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Original Article

REPRESENTAÇÕES SOCIAIS DE GESTANTES QUE FREQUENTAM SERVIÇO ESPECIALIZADO EM GESTAÇÕES DE ALTO RISCO

SOCIAL REPRESENTATIONS OF PREGNANT WOMEN ATTENDING SPECIALIZED SERVICE IN HIGH RISK MANAGEMENT

REPRESENTACIONES SOCIALES DE MUJERES EMBARAZADAS QUE ASISTEN A UN SERVICIO ESPECIALIZADO EN GESTIÓN DE ALTO RIESGO

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RESUMO
Objetivo: compreender as representações sociais e experiências das gestantes que frequentam serviços especializados em gestação de alto risco. **Método:** estudo qualitativo, realizado com mulheres em assistência pré-natal de um serviço público especializado em Gestação de Cuidados Especiais de um município mineiro de médio porte. A coleta de dados ocorreu, por meio de entrevista semiestruturada na qual se utilizou as noções da Teoria das Representações Sociais e os dados organizados, por meio da Análise Estrutural de Narração, para realizar a interpretação das respostas. **Resultado:** as representações encontradas estão em torno das ideias relacionadas ao risco presente nas gestações e à experiência vivenciada nos atendimentos realizados nos serviços de referência, emergindo da análise três categorias temáticas: representações relacionadas ao modelo biomédico, representações relacionadas ao medo e representações relacionadas à morte. **Conclusão:** como consequência desse estudo, foi possível evidenciar que as representações das gestantes de alto risco giraram em torno de sentimentos de medo relacionado à gestação e da morte em decorrência dos agravos da condição de risco, além da valorização do modelo biomédico e do profissional de medicina em detrimento do trabalho em equipe multiprofissional e da promoção da saúde.
Descritores: Cuidado Pré-natal; Enfermagem; Gestação de Alto Risco.

ABSTRACT
Objective: to understand the social representations and experiences of pregnant women who attend specialized services in high-risk pregnancies. **Method**: qualitative study carried out with women in prenatal care from a public service specializing in Special Care Gestation in a medium-sized town in Minas Gerais, Brazil. Data collection through a semi-structured interview in which the notions of the Theory of Social Representations and the data organized through the Structural Narration Analysis were used to interpret the responses. **Result**: the representations are around the ideas related to the risk present in pregnancies and the experience lived in the care provided in reference services, emerging from the analysis three thematic categories: representations related to the biomedical model, representations related to fear and representations related to death. **Conclusion**: as a result of this study, it was possible to show that the representations of high-risk pregnant women revolved around feelings of fear related to pregnancy and death due to the worsening of the risk condition, in addition to the valorization of the biomedical model and the health professionals in detriment of multiprofessional teamwork and health promotion.
Descriptors: Prenatal Care; Nursing; Pregnancy, High-Risk.

RESUMEN
Objetivo: comprender las representaciones sociales y las experiencias de las mujeres embarazadas que asisten a servicios especializados en embarazos de alto riesgo. **Método:** estudio cualitativo, realizado con mujeres en atención prenatal de un servicio público especializado en gestación de atención especial en una ciudad mediana de Minas Gerais. La recopilación de datos se realizó a través de una entrevista semiestructurada en la que se utilizaron las nociones de la Teoría de las representaciones sociales y los datos organizados a través del Análisis estructural de la narración para interpretar las respuestas. **Resultado:** las representaciones encontradas giran en torno a las ideas relacionadas con el riesgo presente en los embarazos y la experiencia vivida en la atención prestada en los servicios de referencia, emergiendo del análisis tres categorías temáticas: representaciones relacionadas con el modelo biomédico, representaciones relacionadas con el miedo y representaciones relacionadas con la muerte. **Conclusión:** Como resultado de este estudio, fue posible mostrar que las representaciones de mujeres embarazadas de alto riesgo giraban en torno a sentimientos de miedo relacionados con el embarazo y la muerte debido al empeoramiento de la condición de riesgo, además de la valorización del modelo biomédico y el profesional de la salud. medicina en detrimento del trabajo en equipo multiprofesional y la promoción de la salud.
Descriptores: Atención prenatal; Enfermería; Embarazo de alto riesgo.

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INTRODUCTION

The woman's gestational period lasts an average of 40 weeks. During this period, the pregnant woman rediscovers her body as changes happen to the body to adapt, to promote the development of the baby. In this way, this step commonly generates contradictions between the experiences of each pregnant woman as a result of physiological, emotional and behavioral problems changes that each woman lives in this process[1].

In this sense, the Ministry of Health, through the *Rede Cegonha*, established, in 2011, the guidelines for improving the care with pregnant women in prenatal care, childbirth, puerperium and in child health care, in addition to regulating obstetric and neonatal beds and safe transport in high-risk situations, supplying all the demands of women and allowing them to have a positive experience in pregnancy. Among these guidelines proposed in the prenatal care, there stand out actions of care and health promotion, diagnostic screening and prevention of diseases and improvement of communication between pregnant women and health services[2].

In Brazil, there was an improvement in the prenatal care offered by the Unified Health System (SUS), with a reduction in the rates of maternal-child mortality, through the deployment and implementation of public programs and policies aimed to ensure the coverage of prenatal care. The maternal deaths from obstetric causes can be of two types: direct causes (poorly addressed complications during the period of pregnancy, childbirth and postpartum) and indirect causes (deaths related to existing diseases or arising during pregnancy), being possible to reduce or even discontinue the occurrences of this group, provided that they receive adequate care[3].

With the changes imposed, from the *Rede Cegonha*, the country showed a reduction in the rates of maternal-child mortality and, despite the policies of the efforts of the government and the entities of classes involved with this situation, the projection of the maternal mortality ratio for 2030 is 30 deaths per 100 thousand live births[1]. To this end, it is important that the Basic Health Unit (BHU) be the entrance door of the pregnant woman, where she will receive attention directed to her needs, thus ensuring continuous monitoring and quality of pregnancy[3].

From the measures already established, BHU initiates assistance to recognize the existence of the pregnancy, thus conducting the first prenatal consultation with exploratory nature, seeking information and performing exams to make the risk classification according to the data obtained. These actions respond to the main goal of prenatal care, which is the embracement and adherence of pregnant women to ensure a healthy pregnancy evolution for the mother-child dyad[4]. From then on, a specific follow-up is offered to each case.

In cases where diseases or possible risks are observed, the pregnant woman is referred to the Service of Reference in Prenatal or High-Risk Care of each region, receiving attention focused on their needs, therefore, without losing the bond with the BHU closest to their residence[1].

A study focused on the perceptions and experiences of women diagnosed with some gestational risk points out that the experience of complications, during this period, can make these pregnant women feel more vulnerable, which may act in an unfavorable direction on the health of the pregnant woman and the fetus. In addition, coping with a negative situation related to her health or of the baby can generate suffering, which directly or indirectly may influence self-care and prenatal care[5].

Therefore, it is of utmost importance that health professionals are aware of the social representations and perceptions of pregnant women diagnosed with some disease or situation of gestational risk, so that they can develop actions aimed at the empowerment and self-care, since effective communication provides greater confidence in the relationship between the mother and the healthcare professionals, in addition to enabling the recognition of the woman's demands and concerns at this life stage[6]. In the healthcare team, the nursing professionals stand out, especially nurses, as a reference in the care with high-risk pregnant women, in the development of health preventive and promotional actions, assuming a crucial role in the promotion of good practices and in the elucidation of knowledge about pregnancy, childbirth and postpartum, as they possess technical, scientific and humanistic training, and the approaches adopted by this professional in prenatal care are directly proportional to the quality of care provided[6-7].

In pregnancies that require special care, the own risk factor sets up a stressful component, which can lead to anxiety and difficulty of emotional adaptation. Furthermore, expectations regarding the evolution of pregnancy, delivery and

newborn care and the mother-baby bond can be influenced by the beliefs and experiences of these women during the gestational period. In this context, it becomes extremely important to know the beliefs and representations of pregnant women about their conditions of risk, in order to help them develop more appropriately their emotions, encourage the coping and demystify their beliefs. Thus, the objective of this study is to understand the social representations and experiences of pregnant women who attend services specialized in high-risk pregnancy. Given the above, the following question emerges: What are the social representations of pregnant women who have gestational risk and how does the diagnosis of risk affect the lives of women in social and emotional contexts?

METHOD

This is a qualitative study based on the theoretical framework of Social Representations. The Theory of Social Representations (TSR) was based on the ideas of Moscovici, who suggested the existence of a social thinking arising from the beliefs and experiences arising in daily life, in the course of interpersonal communications that act as a type of theory of common sense. The TSR has been widely used in studies in the health area and has contributed to the Moscovician epistemological definition, for the reconfiguration of the objects of research, intervention and of health practices. This theoretical reference was chosen because the construction of representations allows groups to identify their human and health needs and, mainly, the re-signification of these needs[8].

The study scenario was a Reference Service Specialized in High-Risk Prenatal Care in a mid-sized city in the state of Minas Gerais. This institution was chosen for being a reference service in the region in which it is located with its activities related to the treatment of risks and problems diagnosed during pregnancy and prevention of complications. The service operates in a unit that meets other population groups, of the type of Medical Specialties Center and the nursing and multiprofessional teams, with the exception of medical specialists, meet users of the service as a whole. Nursing consultations to high-risk pregnant women is not part of the service routine, and other professionals of the multiprofessional team meet this population as scheduled according to the referrals. The data collection was carried out between January and September 2019, and the project was approved by the Research Ethics Committee at the Federal University of São João Del-Rei, West Campus (CEPCO) under opinion n. 3.173.674.

For this purpose, the participants were 17 women who met the following inclusion criteria: being pregnant and having received a diagnosis of some gestational risk, in the current pregnancy, age greater than or equal to 18 years, have full capacity of action, accepting to participate in the study and being out of crisis and in conditions of dialog, in case of mental disorder or use of drugs. The data were collected using the saturation criterion to define the interruption of collection or the inclusion of new interviews, i.e., when there Is the recurrence of information, without disregarding, however, odd information taken into account in the search for the essence of the phenomenon in each interview[9]. To contact them, the researchers attended the service, on days previously agreed with the management, and performed the invitation, before or shortly after the call of health professionals of the institution. There was a formal presentation of the research, explaining the ethical standards and legal rights of participants.

As a source of evidence, the semi-structured interview was used and, initially, there were questions relating to sociodemographic conditions followed by the following guiding questions: “Tell me what you think about pregnancy risk.”, “How did you feel upon receiving the news that you would be referred to a High-Risk Prenatal service?”, “Currently, how do you feel in relation to pregnancy?”, “Tell me about the call, here in the High-Risk Prenatal service.” The interviews were recorded on digital device, and later fully transcribed. To preserve the secrecy, the participants were identified through the adoption of the letter I (INTERVIEWEE), followed by a sequential number of interviews conducted randomly (I1, I2, I3, I4, etc.) and the results were disclosure in order not to identify the volunteers.

The data were treated by means of structural analysis of narrative described by Demazière and Dubar[10]. The structural analysis of narrative considers the interviews of study subjects as a reflection of the topics addressed. The reports of the interviewees are treated, a priori, and unconditionally, as a truth, taking into consideration that the narrative corresponds to what they believe, being subsequently interpreted. The researcher is responsible for treating the interviews in their entirety, covering

the possible contradictions, conjunctions and disjunctions of speeches[10].

The structural analysis of narrative is composed of three steps described by Blanchet and Gottman[11]: the vertical, horizontal and cross-sectional readings. The vertical reading seeks to remove the overall sense of each interview, allowing surveying the themes present. During the horizontal reading, we performed the deconstruction and reconstruction of each interview, which allowed us to clarify the meanings attributed by the interviewed subjects to objects cited in the narrative. The interviews were sequenced (S) by themes/wordings, listed in ascending order by order of appearance in the narratives. In each sequence, the facts narrated (F), the justifications, explanations and reflections on these facts (J), and the research participants, i.e., people who took part in the research (P) are identified. Subsequently, the sequences were grouped per subject, being performed a data categorization. In the cross-sectional reading, we compared and stressed the meanings emerged in the interviews, in what they were concordant and discordant. The last stage of the work consisted of raising the basic categories of study, constructed from the theoretical reference, for comparison and discussion of the findings with other studies.

RESULTS AND DISCUSSIONS

Among the participants of the study, 16 were referred by the basic health unit and one was referred by the maternity hospital, due to a complication in the first quarter. The age range of participants was between 23 and 41 years, with a mean age of 32 years. The family income of five of these women is between two and four minimum wages, one of them is above five minimum wages and the other reported an income of up to two minimum wages. Among the conditions of risk identified by participants. 5.8% presented pregnancy-induced hypertensive disease; 35.2% chronic arterial hypertension (CAH); 11.76% gestational diabetes mellitus; 5.8% CAH + gestational DM; 17.6% autoimmune diseases; 5.8% uterine fibroid; 5.8% prior detachment of the placenta and 11.7% were not able to specify. Concerning gestational history, four are nulliparous and thirteen, multiparous, and six interviewees reported abortions in previous pregnancies. The gestational age of the participants, at the time of interview, ranged between six and thirty-nine weeks.

The representations are around the ideas related to the risk present in pregnancies and the experience lived in the visits made to reference services, emerging three thematic categories from the analysis: representations related to the biomedical model, fear-related representations and death-related representations.

Representations related to the biomedical model

The first thematic category, the representations of women interviewed revolved around the appreciation of the biomedical model, the medical-centered care and the structure of the specialized reference service.

The speeches unveils the valorization of the care centered on the medical professional and that knowledge and practice in health are focused only on this professional, evidencing the lack of recognition of the assistance of other actors. “We feel we are being followed-up by a good doctor who is already familiar with all of this” (I7). “The two times I underwent prenatal here was with doctor X, I do not know the other doctors (and professionals) that work here” (I8). The study of Amorin et al.[12] points out that, although public policies of women health care in areas of high-risk pregnancies advance in the provision of health care service, it evolves in the point of view of the biomedical model, and it is necessary to consider that the results achieved with a multiprofessional team, of which the nursing is part, can offer, in addition to clinical care, emotional and educational support in all care moments.

In relation to the specialized service, the statements demonstrate that the quality and effectiveness of the service were translated into completion of exams and the follow-up continuity by the same professional: “[...] I find it nice that it is always the same doctor who meets me, since my first visit here” (I1). “I trust him as a doctor and all I ask him, he clarifies in the best way possible, he always request all examinations. The embracement we have here and the structure already calm us down. So, I feel safer of doing the prenatal here, because the medical follow-up is differentiated” (I8).

Another study points out that the centrality of the high-risk prenatal care lies in medical consultations without interfacing with socioeconomic issues, which are known to interfere in maternal-child health[13]. According to Cardelli et al.[14], corroborating the results of this study, the prenatal care is a crucial time for a safe pregnancy, although it is often centered on the

figure of the doctor and the guarantee of access to laboratory and imaging tests.

In this sense, the prenatal nursing consultation allows identifying problems and needs of pregnant women, preparing the planning of actions and care required and applying the nursing process as a methodological tool that systematizes the consultation and justifies the decision-making[15]. Nevertheless, in secondary care services, there is a logic toward the medical care with little participation of other professionals, including nurses, which was also observed in this study. Despite the presence of a multiprofessional team in the service, there is a predominance of the biomedical model, translated into medical consultations and examinations. The performance of the nurse as part of the assistance to high-risk pregnant women can overcome the predetermined vision, when the nurse has limited activity in spaces where there is a predominance of hard and soft-hard technologies. Therefore, the High-Risk Prenatal Care Services constitute as spaces where the nurse can act as a team and with autonomous actions, and the effectiveness of his/her work lies in the possibility of dialog with hard and soft-hard technologies through his/her grasp of soft technologies[15].

Thus, the participation of nurses in the gestational process brings quality to the assistance to pregnant women, since the goal of prenatal consultation, instituted by the Ministry of Health[16], has its characteristics wrapped for the process of embracement and humanization, and, although the medical professional's follow-up of high-risk pregnancy is essential, this does not exclude the participation of other professionals. In contrast, in the doctor-centered care model, the environment that should include the active listening to meet the biopsychosocial needs of pregnant women at risk becomes a consultation focused only on the clinical problem without evaluating other human conditions[14].

Upon developing the study, we noticed that the nurse prioritizes only the embracement and screening of pregnant women before each prenatal consultation, performed by the institution's physician, hindering the perception of the contribution and positive influence that the nursing professional has on the prenatal care provided. This practice contradicts the idea presented by Melo et al.[17] that the nursing consultation needs to ensure the highest quality of prenatal care, once the professional may seek more in-depth information about the patient's experience of gestational age, allowing performing the systematization of nursing care and planning according to her particularities. The consultations may also be used for grounding new multiprofessional practices and behaviors in prenatal care.

Fear-related representations

When questioned about the feelings in relation to the gestational risk, the participants related the finding to life habits, diseases and complications developed before or during pregnancy, demonstrating that this causes fear, concern with the development and acceptance of the pregnancy. The participants of this study presented, in their speeches, the fear of complications in pregnancy and at the time of delivery. The fear was related to insecurity in the development of pregnancy and negative outcomes at the time of delivery. Such feelings are represented in the statements "I really wanted to have a normal delivery, did not want to evolve to a cesarean section. But it involves several factors, I had detachment. So I do not know whether it will be all right!" (I3). "So, I am a little afraid, got it? Even of the delivery. Because of my pressure issue, we do not know what can happen" (I6). "I am afraid that, as I already had eclampsia, my sister was afraid to happen (increased blood pressure) at the time of delivery" (I10).

Upon analyzing the data collected, we realized that the lack of information and clarification about the risks, in conjunction with the social representations, are the main responsible for generating anxiety and fear in the participants in relation to the future of the gestation and possible complications in the baby's health. Almeida et al.[17], in their study with 18 normal-risk pregnant women, observed that 43% of the participants in their study were not informed about the birth and 34% had incomplete information. This deficit in information influenced negative feelings and anxiety in those participants who reported fear of suffering obstetric violence, fear not to bear the pain and malaise during labor, fear of dying, during the parturition process and fear of being submitted to cesarean section.

Cabral et al.[18] brought similar results in a study conducted with high-risk pregnant women, in which 19% of the interviewees showed fear in relation to the outcome of the pregnancy, their health and the baby, and 34% reported unawareness of the diagnosis of risk and how it can influence the development of pregnancy. In

another study, Vieira et al.[19] observed feelings of stress and anxiety in pregnant women and their families regardless of the risk situation having been diagnosed previously or during the current pregnancy.

Based on the reports of the participants in these and other studies, it is possible to realize that the diagnosis of risk may result in negative psychological factors that influence, directly, the progress of the pregnancy and the experience of the pregnant woman. Bezerra[20], in her study, realizes that the coping measures minimize these factors, highlighting, then, the need for a prenatal with methods of coping strategies focused on the provision of clear information about the diagnosis and the risks involved, with multiprofessional care and greater inclusion of the family during the process, allowing the development of a positive experience for the pregnant woman and her social circle.

Even with the feeling of fear, it is worth mentioning that interviewees cited the faith as a coping resource used for the maintenance of the hope that the pregnancy will develop in the best way possible. “May God bless me, because it is only a stage and I have faith in God that soon it will be over. Regarding having my baby, it is like I have said before, I do have insecurities, but I have faith in God” (I9).

In her study, Porto[21] noticed that 85% of the risk pregnant women interviewed reported being practitioners of some religion and using their faith to renew the strength in coping with and accepting the risk. Religion has close relationship with the lifestyle, and needs to be understood as something that gives meaning to the crisis and suffering of the user and assists in the recovery of health. Thus, it should be encouraged by health professionals as a fundamental part to face the diagnosis and create mechanisms that facilitate the assistance provided and adherence to the necessary treatment.

Death-related representations

When questioned about what is high-risk pregnancy, from the point of view of pregnant women, many reported the risk of death of the fetus or their own death. “You feel like you are about to die, but you stand still, then any little thing can be fatal in our life. My fear in the very beginning was the baby dying or being born with some sequela” (I9). “They say that it can lead to eclampsia and even death, so we get really concerned with this” (I10). “A huge difficulty for a pregnant woman is the risk of losing the baby. It is a terrible suffering” (I14).

The fear of loss and the feeling of impotence make them engage in treatment, in order to ease the situation, mainly psychological, doing everything possible to prevent a tragic evolution of childbirth. “But with the follow-up we have here in the high-risk, things are getting calmer, we start to understand a bit more our condition, doing the proper follow-up, the correct treatment with the medication” (I8).

Despite the considerable reduction of maternal deaths,[1] there are still concerns related to maternal-child mortality. A study on the epidemiological profile of maternal mortality reported that 95% of maternal deaths result from preventable causes, primarily by the guarantee of a quality obstetric care, covering all the needs and demands experienced by pregnant women, whether normal- or high-risk[16].

Corroborating these data, a study with pregnant women with heart diseases also pointed out the anguish and fear of death and of fetal losses, as well as the feeling of vulnerability experienced by pregnant women in situation of risk[12]. It is known that, in all pregnancies, there is the risk classification for the appropriate procedure in each case. Thus, with the breaking of this entire process built, in case of a following pregnancy classified at risk, the pregnant women whose hope was dissipated will understand that this may repeat and increase the risk of the so-feared life loss or fetal death.

Therefore, to soften the representations related to the fear of death, investments in the health care networks are necessary, especially in the case of referral and counter-referral and training of professionals providing care to this population, both to improve the care to the mother-child dyad, as to ensure a more humanized assistance and provision of information and clarifications that will allow improving the care, such as reducing anxiety, fear and other psychological aspects, due to lack of a multiprofessional management.

CONCLUSION

The representations of high-risk pregnant women encompassed feelings of fear related to pregnancy and death, because of the worsening of the risk condition, in addition to the appreciation of the biomedical model and medical professional to the detriment of the work in a multiprofessional team and health promotion.

Such feelings can be worked in multiprofessional follow-up, during pregnancy, and the nurse has a primary role as a member of the healthcare team, who may identify the demands of each pregnant woman and offer an individualized care, including the emotional support and education for self-care. However, this professional needs to be able to make decisions and have communication skills with the user, with other professionals and with other Care Network services.

Furthermore, this study showed that there is little involvement of the multiprofessional team and of the nurse in the direct care with the high-risk pregnant women, mainly in what refers to consultations and individual and in-group guidelines, which is consistent with that found in many studies, which indicate the valorization of biological aspects in comparison to other aspects. This view is closely linked to the quality of care provided to high-risk pregnant women, since the risk condition, by itself, increases the negative feelings under numerous biopsychosocial aspects. Although covering the social representations of women diagnosed with some gestational risk, it is worth pointing out the limitations of the study, since the method used does not allow generalizing the results.

Nonetheless, this study may contribute to expanding the knowledge and space for discussion on high-risk pregnancies, from the experiences and social representations of pregnant women. Moreover, it can facilitate the reflection of professionals for a humanized and integral care, focused not only on the diagnosis and clinical conditions, but also on the psychosocial aspects. The flaws in the care with pregnant women of the specialized service can be met with the organization of the care flow and implementation of multiprofessional assistance towards the user's demands using soft technologies, such as nursing consultations and of other members of the multiprofessional team, inclusion, in the routine, of groups for exchanges of experience and calls in the waiting room to ensure an assistance focused on the embracement and qualified listening.

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