








ORIGINAL ARTICLE

Emotional and social dimensions of high-risk pregnancy in specialized care: a qualitative study*

HIGHLIGHTS

1. High-risk pregnant women require constant obstetric surveillance.
2. Obstetric protocols promote maternal and infant safety.
3. Humanized care in obstetric assistance is fundamental.
4. The multidisciplinary team must be valued.

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ABSTRACT

Objective: To analyze the emotional and social experiences of high-risk pregnant women under follow-up at a referral center, in light of Imogene King's Theory of Goal Attainment. **Method:** A qualitative study conducted with 20 pregnant women from Três Rios, Rio de Janeiro, between November and December 2024, using semi-structured interviews. Data were analyzed by lexical analysis with the aid of the IRaMuTeQ software, and subjected to thematic Content Analysis. **Results:** The participants were predominantly women with a high school education, low family income, and self-declared of mixed race. The findings were organized into two central axes: Emotional experiences in the face of high-risk pregnancy and Perceptions of follow-up at the Women's Health Specialty Center. The narratives revealed fear, shock, and concern, which were reframed through interaction with the multiprofessional team. **Final Considerations:** Pregnancy demands comprehensive care that transcends the clinical dimension. Therapeutic interaction and goal negotiation contribute to autonomy and the strengthening of the therapeutic bond.

DESCRIPTORS: Obstetric Nursing; Patient Care Team; Prenatal Care; Pregnancy, High-Risk; Maternal Mortality.

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INTRODUCTION

High-risk pregnancy (HRP) is characterized by the increased probability of maternal or fetal complications associated with pre-existing clinical conditions, complications in the current pregnancy, or socio-environmental factors that increase the woman's vulnerability¹. High-risk pregnancies predispose women to severe maternal morbidity, *near miss*, and increased risk of maternal mortality. This scenario demands specific government attention, poses challenges to health services, and reinforces the need for an organized network providing comprehensive and safe follow-up, including the use of obstetric surveillance tools, with the understanding that maternal death cannot be attributed to a single factor².

Severe Maternal Morbidity (SMM) is a relevant marker of care quality and inequalities in health systems, requiring the use of improved methods to identify, document, and review maternal deaths³. International studies indicate weaknesses in adherence to surveillance tools such as the Modified Early Obstetric Warning Score (MEOWS) and heterogeneity in the availability of resources, beds, and protocols⁴. In Rwanda, for example, 54.3% of high-risk pregnant women admitted to Intensive Care Units progressed to death, highlighting the importance of clinical monitoring⁴.

The MEOWS, recommended by the Confidential Enquiry into Maternal and Child Health (CEMACH 2003–2005) report, has high sensitivity and predictive value, enabling early identification of morbidities such as hemorrhage, gestational hypertension, and infection⁵. However, resource limitations, the absence of standardized protocols, and diagnostic restrictions contribute to adverse outcomes, including Near Miss and maternal death, highlighting disparities between countries at different levels of development⁶⁻⁷.

In Brazil, the maternal mortality ratio was 44 per 100,000 live births in 2015, higher than that of high-income countries such as Italy (2), Sweden (4), Canada (10), and the United States (19)². Despite a 49% reduction between 1990 and 2019, as reported in the *Global Burden of Disease Study*⁸, the country has yet to meet the World Health Organization (WHO) targets within the Sustainable Development Goals (SDGs), which project fewer than 70 deaths per 100,000 live births by 2030 and, for Brazil, 30 per 100,000 in the same period. This scenario highlights the persistence of inequalities and preventable deaths related to pregnancy and childbirth⁹.

Although public policies such as the Rede Alyne (Alyne Network), launched in Brazil in 2024 with the aim of reducing maternal morbidity and mortality, seek to articulate levels of care and ensure continuity in maternal and infant care¹⁰, weaknesses persist, especially in qualified listening and in pregnant women's agency, which remain significant barriers to care-seeking¹¹⁻¹². Prenatal care, especially in the follow-up of high-risk pregnancies, plays a central role in the early identification of risk situations and in the organization of referral and counter-referral flows¹.

Given this context, the present study is justified; it is part of a doctoral research project entitled: Modified Early Obstetric Warning Score, in Light of Imogene King's Theory of Goal Attainment, in a Municipality in the Southern Fluminense Region.

The theoretical framework adopted was Imogene King's Theory of Goal Attainment, which directs attention to the interaction between the professional and the pregnant woman, valuing dialogue, the joint construction of objectives, and the comprehensiveness of care¹³. This approach allows understanding of narratives beyond clinical aspects, incorporating relational and social dimensions that underpin humanized and participatory practices¹³⁻¹⁴ recommended for the care of pregnant women¹⁵.

The guiding questions were constructed from the articulation of three fundamental axes: the theoretical framework, which values interaction and the shared construction of goals in care; the local empirical reality, marked by weaknesses in the organization of the maternal and infant care pathway and by delayed referrals to the specialized service; and the research object, centered on the emotional and social experiences of high-risk pregnant women followed at the Centro Especializado em Saúde da Mulher (Women's Health Specialty Center - CESM).

For this study, questions related to the discovery of the pregnancy, prior care, and feelings associated with the initial visit to the CESM were analyzed. The analyses were guided by the following research questions: How do high-risk pregnant women perceive and reframe their emotions throughout follow-up at a specialized service? In what ways does interaction with the multiprofessional team influence the construction of safety, autonomy, and adherence to high-risk prenatal care? What elements of specialized care are perceived as mediators between initial insecurity and trust in the gestational process?

The convergence of these elements revealed the need to understand, beyond clinical aspects, how these women perceive, feel, and assign meaning to the care received in high-risk prenatal care, particularly with regard to the relationships built with health professionals and their participation in the care process.

Thus, this study aimed to analyze the emotional and social experiences of high-risk pregnant women under follow-up at a referral center, in light of Imogene King's Theory of Goal Attainment.

METHOD

This is a descriptive study with a qualitative approach, in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist¹⁶⁻¹⁷, ensuring methodological rigor, transparency, and reproducibility. The design was consistent with the aim of analyzing the emotional and social experiences of pregnant women in high-risk prenatal care within a clearly defined care setting. Sample definition followed the criterion of theoretical saturation, and data collection was carried out through semi-structured interviews that were recorded and subsequently transcribed, combined with the sociodemographic characterization of participants. The analysis was conducted systematically using the IRaMuTeQ software¹⁸ and thematic Content Analysis¹⁹, ensuring analytical consistency and reduction of interpretive subjectivity.

Accordingly, 20 interviews were conducted and analyzed concurrently with data collection. The sample was defined by the criterion of theoretical saturation, reached at the end of data collection when no new meaning nuclei or relevant categories emerged, indicating sufficiency of the corpus for understanding the emotional and social experiences in the context of high-risk prenatal care.

Inclusion criteria comprised pregnant women classified as high-risk, regularly followed at the CESM, aged 14 years or older, in clinical and cognitive conditions to respond to the interviews, and who voluntarily agreed to participate in the study, with free and informed expression of consent, in accordance with the ethical principles governing research with human subjects.

Participants were approached in person by the lead researcher after routine consultations at the service. During the data collection period, 20 pregnant women

were invited to participate in the study. There were no withdrawals after acceptance, as all participants who consented were interviewed through the completion of data collection.

Data collection was carried out between November and December 2024 at the CESM, located in the municipality of Três Rios (RJ). Interviews took place after the medical or nursing consultation, at a previously scheduled time in accordance with participants' availability, and were conducted in a private room within the service itself, ensuring privacy and confidentiality.

Initially, data were collected by means of a Semi-structured Interview Guide developed by the lead researcher based on the study's objectives and theoretical framework. The instrument was organized by the researchers into four parts: (1) socioeconomic and demographic data; (2) obstetric data; (3) research-specific data; and (4) experience in high-risk prenatal care.

Qualitative data were produced through semi-structured interviews guided by a previously developed guide, with the following triggering question: Tell me how it was for you to discover that your pregnancy is high-risk and how your experience at the CESM has been. All interviews were recorded using the Easy Voice Recorder application upon prior authorization, following explanations about the objectives, procedures, risks, and benefits of the research, and after signing the Informed Consent Form (ICF) and, for participants under 18 years of age, also the Informed Assent Form (IAF). Participants were informed that they could refuse or discontinue their participation at any time, without any impairment to their care.

Interviews were recorded and subsequently transcribed in full. Transcriptions were verified against the original audio recordings by the researcher herself to ensure the accuracy of the empirical material. The textual material was processed in IRaMuTeQ software, enabling the application of textual statistics, including corpus distribution, the Zipf graph, word cloud, and similarity analysis. Subsequently, data were analyzed using the thematic Content Analysis technique, enabling the identification, coding, and organization of meaning units.

Coding and organization of meaning units were performed by the lead researcher. To strengthen analytical rigor, the initial categories and interpretations were discussed with the research supervisor, who served as an external critical reviewer, contributing to the improvement of the interpretive process. Independent coding by multiple researchers was not performed due to the study design and its exploratory nature. Nonetheless, repeated reading of the *corpus* and continuous reflection on the emerging categories were adopted as strategies to broaden analytical consistency and coherence.

Transcriptions and results were not submitted to validation by participants (member checking). This step was not performed due to time constraints and the difficulty of re-establishing contact with the women after the end of follow-up at the service, an aspect considered in the interpretation of the findings.

Results were interpreted in light of Imogene King's Theory of Goal Attainment¹³, which guides understanding of the nurse–pregnant woman interaction, highlighting the negotiation of care objectives, the centrality of communication, and the construction of shared goals. This perspective allowed analysis of the discourses not only in terms of textual content but also considering interactions and health goals, reinforcing the relational and comprehensive dimension of care in high-risk prenatal care.

The study adhered to the ethical principles set forth in Resolution No. 466/2012 of the National Health Council²⁰ and was approved by the Research Ethics Committee (opinion No. 7.076.282/2024). To preserve anonymity and confidentiality, women were identified using pseudonyms inspired by nursing theorists and historically significant women.

RESULTS

Characterization of participants and the analyzed corpus

Twenty pregnant women under high-risk prenatal follow-up participated in the study, aged 14 to 41 years, all Portuguese speakers. Conditions associated with high risk included prior chronic diseases, gestational complications, advanced maternal age, unfavorable reproductive history, and unplanned pregnancies.

The textual corpus comprised 1,562 lexical occurrences distributed across 162 distinct forms, of which 77 were hapax, corresponding to 4.93% of occurrences and 47.53% of forms. The average of 78 occurrences per interview indicates homogeneity of the material and analytical density adequate for qualitative interpretation.

Regarding the sociodemographic profile of participants ($n = 20$), there was a predominance of women with complete secondary education (14; 70%) and family income between one and two minimum wages (17; 85%), as shown in Table 1.

Table 1. Sociodemographic profile of high-risk pregnant women. Três Rios, RJ, Brazil, 2025

Sociodemographic variables	n	%
Education level		
Incomplete elementary education	6	30
Complete high school education	14	70
Family income (minimum wages)		
1 to 2	17	85
3 or more	3	15
Self-declared ethnic-racial identity		
Mixed-race	12	60
White	5	25
Black	3	15

Source: The authors (2025).

Results were organized into two central thematic categories: (1) Emotional experiences in the face of high-risk pregnancy and (2) Perceptions of follow-up at the CESM, which express the transformative movement of pregnant women's experiences throughout specialized care.

Emotional experiences when faced with a high-risk pregnancy

The discovery of a high-risk pregnancy was, for most participants, a moment marked by fear, shock, and concern. These feelings were related to the diagnosis of clinical conditions, the possibility of maternal and fetal complications, prior reproductive experiences, and uncertainties about the progression of the pregnancy.

The word cloud (Figure 2) deepens understanding of the pregnant women's experience by highlighting the centrality of the term CESM as a structuring axis of the narratives. The high frequency of this term, articulated with technical terms such as physician, obstetrician, and team, indicates that the specialized service occupies a central place in the organization of care and in the perception of clinical safety. Simultaneously, the recurrent association with affective words such as calm, happy, and feeling reveals that the experience at the CESM goes beyond the biomedical dimension, incorporating elements of welcoming, listening, and bonding.

This coexistence of technical and emotional terms suggests that high-risk prenatal follow-up is perceived by pregnant women as a space of comprehensive care, in which professional support acts not only in the management of clinical conditions but also in mediating the emotions aroused by high-risk pregnancy. The narratives indicate that the continuous presence of the team and the organization of the service contribute to the reframing of the gestational experience, transforming initial feelings of fear and insecurity into greater trust and calm throughout follow-up.



Figure 2. Word cloud of interviews analyzed in IRaMuTeQ. Três Rios, RJ, Brazil, 2025

Source: The authors (2025).

In an integrated manner, the results show that the experience of high-risk pregnancy is initially permeated by feelings of fear, shock, and concern, strongly related to clinical conditions and uncertainties about gestational progression. However, as pregnant women are enrolled in specialized follow-up, a progressive reframing of this experience is observed, mediated by the presence of the service, the performance of the multiprofessional team, and the bond established throughout prenatal care.

Lexical analysis, in consonance with the narratives, demonstrates that the CESM is configured as a central element in the organization of care and in the perception of safety, articulating technical and affective dimensions. These findings reveal that high-risk prenatal care, when structured around a logic of comprehensive care, contributes not only to clinical management but also to the reduction of pregnant women's emotional insecurity.

DISCUSSION

Analysis of the interviews highlighted the complexity of the experience of pregnant women under follow-up at the CESM, marked by the coexistence of ambiguous feelings and a process of progressive reframing throughout prenatal care. This context reflects conditions of social and emotional vulnerability that directly influence the perception of risk and the relationship with specialized care.

The findings show that the initial feelings of fear, shock, and anxiety associated with the diagnosis of high-risk pregnancy come to coexist with perceptions of welcoming, safety, and trust as women are enrolled in specialized follow-up. This shift confirms the relevance of comprehensive care in reducing emotional insecurity and in strengthening the bond with the health service²¹⁻²².

The centrality of the CESM, evidenced in lexical analysis and in the narratives, reinforces the role of the service as an organizing axis of the gestational experience. The constant presence of the multiprofessional team, the performance of consultations and tests in the same space, and the continuity of follow-up were recognized as elements that contribute to greater calm and adherence to prenatal care, a finding consistent with the literature²¹⁻²³.

In light of Imogene King's Theory of Goal Attainment, the results can be understood as the expression of an interactional process in which the relationship established between pregnant women and professionals favors the reframing of the risk experience. At the personal level, feelings of fear and concern reflect the individual's perception of threat; at the interpersonal level, the bond with the service and the team sustains the construction of trust; and, at the social level, access to specialized care broadens the sense of support and safety¹³⁻¹⁶.

The identified categories, initial fear, shock, and concern; safety and trust in the CESM; joy and satisfaction with care; emotional ambivalence; and progressive reframing of the gestational experience, show that high-risk pregnancy does not constitute a linear process but rather a dynamic experience permeated by emotional transformations throughout follow-up. These results reinforce that bonding, communication, and welcoming are central elements for the construction of a more positive experience^{22,24}.

Access difficulties, particularly those related to distance and transportation costs, also emerged as aspects that interfere with pregnant women's experiences, indicating the need for public policies guided by equity in access to health services²³⁻²⁵. Nevertheless, follow-up at the CESM was recognized as essential for maternal and fetal safety, reinforcing the importance of specialized services as devices of emotional and technical support.

As a limitation, the study was conducted in a single service with a restricted number of participants, which may limit the transferability of the findings. Future research is recommended to broaden the settings investigated and to deepen the analysis of the emotional and relational dimensions involved in high-risk prenatal care.

In an integrated manner, the results show that the experience of high-risk pregnancy transcends the biomedical dimension, being traversed by emotional and relational aspects that are progressively reframed through the bond with the service and with professionals^{13-14,26-27}. The findings thus reinforce the relevance of multiprofessional practices and comprehensive care as foundations for safe, humanized, person-centered maternal care^{14,22,24,26-30}.

The lead researcher, an obstetric nurse, doctoral student, PACCS researcher, and service coordinator, acknowledges that her institutional position and professional trajectory in the care of high-risk pregnant women may have influenced data collection and interpretation. Her coordinating role, combined with her professional identity, may have been perceived by participants as a position of authority, favoring socially desirable responses.

FINAL CONSIDERATIONS

Throughout high-risk prenatal care, the feelings of fear, shock, and anxiety present since the discovery of the pregnancy do not disappear, but come to coexist with experiences of welcoming, safety, and hope. Interaction at the Women's Health Specialty Center, based on the bond with the multiprofessional team, proved relevant for reframing negative experiences, promoting adherence to care, trust in professionals, and maternal agency. By addressing subjective dimensions, the study contributes to the advancement of knowledge by complementing predominantly clinical and biomedical evidence.

In clinical practice, the application of Imogene King's Theory of Goal Attainment showed that effective communication and the negotiation of shared goals are central to the delivery of qualified care. The findings point to the need for actions such as strengthening the therapeutic bond, qualified listening, welcoming of emotional demands, and valuing women's autonomy. The nurse's role as mediator of the therapeutic interaction stands out, integrating technical, emotional, and social aspects for the safety and quality of care.

In the realm of public policy, the results support the improvement of protocols and strategies for comprehensive care in the Brazilian National Health System, in consonance with the Rede Alyne. The importance of incorporating, in normative documents and care flows, approaches that value therapeutic interaction, goal negotiation, and emotional welcoming as structuring components of care is highlighted. These elements contribute to the qualification of the network, strengthening multiprofessional performance, maternal agency, and care continuity, with the potential to positively impact maternal outcomes and to broaden the effectiveness, safety, and humanization of care in high-risk prenatal services.

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