the baby. [3] They are also at risk for difficulties with their contraception. [10] It is “difficult if not impossible” to demonstrate a causal link between UPP and negative maternal health outcomes [8], and not all women with a UPP will find themselves with psychosocial difficulties. Still, UPP brings women who may be particularly vulnerable to psychosocial problems into the care of a clinician.

The American College of Obstetricians and Gynecologists (ACOG) recommends conducting psychosocial evaluation for all women [11] and helping women manage psychosocial stressors “as part of comprehensive care for women.” [12] In its 2006 Committee Opinion “Psychosocial Risk Factors: Perinatal Screening and Intervention,” ACOG recommends in-depth psychosocial screening for all women seeking prenatal care. [12] Some elements of the recommendations include screening for depression, stress, psychosocial support, and pregnancy intention. This is in-line with research that suggests that the identification of health risks for post-partum depression during prenatal visits should consider pregnancy intention and how it relates to stressors, social support, and symptoms of depression. [2] The ACOG recommendations also include follow-up after the screening in order to identify areas of concern, give the patient information, and suggest possible changes if indicated. [12] Patients should also be counseled about the full range of pregnancy options, including adoption and abortion, if a pregnancy remains unwanted. [12] ACOG emphasizes that an effective referral system can help augment “the screening and brief intervention that can be carried out in an office setting.” [12]

The first prenatal visit, which is the most in-depth, provides a key opportunity for communication between a woman and her provider. It gives providers an opportunity to learn about the context of the patient's pregnancy and about the patient's psychosocial environment, as well as to provide support and offer necessary referrals. Given the opportunity that arises for communication, we investigated the discussions that occur during this visit. While ACOG recommendations for psychosocial screening apply to all women seeking prenatal care, due to their increased vulnerability we focused our analysis on appointments with patients who indicated that the pregnancy was unplanned.

2. Methods

Drawing on data from a larger study of patient-provider communication during the first prenatal visit [13], we analyzed discussions about pregnancy options, birth control options, and psychosocial issues related to unplanned pregnancy at first prenatal visits. The University of Pittsburgh Institutional Review Board (IRB) approved this study. All patient and provider participants provided written informed consent for audio-recording, transcription, and qualitative analysis of their visits.

2.1. Setting and Participants

We conducted this study at a hospital-based obstetrics and gynecology clinic at an urban academic medical center in Pittsburgh, Pennsylvania. The clinic primarily serves young, lower-income women, 55% of whom are African American and over 90% of whom are on medical assistance. We recruited clinic health care providers and patients to participate in the study. Eligible provider participants were obstetrics and gynecology resident physicians, nurse practitioners, and nurse midwives who saw patients for initial prenatal visits at the clinic. Eligible patient participants were English-speaking pregnant adults presenting for a first prenatal visit with an obstetrics care provider who was enrolled in the study.

2.2. Data Collection

We collected information about each provider participant's gender, race, and training level for resident physicians and years of practice for nurse practitioners and nurse midwives. From each patient participant, we collected information on age, parity, race/ethnicity, and marital status. Each patient's first prenatal visit was audio-recorded, de-identified, and transcribed verbatim. We conducted qualitative analysis of the transcripts and used ATLAS.ti 5.2 (Scientific Software, Berlin, Germany) to organize and manage our data.

2.3. Qualitative Approach

Using the “editing” approach to qualitative analysis developed by Crabtree and Miller [14], we analyzed discussions about pregnancy intention from patient visits. Consistent with the “editing” approach, we developed a code designed to identify cases of UPP. Two study investigators applied this code to each of the 48 transcripts, coding for presence or absence of a UPP. We considered a pregnancy unplanned if there was some discussion during the appointment about pregnancy intention, and the patient did not state without ambiguity that the pregnancy had been planned.

As the aim of our analysis was to describe communication in the context of an unplanned pregnancy and not to identify patient outcomes, we used a broad definition of UPP that incorporates mistimed pregnancies, unwanted pregnancies, and pregnancies with ambiguous intention, all of which are associated with elevated psychosocial risk. [3,6]

After two investigators identified cases of UPP, a single investigator conducted a fine-grained thematic analysis of discussions in those visits about psychosocial issues related to UPP. The investigator used an iterative process arising from the “editing” approach [15,16] to develop a codebook of relevant topics. Each of the topics that emerged was given its own code, as listed in Table 1. The investigator used the codebook to analyze visits involving UPPs, applying a code to the verbatim transcript if the topic was touched on at least one time during the clinic visit. We conducted all coding using ATLAS.ti 5.2 qualitative data analysis software.

3. Results

3.1. Patient and Provider Participants

Fifty-one patients participated in this study with 16 different provider participants conducting the initial prenatal visits. If audio recording ended before a patient's physical exam was completed, due to technical malfunction or any other reason, we excluded that patient's data from this analysis as incomplete. We excluded three appointments as incomplete, leaving data from 48 patients seen by 16 providers. Thirty-five of 48 (73%) patients' pregnancies were unplanned. Patient and provider sociodemographic characteristics were similar for the 48 complete appointments and the 35 cases of UPP. They are presented in Table 2.

The 35 patients with a UPP ranged in age from 18–36 years old, with a mean age of 24 years. Twenty (57%) were African-American and all others (15; 43%) were white. Thirty-one (89%) were single, and 20 (57%) had given birth in the past. All 13 obstetric care providers who saw these patients were white and female. Eight (62%) were obstetrics and gynecology resident physicians, 3 (23%) were nurse midwives, and 2 (15%) were nurse practitioners. One nurse practitioner saw 20 patients with UPPs, while others saw 1 to 2 each.

3.2. Coding

While the discussions were limited, patient-provider communication about pregnancy intention pivoted on six main topics in our analysis: 1) patient feelings about the pregnancy; 2) partner support for the pregnancy; 3) patient's decision regarding pregnancy options; 4) other family/friend support for the pregnancy; 5) referral to a counselor, social worker, or other social service; and 6) contraception for use after the pregnancy.

The two independent coders coding for UPPs achieved a kappa score of 1 for perfect agreement [17], identifying 35 cases of UPP. In most cases, providers assessed pregnancy intention by asking whether the pregnancy was planned or not, and they did not attempt to distinguish between unwanted and mistimed pregnancies. Some discussions about pregnancy intention were more extensive than others. In 28 cases, the patient stated clearly that the pregnancy was unplanned or expressed surprise or disappointment that indicated a UPP. In the other cases, patients described circumstances that demonstrate the complexity of the concept of pregnancy intention. In 3 of these cases, the patient indicated that her partner planned or may have planned the pregnancy but that she did not. For example:

Provider: And was this pregnancy planned or unplanned?

Patient: It was planned for him and unplanned for me (laugh)

Provider: (Laugh) Alright that one's right in the middle.

Patient: (Laugh)

Provider: How do you feel about that? (laugh)

Patient: Got to deal with it now

Provider: (Laugh)

Patient: Got to make the best of it

In 4 cases, the patient's description of pregnancy intention revealed ambiguity; these patients could not easily and cleanly categorize their pregnancy as “planned” or “unplanned.” Providers did not tend to ask for clarification, switching immediately in 3 of these cases to a biomedical question, as in this example:

Provider: Pregnancy planned or unplanned?

Patient: Um in the middle, it kind of was, but it kind of wasn't

Provider: Okay good. And how old were you when you first started periods?

Table 1 illustrates the distribution across patient visits of the six topics that emerged in our analysis. In most cases of UPP, there was discussion of the patient's feelings about the pregnancy (29 of 35 cases; 83%). In more than half of these cases (16; 55%), the provider framed the discussion of feelings in a way that assumed the patient's acceptance of the pregnancy. Here is an example of such a discussion:

Provider: Okay.....And was this pregnancy planned or unplanned?

Patient: Unplanned

Provider: You're okay with it?

Patient: Ah I'm dealing with it now at first I'm like oh [explicative] (laughs)

Provider: And any exposure to any radiation, x-rays, chemicals this pregnancy?

In this case, the provider abruptly switched topic after the patient expressed a negative initial reaction to her pregnancy. In some visits, providers asked about patient feelings using an open-ended frame, such as "...what are your thoughts on the pregnancy now that you know you are pregnant?" This open-ended approach was used in less than half of the visits in which patients' feelings were discussed (13; 45%).

Pregnancy options include continuing the pregnancy and parenting, continuing the pregnancy and placing the baby for adoption, or terminating the pregnancy. Eight of the 35 appointments (23%) touched on the patient's pregnancy options explicitly or implicitly, e.g.:

Provider: And was this pregnancy planned or unplanned?

Patient: Unplanned. Well, on my behalf.

Provider: Are you guys okay with that or were you thinking of adoption or termination?

Patient: Huh-uh.

A majority of the visits (27 out of 35; 77%) did not touch on pregnancy options at all.

Seven of the 35 visits (20%) touched on social support for the patient from family and/or friends. Eighteen of the 35 visits (51%) touched on the issue of the father of the pregnancy's support for the pregnancy (denoted in Tables 1 and 3 as "Partner Support"). These exchanges ranged from the provider asking "Are you guys okay [with the pregnancy]" to more in-depth discussions such as the following example:

Provider: Okay. And is he going to be involved with you during this pregnancy and the baby?

Patient: I have no idea because he has been acting very bipolar like. So I don't know what he's doing...

Provider: Are you worried about him acting weird or violent?

Patient: No.

Provider: Or just he doesn't know what to do.

Patient: Yeah. He doesn't. Like one minute he's like I can't afford it, what are we going to do. So I don't know. I have enough support system outside of him that I think I'll be okay --

Provider: Okay.

Patient: -- if he isn't involved.

In 6 out of 35 visits for UPPs (17%), the provider referred the patient to a counselor or other social service or mentioned that these services were available. Here is an example of one particularly comprehensive referral:

Provider: Now because this was an unplanned pregnancy, I want to know would you like to see our social worker? Sometimes it's helpful. Social workers kind of stay on top of the social issues that happen um, with pregnancies where as I'm going to be very focused on like are you bleeding, how are you doing, is the baby moving okay. You know, I'm very focused on that kind of thing. And I'll ask you how you're doing, if you're safe, et cetera, but social workers are really in tune with the kind of social aspects in case something comes up with the fact that it was unplanned.

Only 4 out of 35 visits (11%) touched on birth control options for use after the current pregnancy.

To assess whether only a few providers were responsible for addressing the topics in this analysis, we examined the distribution of these discussions by provider, as shown in Table 3. In appointments with all 13 providers, there was discussion of at least one topic related pregnancy options, birth control options, or psychosocial problems related to UPP. In appointments with 11 different providers (85%), patients' feelings were discussed. At least 3 different providers were involved in discussions of each topic in this analysis.

4. Discussion and Conclusion

4.1. Discussion

Pregnancy intention was addressed at most first prenatal visits in our study, but was framed by the providers as a “planned”/“unplanned” dichotomy. Some studies have challenged this dichotomy, suggesting instead that pregnancy intention is better understood on a continuum. [2,8] Ambivalence and a lack of formed intentions about fertility seem to be common [18], and research suggests that for some women the notion of planning a pregnancy may not be meaningful at all. [19] The experience of UPP itself and its underlying factors can be mediated by cultural or social context. [2] Without further assessment of pregnancy intention, providers risk making inappropriate generalizations and assumptions. The tendency to only consider a single category of “planned”/“unplanned” limits the providers' understanding of the larger context of concerns and issues a patient may be facing in relation to her pregnancy.

Visits in our study typically included some discussion of the patient's feelings about her UPP. These discussions, however, tended to be brief, and providers' questions about patients' feelings were often framed as closed-ended questions. Few patients were offered a referral or directly referred to a counselor or to other social service. This is concerning given that UPP is a risk factor for depression both during and after pregnancy [4,6,8,9], and a lack of access to personal or family counseling is associated with symptoms of post-partum depression. [7] For all pregnant women, ACOG recommends in-depth psychosocial screening with follow-up. [12] In our study, however, opportunities to discuss psychosocial issues related to UPP were often missed.

Social support is an important factor in maternal psychosocial health during and after pregnancy. Low marital satisfaction and low levels of perceived social support are both associated with depressed mood during pregnancy [20,21], and a lack of social support and arguing with a partner more than usual are risk factors for post-partum depression. [4,7] Research shows that a large percentage of women with UPPs report low levels of support from the father of the baby [3], and women with UPPs and their partners are especially at risk for relationship difficulties. [9,22] Despite these risks, in our study, support for the pregnancy from the father of the pregnancy, from the patient's family, or from her friends was only discussed in about half of the visits.

Patients with a UPP may benefit from early consideration of a future contraceptive method. Previous UPP is a risk factor for a future UPP [23], and women with UPPs tend to have more problems with contraception than do other pregnant women. Compared to women with planned pregnancies, women with UPPs report lower satisfaction with their contraception and greater difficulty remembering to take it. [10] When asked about prior birth control use, they are also more likely to report using no contraception or “withdrawal.” [10] Few visits in our analysis, however, contained any discussion of birth control options for use after the current pregnancy.

Our findings demonstrate that providers tend to miss opportunities to learn more about the patient's psychosocial environment, to understand the context of the patient's UPP, and to understand how the pregnancy fits into the patient's life. A more in-depth understanding of the patient's circumstances can enable providers to best tailor the care, counseling, and referrals that they provide to the patient. Incorporating more in-depth discussion of psychosocial issues into prenatal care need not be laborious or intrusive in order to be useful. In a randomized controlled trial of the Antenatal Psychosocial Health Assessment (ALPHA), a tool “designed to identify antenatal psychosocial risk factors for poor postnatal psychosocial outcomes,” 67% of providers in the intervention group reported that the ALPHA form was easy to use and 86% said that they would use it if it were recommended as standard practice. [24] Eighty-six percent of these providers reported learning “a lot” or a “moderate amount” of new psychosocial information by using the form. [24] Of patients in the intervention group, 72.7% reported feeling comfortable discussing personal issues with the provider, and 76.3% felt that this was a part of the provider's job. [24] Other research suggests a consistent positive relationship between communication about psychosocial topics, including questions from the provider about psychosocial topics, and patient satisfaction. [25]

4.2. Conclusion

We sought to investigate the discussions between patients and providers about psychosocial issues related to pregnancy for women with a UPP, who face an increased risk of psychosocial problems compared to women with a planned pregnancy. We found that pregnancy intention and feelings about unintentional pregnancy were routinely, but often minimally, addressed, and that providers tended to frame discussions in a way that obscured more complex distinctions between mistimed and unwanted pregnancies. Providers often used a narrative frame that assumed as a premise that the patient had accepted the pregnancy, and they rarely offered referrals to counselors or other social services. Opportunities to discuss the patient's level of social support for her pregnancy were missed about half the time, and providers rarely mentioned adoption or abortion as pregnancy options. Finally, discussions about contraception for after the pregnancy were rarely initiated in the first prenatal appointment.

Additional research is needed to fully understand the implications of this study's findings and the type of interventions that may improve the prenatal care of women with UPP. An

important first step is to investigate providers' reasons for not pursuing more in-depth discussion about patients' pregnancy circumstances and about psychosocial issues related to UPP. Further research should seek to determine if more in-depth discussion of the issues explored in this analysis would lead to more nuanced distinctions between unwanted and mistimed pregnancies, as well as improved outcomes for women with UPP.

4.3. Study limitations

As is true with all qualitative studies, our sample is not meant to generalize to a larger population as much as to provide richer insight into the dynamics that surround communication about UPP. In addition, this study was conducted at a single clinical site, with a racially homogenous group of female providers. However, this limitation would be typical of many academic low-income gynecology clinics. In addition, patients were not equally distributed across provider participants. One nurse practitioner saw 20 patients with UPPs, and all other providers saw 1 or 2 patients with UPPs. However, when we assessed the distribution of providers involved in discussions of each topic addressed in this analysis, no one or two providers were responsible for all discussions of any of these topics.

Our study was conducted in a clinic that serves a vulnerable population based on age, income level and race. The patients in our study were generally young and unmarried, characteristics associated with post-partum psychosocial problems. [4,7] Fifty-seven percent of our sample was African American, a minority status that may indicate a heightened exposure to psychosocial stressors. [3] ACOG recommends psychosocial screening for all pregnant women [12], but given the multiple risk factors present in this patient population, providers at this clinic especially would have had cause for diligence in addressing psychosocial issues. In this regard, the conversation content and styles in our study could not be generalized to patient populations with different demographic characteristics. Additionally, our study reflects practices, policies, and issues that are specific to patient care in the United States, and may not extend beyond the U.S. borders.

This analysis is cross-sectional and only includes the initial prenatal appointment. Issues addressed in this analysis, especially contraceptive options for use after the current pregnancy, may occur at future prenatal appointments. However, the first visit is the longest and provides an ideal opportunity for discussing these issues. In addition, women with UPPs, who are particularly vulnerable to a host of psychosocial and contraceptive problems, may benefit from addressing these issues earlier rather than later in the pregnancy.

4.4. Practice implications

Between 1970 and 1990, “appreciation of the significance of psychosocial issues during pregnancy emerged.” [12] The importance of managing psychosocial problems is twofold: Psychosocial problems are associated with adverse outcomes for the pregnancy [12], and they compromise the well-being of the pregnant woman. In 1997, Orr, et. al wrote:

“The traditional medical focus during pregnancy has been on the outcome of the pregnancy: a healthy baby. The women may be viewed as a vehicle to create a healthy infant. However, our results suggest significant risks to the well-being of women themselves associated with unintended pregnancy, especially unwanted pregnancy.” [3]

Prenatal care providers have a role to play in caring for both the patient and her pregnancy. According to ACOG:

“Practitioners should identify patients under stress. The stress associated with pregnancy itself, concerns about labor and delivery, and projected fears about

parenting often can be reduced by providing counseling, information, and social support during the course of prenatal care.” [12]

Our research shows that patient-provider communication about psychosocial issues related to UPP is often limited, and that referrals for counseling or to other social services are rare. In terms of pregnancy intention, providers might consider using more nuanced wording or asking additional questions to more precisely assess the circumstances and issues related to the unplanned nature of the patient's pregnancy. For example, this study identified a provider tendency to word questions about patient feelings regarding a UPP in a way that assumes the patient's acceptance of the pregnancy. In light of this finding, providers would be well advised to avoid this assumption, and instead to use open-ended questions in order to offer the opportunity for patients to discuss their feelings about the pregnancy.

ACOG reported on a psychosocial screening tool developed by the Healthy Start Program of the Florida Department of Health, which has been used widely and refined. [12] This simple tool, which can be used for interview or self-report, focuses on pregnancy timing, housing stability, stress, sexual and physical abuse, smoking/drugs, safety where the patient lives, and barriers to healthcare access. For providers who would like to do a more in-depth psychosocial assessment of prenatal care patients using an established tool, or for those who would like examples of simple questions used to address these topics, this tool may be a useful resource.

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Table 1

Number of cases touching on issues related to unplanned pregnancy (N=35)

Issue	Number of Cases	Percentage of Cases
Patient Feelings	29	83%
Partner Support	18	51%
Decision	8	23%
Other Support	7	20%
Referral	6	17%
Future Contraception	4	11%

Table 2

Sociodemographic Characteristics of Study Participants

Characteristics of Patient Participants	All Complete Cases Number or mean (range)	Cases of Unplanned Pregnancy Number or mean (range)
Patient Participants	48	35
Age (years)	24 (18–36)	24 (18–36)
Race		
African-American	29	20
Caucasian	18	15
Asian	1	0
Marital Status		
Single	40	31
Married	6	3
Divorced	1	0
Separated	1	1
Pregnancy history		
Prior births	29	20
Nulliparous	19	15

Characteristics of Provider Participants	Number within All Complete Cases	Number within Cases of Unplanned Pregnancy
Provider Participants	16	13
Provider type		
Obstetrics-gyn ecology resident physician	9	8
Nurse midwife	5	3
Nurse practitioner	2	2
Provider race		
Caucasian	16	13
Provider gender		
Female	16	13

Table 3

Number of providers from cases touching on issues related to unplanned pregnancy (N=13)

Issue	Number of Providers
Patient Feelings	11
Partner Support	10
Decision	6
Other Support	7
Referral	6
Future Contraception	3