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Exploring perceptions of vulnerability among women facing psychosocial adversity before, during and after pregnancy: A qualitative interview-study using thematic analysis

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ABSTRACT

Objective: The term 'vulnerable' is often used to describe women facing psychosocial adversity during pregnancy, implying a heightened risk of experiencing suboptimal pregnancy outcomes. While this label might facilitate the pathway to appropriate care, it can be perceived as stigmatizing by the women it intends to help, which could deter their interaction with healthcare services. This study explores how women facing psychosocial adversity before, during and after pregnancy perceive the concept of vulnerability and experience being labeled as such.
Methods: We conducted a thematic analysis of semi-structured, in-depth interviews. Through purposive sampling targeting maximum variation, ten women of diverse backgrounds were included.
Results: Three central themes emerged: defining vulnerability, embracing vulnerability and the feeling of being stigmatized. Women perceived vulnerability as an inability to adequately care for themselves or their children, necessitating additional support alongside routine antenatal care. Acceptance of the 'vulnerable' label came when it also acknowledged their proactive efforts and strengths to improve their situation. Conversely, if discussions surrounding vulnerability failed to recognize women's agency – specifically, their personal journeys and the courage needed to seek support – the label was perceived as stigmatizing.
Conclusions: Addressing vulnerability effectively in maternity care requires a nuanced, patient-centered approach, acknowledging both the challenges and strengths of women facing psychosocial adversities. Emphasizing personal narratives and their courage in seeking support can mitigate the stigmatizing effects of the 'vulnerable' label. Integrating these narratives into maternal healthcare practices can foster deeper connections with the women involved, enhancing the overall quality of care.

Introduction

Investing in the first 1000 days of life – the period from conception up to two years after birth – is likely to yield health benefits throughout the entire life course. During this period, significant developmental stages occur that are important for lifelong physical and mental health [1–3]. Moreover, even the 100 days before conception are pivotal, as development already occurs among prospective parents, laying down the foundation for the health of their future children [4,5]. Addressing concerns during this early life course provides a window for unprecedented preventive measures [6]. These concerns encompass not only medical conditions but also factors related to environmental, social, and mental well-being including poverty, illicit substance use, mental health issues, and domestic abuse. Early identification of these psychosocial adversities followed by integrated care and support is crucial and widely advocated [7–10]. In this context, women navigating such adversity, who are at an elevated risk of facing unfavorable health or pregnancy outcomes, [9] are often labeled as 'vulnerable' by maternity care providers or policymakers [7,10,11]. While this labelling stems from the intention to facilitate access to appropriate care, it can

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unintentionally lead to a disregard of the women's own experiences and perceptions, possibly resulting in them feeling stigmatized and inadequately supported [12,13].

Given the importance of addressing psychosocial adversities during and even preceding pregnancy, the term 'vulnerability' has become a focal point in discussions related to maternity care or population epidemiology. Nonetheless, this term lacks a universally accepted definition due to its multifaceted nature and the array of biological, social and environmental determinants it encompasses [7,9] 14. Traditionally, the discourse around vulnerability has been centered on the identification of risk factors. However, there is a growing consensus on the importance of acknowledging protective factors that mitigate vulnerability and promote resilience [15,16]. Several initiatives, especially in the Netherlands, have aimed to construct a comprehensive definition of vulnerability, integrating both risk and protective factors [11,15,17]. Despite those efforts, a significant gap persists regarding the inclusion of the perspectives of the women identified by this term. There is only a limited number of studies exploring women's viewpoints, with the existing ones predominantly concentrating on their experiences with received care and the relationship with care providers [18]. This leaves the deeper understanding of what it means to be 'vulnerable' and the emotional and practical implications that come with such a label unexplored.

The diversity in interpretations and the lack of a universal definition lead to significant discrepancies in determining a woman's vulnerability status among different studies and within healthcare and policy contexts. Furthermore, while the term 'vulnerable' is intended to guide women to suitable care and, ideally, empower them, it could paradoxically undermine their agency. This happens due to subsequent stigmatization and misconceptions regarding their capacities and autonomy, thereby overshadowing their inherent resilience and strengths [7,19,20]. Care providers often struggle to balance collaborative relationships with women while also addressing their psychosocial vulnerabilities, as noted in previous research [21]. The inclusion of women's voices is not only morally imperative but also key for patient-centered and effective maternity care. It is also crucial for addressing potential issues related to the perceived stigmatization linked to the term 'vulnerability' [22]. Women's perspectives are vital to prevent potential harm from stigmatization and to enhance the efficacy of policies and care aimed at improving outcomes. A shared understanding between women and maternity care providers is fundamental for navigating the complexities surrounding the perceptions and implications of vulnerability in maternity care [23].

The objective of this study is, therefore, to explore women's perceptions and meanings attributed to being labeled as 'vulnerable' within the context of maternity care. Specifically, women who have encountered psychosocial adversity before, during, or after pregnancy. By doing so, this study aims to enrich the comprehension of vulnerability from the lived experiences of these women, providing crucial insights that can guide clinical practice and inform policy development.

Methods

Setting

This study was done as an exploratory study with the aim of improving care provision to women facing psychosocial adversity before, during, or after pregnancy through a collaborative network of care providers, policy-makers, and (pregnant) women. Care providers and policy-makers in the Netherlands usually refer to psychosocial adversity as 'vulnerability', reflecting a condition requiring awareness and additional care to mitigate the effects of this adversity on pregnancy complications [21]. However, given the possible stigmatizing effect of labeling this as 'vulnerability' as a first step in the cocreation of this action research project we aimed to explore women's own perceptions and meanings attributed to being referred to as 'vulnerable'.

This study was conducted in Rotterdam, the second-largest city in the Netherlands. In the Netherlands, maternity care is organized into different levels of care, the boundaries of which are determined by medical risk. Women without increased risk for complications receive care from community midwives, who also facilitate home births, whereas women with increased risk of obstetric complications receive care from gynecologists and deliver in the hospital. Both community midwives and gynecologists routinely enquire into psychosocial adversity, sometimes by standardized questionnaires. In the presence of risk factors for obstetric complications or impaired parenting without sufficient resources to counter these risk factors, the need for additional care is evaluated. Some women may already receive additional care, such as mental health care, addiction care, or social care [21,24].

Design

This study employed a qualitative design using thematic analysis of semi-structured and in-depth interviews using a topic list. A qualitative design was chosen because of its capacity for exploratory research and because this approach is particularly suitable for exploring sensitive topics, allowing for a detailed and nuanced understanding of the participants' lived experiences [25]. Thematic analysis was chosen because it is beneficial for applied research [26], offering a systematic yet flexible method for identifying, analyzing, and reporting patterns (themes) within data. This approach supports the development of practical implications based on the insights gathered from participants. The SRQR (Standards for Reporting Qualitative Research) guidelines were followed to report this study [27].

Participants and recruitment

Women were eligible for inclusion if they received additional care for psychosocial adversity beyond routine antenatal care or preventive youth health care, either during the preconception period, pregnancy, or within two years following delivery. "Additional care beyond routine antenatal care or preventative youth health care" refers to psychiatric care, addiction care, or social care. Women are often referred to these services because of mental illness, substance use disorder, intellectual disability, or severe social problems (e.g., severe financial problems resulting in lack of basic necessities such as food, diapers or baby clothes, or housing instability). Only women who spoke and understood Dutch sufficiently were eligible for inclusion, to ensure effective communication during the interviews. Women in the preconception period were also invited to participate, since the impact of psychosocial adversity on pregnancy outcomes begins during this critical period. Plus, methodologically, the boundary between preconception and early pregnancy is not clear-cut, as women often realize they are pregnant several weeks in. This initial phase is biologically crucial, with high susceptibility to adverse circumstances that can affect pregnancy outcomes [28].

The study employed purposive sampling to recruit a diverse group of women with varying needs for additional care. Sampling was continued until data saturation, that is when no new themes regarding perceptions and experiences of vulnerability emerged [29,30]. Eligible women were approached by their respective care provider of one of the participating organisations[a]. These organizations, both hospital and community based, offered maternity care, mental health care, addiction care, or social care. Women who were willing to participate were contacted by one of the lead interviewers (LM) who provided them with detailed oral and written information regarding the study. All ten women approached agreed to participate.

Data collection

In accordance with the preferences of the participants, interviews were conducted at their homes (N = 3), their care organizations (N = 3),

their residential facilities (N = 2), a public location within the hospital (N = 1) or by telephone (N = 1), the latter due to the presence of COVID-19 symptoms. The interviews took place between July and October 2020, with an average duration of 50 min, ranging between 35 and 75 min. All semi-structured, in-depth interviews were conducted jointly by two interviewers, using a topic list (see Table 1). This list was developed in three iterative cycles based on relevant literature and on practice experience from the research team. The topics included: experiences with received care or support, views on the content of vulnerability and opinions on the use of the term 'vulnerability'. Furthermore, demographic characteristics were also collected during the interviews. The interviews covered all topics on the list, though not necessarily in the same order, allowing the conversation to flow naturally. This flexibility ensured that participants could share their unique experiences and narratives in depth. Additional questions were asked when necessary to broaden and deepen the discussion, providing a comprehensive understanding of each participant's perspective. As compensation for their time, participants received a gift voucher worth €25.

Data analysis

With oral and written consent, the interviews were audio recorded and transcribed verbatim. Participants were offered to receive the transcribed interview with the possibility to verify the content. A thematic content analysis guided by the Framework approach was undertaken.[31] The first four interviews were open-coded by two researchers (LM, HES). The coding was discussed up to consensus to identify labels. Thereafter, all interviews were labelled thematically using the identified labels. Throughout the analysis process, regular meetings were held between the researchers to discuss and refine the codes and themes. This collaborative approach facilitated the identification and resolution of any discrepancies, enhancing the dependability of the findings. NVivo 12 qualitative data analysis software (QSR International 2012, Melbourne, Vic., Australia) [32] was utilized throughout the entire analysis process. Initially, NVivo was used to import and store all transcribed interviews, serving as a centralized data repository. The software facilitated the coding process by allowing the researchers to create a coding schema, apply codes to relevant text segments, and link related codes together. Data from the interviews were then organized and summarized in a matrix to facilitate the analysis of the content. Table 3 provides an example matrix with the identified themes, accompanied by the relevant subthemes and illustrations of interview codes.

Reflexivity

The main researcher (LM, female gender, sociologist, PhD-student) worked as a researcher at the Department of Obstetrics and Gynaecology of a large University Hospital in Rotterdam and had a comprehensive understanding of the standard routine practices of maternity care. Reflexivity was enhanced by regular sessions with two senior supervisors experienced in qualitative research (HB, AW). Furthermore, the topic list was cocreated with representatives of all participating organizations and a woman with psychosocial adversity, and the results of the first 5 interviews were discussed with the senior supervisors (HB, AW, MB) and in a session of representatives of all participating organizations.

Trustworthiness

To enhance the rigor of this study, we employed several strategies. Credibility was enhanced by inviting all participant to review the transcript of the interview for accurateness as well as involving independent researchers to conduct the interviews and analyze the data. Dependability was pursued by thoroughly describing the study's methodology and following the SRQR criteria. Confirmability was achieved by using NVivo for systematically managing the data and having two independent researchers analyze, code, and discuss the identified labels and themes, ensuring that the findings were shaped by the data rather than by researcher bias. Transferability was facilitated by a detailed description of both the research context and participants' experiences, enabling readers to assess the applicability of the findings to other contexts.

Ethics statement

All participants gave informed consent for participation. The study has been carried out in accordance with The Code of Ethics of the World Medical Association (Declaration of Helsinki). The study was approved by the Medical Research Ethics Committee of the Erasmus Medical Centre (MEC-2020–0473). This independent research resulted from a grant (50–55400-98–123) supported by The Netherlands Organization for Health Research and Development (ZonMw). The funder had no role in designing the study, collecting or analyzing the data nor in preparing or publishing the manuscript.

Findings

Table 2 presents the characteristics of the participants. Ages ranged from 17 to 41 years. Of the participants, nine had given birth to either their first (N = 8) or second (N = 1) child within the last two years. Three women were six to 12 months after delivery, and six women were 12 to 24 months after delivery. One woman was pregnant with her second child during the interview, and one was in the preconception phase. All

Table 1
Topic list.

Topics
Experiences with received standard maternity care and additional care for psychosocial adversities
• Kind of care or support
• Reasons for in care
• Establishment of contact
• Positive and/or negative experiences
• Contact between multiple care or support providers
Characterisation of being vulnerable
• Feelings about being perceived as vulnerable
• Recognition of being vulnerable
• Description of own (vulnerable) situation
Content of vulnerability
• When is someone perceived as vulnerable?
• Implications of vulnerability
• Other terminology

Table 2
Characteristics of participants.

Number	Age	Relationship	Educational attainment	Occupation	Planned pregnancy[†]	Obstetric care led by midwife or obstetrician[†]	Number of children	Main area of received care or support[‡]
1	20	Partner	Low	Unemployed	Unplanned	Obstetrician	1	Severe depression
2	41	Single	Low	Unemployed	Unplanned	Obstetrician	1	Illicit substance use
3	24	Single	Medium	Employed	Unplanned	Midwife	1	Financial issues
4	32	Partner	High	Unemployed	Unplanned	Midwife	1	Anxiety and depression
5	19	Single	Low	School	Unplanned	Obstetrician	1	Intellectual disability
6	37	Single	Low	Unemployed	Unplanned	Obstetrician	2	Intellectual disability
7	24	Partner	Low	School	Planned	Midwife	1	Financial and housing issues
8	17	Partner (abroad)	Low	School	Unplanned	Midwife	1	Financial issues and stress
9	18	Single	Low	School	NA	NA	0	Psychosocial issues
10	30	Partner	Medium	Unemployed	Unplanned	Obstetrician	1	Homelessness

[†] Of current or latest pregnancy.
[‡] Ongoing care or support at the time the interview was conducted. NA: not applicable.

women received additional care or support for psychosocial adversity.

Three main themes, and several sub-themes, were found: defining vulnerability, embracing vulnerability, and the feeling of being stigmatized (Table 3).

Theme 1: Defining vulnerability.

The women in the study provided insights into their perceptions and experiences of vulnerability, mentioning two distinct dimensions of it. The first dimension is characterized by an inability to safeguard one's own needs, which is often paired with feelings of hopelessness and a lack of control over one's life. The second dimension revolves around the potential harming effects vulnerability can impose on their (unborn) children.

Vulnerability means being unable to safeguard one's own needs

The women's narratives illustrated vulnerability as an inability to manage personal aspects of life, such as self-care and finance, leading to increasingly worsening conditions. This state is accompanied by feelings of hopelessness and being trapped without a clear path forward. The struggles encountered can be unique for every woman. Participant 2 articulated vulnerability as the culmination of making bad choices and the inability to take care of oneself, stating:

> *"If you take the wrong paths in life and you don't think it through. … Not being able to look after yourself, your finances, your hygiene, or know how to take care of your child, all those things. … At some point, everything is lost. I can imagine feeling helpless, vulnerable, lost. If someone reaches out a hand to you, and you don't want it, it gets from bad to worse."* (Participant 2)

Similarly, Participant 10 also illustrated how an accumulation of problems lead to an increased state of vulnerability. For her personally, dealing with a multitude of problems led to her ending up in a shelter while being pregnant. She mentioned the sense of degradation accompanying vulnerability:

> *"There were problems that led to more problems, eventually resulting in ending up in a shelter. You don't just end up in a shelter, and once you get there, it only gets worse. You feel miserable, you feel worthless, and you feel lonely, even though you're with a group of women, or a group of men or whatever, you still feel lonely."* (Participant 10)

Participant 9 described vulnerability as being susceptible to hurt due to prioritizing the needs of others one's own needs, reflecting:

> *"I am very vulnerable in some areas. To me, being vulnerable just means that people can hurt you very quickly. Or that you are more likely to pay attention to other people and not yourself, and in that way, you get hurt."* (Participant 9)

Vulnerability means a potential negative impact on the (unborn) child

For the women, another characteristic of vulnerability is its potential negative impact on the health and development of their (unborn) child. When asked to describe what vulnerability meant to them, women provided examples of being in a situation that had the potential to negatively impact the health and development of their (unborn) child:

> *"I was suffering from stress, that can never be good for the baby. Even after the pregnancy, my stress level was sky-high, my whole world came crashing down. I no longer had a social network. I foresaw that my kid would not be able to form relationships and would miss the necessary social skills that I was not able to give."* (Participant 4)
>
> *"Well, in my situation, for example, I was using drugs. It didn't endanger my child's life in the end, but he was definitely at risk. And the same goes for other people too, stress can be a cause of a miscarriage. Or maybe lead to a child with a congenital heart defect or whatever."* (Participant 6)

The participants expressed deep concern for their children's well-being, acknowledging their innocence and helplessness. Particularly, participant 2 and 5 illustrated how these feelings shaped their narratives. Participant 2, for instance, expressed how her inability to get the help she needed affected both her and her unborn child, emphasizing,

Table 3
Framework matrix.

Theme	Subtheme	Illustrative codes
Defining vulnerability	• Vulnerability means being unable to safeguard one's own needs	• Making the wrong choices • Feeling helpless and lost • Initially not willing to accept help from others
	• Vulnerability means a potential negative impact on the (unborn) child	• Stress from experiencing problems can affect the child • Feeling guilty by being unable to do the right thing for the child
Embracing vulnerability	• Accepting vulnerability as reflection of reality	• Vulnerability stands for all that the woman has had to endure and overcome • Being perceived as vulnerable helps women to acknowledge their own vulnerability
	• Strength and courage in embracing vulnerability	• It takes strength and courage to seek or accept help • There is pride in overcoming vulnerability
The feeling of being stigmatized	• Not including the whole story	• Assessment of vulnerability based on an incomplete story leads to misinterpretations • Not recognising what the woman has been through makes the woman feel unseen
	• Repercussions of labelling	• One-dimensional labelling • Feelings of restrictive agency due to labelling

"I immediately sought help when I was pregnant. My son is innocent and helpless. That hit me so deeply; he is innocent. … I didn't get the help I needed right away; I was forced to keep using drugs for two weeks. My son is innocent and you should never give an addict an excuse to keep using, you just can't." (Participant 2)

These worries were echoed by Participant 7, who shared her constant feeling of stress and fear over the well-being of her son:

"I am always concerned for my son. Is he healthy or not? I am just always concerned. […] We want a new house; we only have this one room and we sleep on the floor. There is mold, there is mold in the bathroom. I just want my son to be healthy. I don't want him to get sick." (Participant 7)

When the women's children were unharmed, despite their vulnerable situations, it brought immense relief and reassurance to them. As participant 6 shared:

"When it turned out he had not been harmed by my drug use, I was in seventh heaven. You certainly don't want to do that to your kids.… Seeing that he's doing well, it's reassuring. Especially when at one point they [care providers] said they weren't worried anymore." (Participant 6)

Theme 2: Embracing vulnerability.

Women in the study aligned with the concept of vulnerability, acknowledging it as a significant aspect of their experiences. This acknowledgment was an essential step for women to show strength and courage, giving way to possibilities to improve the situation for themselves and their children. Embracing their vulnerability enabled them to be more receptive and proactive in seeking change and support.

Accepting vulnerability as reflection of reality

The women could accept and embrace their vulnerability, seeing it as a realistic reflection of their struggles and experiences. This acceptance helped them to be seen and supported by others, even during times when they were unable to comprehend their situation fully. Participant 5 and 10 spoke proudly of accepting their vulnerability, viewing it as a part of their life. Participant 10 stated:

"Actually, I am proud of it. Anyone can call you vulnerable, but you know yourself how vulnerable you really are. I know I have a history and I fought for what I have now." (Participant 10)

The relief that accompanies the acceptance of vulnerability and receiving support were highlighted by Participant 2:

"I was extremely vulnerable. I felt like a feral cat stuck under a couch. And they [care providers] saw me and pulled me out from under that couch. I was really scared, but extremely happy that I was able to get help." (Participant 2)

Participant 10 further emphasized that being vulnerable is not a weakness but rather an acknowledgement of all the difficulties someone is facing:

"No, because … something has happened that put you there. You don't just end up there, there have been problems that caused further problems. … You just have multiple problems before you end up, for instance, in a shelter. You encounter so many problems and situations where you have to fight to survive." (Participant 10)

Driven by a desire to create a safer environment for her child, Participant 6 was able to accept her vulnerability:

"I was very scared that something would happen to my baby [caused by the use of illicit substances]. And that does a lot to a person. I found it difficult to see myself as vulnerable, but I knew I was, because of my drug use. Then one accepts it a little easier. Why? Because you don't want to endanger your little one or yourself." (Participant 6)

For Participant 1, it took a while to accept her vulnerability, due to the fear of how others would perceive her if she acknowledged that she needed help. It was a gradual process to come to terms with her vulnerability and eventually accept the necessary support:

"When I was 8 months pregnant, I was standing on top of a high apartment building, I wanted to jump. I could have … ended my life. And certainly, the baby's life. And that's on me. They had offered help, but I didn't take it. Looking back now, I would say yes. … Even if it should have been done in secret." (Participant 1)

Strength and courage in embracing vulnerability

Embracing vulnerability not only requires acknowledgment but also considerable strength and courage to ensure the severity of women's circumstances was understood by others. Strength and courage are also needed to reach out and seek help, and equally, to accept it when offered. Participant 10, who was pregnant and homeless at the time, recounted her pursuit of support during her vulnerable state:

"And then for 3 days, between eight in the morning and nine in the evening, I went to city hall. I just stayed there until finally someone came to me asking what was going on. What can we do for you? And then it went pretty quickly. I had a place in a shelter within two weeks." (Participant 10)

The women portrayed strength and courage as essential components to overcome internal struggles and articulate their needs and struggles, especially when driven by concern for their children's well-being, as Participant 2 noted:

"If it is a big step to ask for help? Yes, perhaps for many, but not for me at the time. If I hadn't been pregnant, it would have been a very big step that I probably wouldn't have taken, but for your child… You'll do anything." (Participant 2)

In retrospect, women can even feel a sense of pride in having overcome their vulnerability and emerging from the situation stronger.

"I was very happy to have found the courage to express my needs. You know, like 'Hey guys, things are really not going well'. … I would describe asking for help as empowering. Because it takes a lot of effort to express your needs and to be honest about what you are going through." (Participant 4)

Theme 3: The feeling of being stigmatized.

The women also shared instances of feeling stigmatized when labeled as vulnerable by their care provider, particularly when this externally imposed label did not align with women's self-perceptions.

This misalignment was most prominent when the label did not capture the entirety of the women's personal narratives, making them feel as though they were being reduced to a single, often negative, aspect or characteristic of themselves. Further, the women described feeling confined due to the vulnerable-label, having to deal with negative consequences of this label that affects, among other things, their interaction with others.

Not including the whole story

The women described examples of their individual stories and life contexts being overlooked or ignored. They felt misjudged due to a lack of understanding and interest about difficulties they have experienced and possibly the positive steps they have already taken. Participant 3, explicitly stated:

"You don't know my story, so you cannot tell me if I am vulnerable or not. If you have been through what I have been through, then you can tell me I am vulnerable." (Participant 3)

It can lead to a sense of frustration and injustice, stemming from the perceived incompleteness and inaccuracies in the representations of their situations. Participant 2′s experiences shed light on the discomfort induced by an uninformed judgments made without grasping the full scope of her narrative:

"When a care provider, who does not know me, walks right in and says: 'we are dealing here with a vulnerable woman here' and has this authoritarian attitude, I experience that as unpleasant." (Participant 2)

Participants conveyed a strong desire for their experiences, efforts, and strengths to be acknowledged, rather than being overshadowed by a one-dimensional and potentially misleading label. To illustrate this point, Participant 3 provided a hypothetical scenario, stating:

"Perhaps a woman has two jobs to support her children, but people only see how she does not pay enough attention to her child, while basically she is doing everything she can to ensure that her child is not short of anything. That could come across as vulnerable, but to me it is not that at all." (Participant 3)

Repercussions of labeling

The women described that being labeled based on a simplistic assessment brings on unpleasant feelings and other negative effects. The participants expressed discomfort and alienation due to being confined to predefined boxes that did not resonate with their self-perceptions and experiences:

"…because I find it normal to talk openly about my situation and other people don't find it normal, I am labelled as a vulnerable person. I think that's weird. … Of course you are vulnerable, but at the same time you are also normal". (Participant 4)

"There is a real tendency to label, perhaps too often. Being labeled, frankly, isn't pleasant. You get put into a category; one you might not even recognize yourself in. Without knowing my story, the term 'vulnerable' feels to me like things can happen to me that I just can't handle. But that's not always the case". (Participant 3)

The participants convey a sense of restriction and categorization due to the label, feeling that it does not resonate with their self-perceptions and contributes to them being seen in a reductive, one-dimensional way. Participant 6 shared her feelings about the surplus advice and attention she received, indicative of an underlying assumption that she might be uninformed or noncompliant, primarily due to her being perceived and labeled as 'vulnerable'. This presumption inadvertently diminished her sense of agency:

"There were times when they advised, 'Be cautious with this or that.' Of course, during pregnancy, you're naturally careful, but they indicated where you should be even more careful. At times, it was challenging. I often felt restricted in my actions and choices." (Participant 6)

Mirroring these feelings, Participant 8 highlighted how being labeled as 'vulnerable' heightened her anxiety, feeling a pressure to appear flawless. She felt this pressure made her prone to mistakes, leading her to give incorrect answers:

"I was surrounded by so many care providers, there were so many different faces. I felt the need to constantly show my strengths, to appear perfect. I was very stressed that I would say something wrong." (Participant 8)

Discussion

This study explores the views of women experiencing psychosocial adversity before, during and after pregnancy, focusing on their perceptions of vulnerability and their experiences with being labeled as such. Firstly, women described vulnerability through two main dimensions. The first dimension revolved around their struggles in self-care, emphasizing a distinct inability to provide adequately for their own needs. The other was the possible detrimental effects their vulnerable state could impose on their child's health. These feelings are accompanied by an overwhelming sense of distress. This distress stems both from their feeling of entrapment in an overwhelming situation and from profound concerns regarding the impact on the well-being of their child. Secondly, the women expressed that they could accept and recognize themselves as vulnerable when it accurately mirrored the circumstances they found themselves in. Such acknowledgment isn't passive; it is an expression of agency that demands courage and strength. As such, it can ultimately empower them to actively pursue change, seek assistance, and overcome their vulnerability. Lastly, the women described that the label of 'vulnerability' could be stigmatizing when it overshadows their personal narrative, reducing them to a mere prejudiced label, disregarding the entirety of their story. This emphasizes the need to understand vulnerability not just as a label, but as a deeply personal and multifaceted experience.

Our findings add novel data to the concept of vulnerability, by providing insights into the lived experience of the women concerned. Many previous studies have primarily examined women's experience with the care they've been offered, with only few studies exploring their perceptions with being identified as 'vulnerable' and their opinion on the terminology [18,22,33]. Our work emphasizes the significance of their individual narratives in collaboratively assessing vulnerability with maternity care professionals [21,33,34]. We found that women are receptive to acknowledge and embrace their vulnerability. However, for some, this process requires time. They need time to reach a level of sufficient empowerment to grasp the full impact of their situation, not only on their own well-being but also that of their (unborn) child. This hesitation often arises from fears regarding how others might react to their need for additional support. These findings align with prior research, suggesting that without considering these women's personal experiences, labeling them as 'vulnerable' can intensify feelings of inadequacy and even lead to them feeling stigmatized [22]. Moreover, the absence of clear explanations as to why they are deemed vulnerable, can lead to women entering the care process with distrust [34]. This initial distrust can hinder the development of a trusting relationship between the care provider and the woman. Yet, such a relationship, built on consistent and personalized attention, is essential to provide continuous care [23,35]. Women not only seek to foster this bond but also desire affirmation that their participation in the care process represents their commitment to exert control and manifest positive changes in their lives [23]. When care providers validate these feelings, it can motivate women to remain proactive in their care.

Several studies have explored how healthcare providers or obstetric care providers approach and understand vulnerability when offering care to pregnant women [14,21,35,36]. Our study shows a notable discrepancy between the clinical perspective of care providers and the personal, subjective experiences of the (pregnant) women. Whereas care providers tend to identify vulnerability as an accumulation of specific risk factors, women view it as a unique and individual experience that is shaped by their narratives and circumstances [34,36]. These findings show that vulnerability is not just an epidemiological term that is essential for care delivery or policy development and evaluation, rather it is a nuanced and multi-dimensional concept, that is tied to a woman's life journey [21]. Recognizing and addressing this subjective experience openly can foster a woman's agency, which can drive positive change. Conversely, a one-dimensional, labeling approach can alienate them, leading to stigmatization and strained communication [18]. Moreover, care providers meet substantial challenges in openly discussing vulnerability, facing constraints like time limitations and apprehensions about possibly alienating women by broaching the topic [35]. Amidst these complexities, care providers have to balance between assessing psychosocial risks on the one hand and valuing women's personal experiences on the other hand. This highlights the importance of fostering open communication and understanding each woman's unique journey [34,37].

Strengths and limitations

To our knowledge, this paper is among the few that explore how

women with a lived experience of vulnerability interpret or resonate with the term 'vulnerable' [10,22,33]. Our results offer unique insight into the perceptions of women who are typically underrepresented in research [38]. The trust they placed in the research group opened up space for candid discussions about a highly sensitive topic. This resulted in data that give a clear sense of their lived experience. As such, this study adds a perspective that is important but often overlooked in both policy-making and care provision. These insights shed light on what is important to facilitate actual change. In understanding these nuances, policymakers and care providers are better equipped to design initiatives and care processes that are not only effective, but also empathetic to the needs and concerns of this specific group.

This study also has several limitations. The participants of our study consisted of a select group of ten women. While we were able to delve deeply into each narrative and identify themes consistent across these narratives, this group of women may not capture the entire spectrum of perspectives present in a broader population. Furthermore, we contacted women already receiving additional care. This selection might favor women who recognized and navigated their vulnerability, possibly missing those who either don't identify with it or are resistant to seeking care, a group inherently more difficult to involve in research. Future research could explore if the discovered patterns within this study also apply to this group. Also, while this study focuses on the perspective of mothers, it is imperative to acknowledge that parenthood is an equally important experience for both parents. Incorporating fathers' perspectives would offer a more comprehensive understanding of vulnerability-related challenges. Future research should consider integrating both views during these pivotal parenthood moments. Lastly, despite the strategies we employed to enhance trustworthiness, certain challenges remained. Although an attempt was made to increase credibility through member checking by inviting participants to validate their interview transcript, only three participants ultimately verified their transcript. Other participants were once reminded to verify their transcript but seemed overburdened with daily life and issues related to pregnancy or caring for their children and did not respond. This could have affected the accuracy of the data. Additionally, while we aimed at transferability through contextual descriptions, the specific nature of the study setting and sample may limit the generalizability of our findings to other populations and contexts.

Implications for clinical practice

In providing care and policy-making the term 'vulnerability' is frequently employed to distinguish specific groups of women based on psychosocial adversity and the risk of unfavorable pregnancy outcomes. While this approach is valuable for large-scale identification and resource allocation, it often fails to capture the nuances and individuality that each of these women experiences. At a group level, 'vulnerability' primarily focuses on identifying risk factors to provide assistance to those most in need. However, at an individual level, 'vulnerability' narrates a deeper, more personal story – often one of strength, resilience, and survival against the odds.

Our findings show that, in the context of maternity care, attunement to women's personal experiences and narratives is crucial when using the term 'vulnerability'. When the term 'vulnerability' is used without sufficient attunement to a woman's narratives, it can be experiences as stigmatizing. Conversely, when the term is used in acknowledgement to the difficulties a woman has experienced, and her efforts and strength in dealing with these difficulties, it can be empowering and enhance the trust and openness in the relationship. In addressing psychosocial adversity, maternity care providers need to not only communicate transparently about why specific circumstances are regarded as vulnerability-increasing factors, but explicitly invite women to share their experiences and narratives around these circumstances. This dialogue should aim to reach a joint perception of the situation. By understanding the stigmatizing and empowering aspects of the term 'vulnerability', care providers can offer care that is more empathetic and effective, ensuring that women feel seen, heard, and valued.

Conclusion

This study sheds light on the understanding of vulnerability among (pregnant) women who face psychosocial adversity in a nuanced way. While the term 'vulnerability' in maternity care is usually associated with risk factors, it has a deeper personal meaning for the women concerned, which is often tied to their own perceived strength and resilience. The differences in understanding between (maternity) care professionals and these women can impede effective care provision. Hence, it's imperative for healthcare providers to balance both clinical and personal perspectives of vulnerability, ensuring women's experiences are recognized and valued, which leads to more empathetic and tailored care.

[a]These included organizations Nu Niet Zwanger, a family planning organization for women facing complex social adversities, mental health issues or intellectual disabilities, [39] the Department of Psychiatry of the Erasmus University Medical Centre, [40] the Department of Obstetrics and Gynaecology of the Erasmus University Medical Centre, [41] ASVZ (care and support for persons with intellectual disabilities), [42] and Mothers of Rotterdam (community-based social care) [43].

Contribution to authorship

LM, HES, MH, AW and HB contributed to the design of the study. LM and MH collected the data. LM and HES analyzed the data. LM, HES, AW and HB interpreted the data. LM drafted the manuscript. All authors made substantial contributions to the revision of the manuscript. All authors read and approved the final version of the manuscript.

Details of ethics approval

The study was approved by the Medical Research Ethics Committee of the Erasmus Medical Centre (MEC-2020–0473).

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CRediT authorship contribution statement

L. van der Meer: Conceptualization, Formal analysis, Funding acquisition, Investigation, Writing – original draft, Writing – review & editing. **H.E. Ernst-Smelt:** Conceptualization, Formal analysis, Funding acquisition, Writing – original draft. **M.P. Lambregtse-van den Berg:** Conceptualization, Funding acquisition, Writing – original draft. **M. van 't Hof:** Conceptualization, Funding acquisition, Investigation, Writing – original draft. **A.M. Weggelaar-Jansen:** Conceptualization, Funding acquisition, Methodology, Supervision, Writing – original draft, Writing – review & editing. **H.H. Bijma:** Conceptualization, Funding acquisition, Methodology, Supervision, Writing – original draft, Writing – review & editing.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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