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# Antenatal group consultations: Promoting wellbeing

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## ABSTRACT

**Background:** Most healthcare encounters take place in a dyadic encounter between a patient and healthcare practitioner, and improving dyadic communication has been the object of much health communication research. However, it seems that an alternative to the dyadic encounter – group consultations – may have distinct advantages for the promotion of patients' wellbeing. **Aim:** This article focuses on antenatal group consultations (AGCs), where groups of pregnant women meet with one or more healthcare practitioners instead of meeting their midwife individually, and explores how the presence of other pregnant women in AGCs may promote wellbeing. **Methods:** Adopting a post-intentional phenomenological approach, we analysed the transcripts of 16 semi-structured interviews undertaken with pregnant women who attended AGCs in Denmark, focusing on their accounts of being with each other. **Results:** The presence of other pregnant women helped to generate trust, with the participants' pregnant bodies symbolising their common situation. The presence of peers prompted feelings of identification and solidarity, generally decreased the women's concerns, and normalised their experiences of pregnancy. **Discussion and conclusion:** This article develops understandings of how patients experience interpersonal healthcare encounters, and suggests the value of alternatives to the clinical dyad, such as group consultations, for promoting the wellbeing of other patient groups.

## KEYWORDS

Antenatal group consultations, post-intentional phenomenology, presence, qualitative interviews, wellbeing

## BIOGRAPHIES

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## Introduction

The clinical dyad, involving one patient and one healthcare practitioner, is the typical format for most healthcare consultations. Acknowledged challenges to the quality of such consultations include informational and interactional discordance between doctor and patient (Coran, Koropecj-Cox & Arnold, 2013), and power imbalance (Schoenthaler et al., 2018). Patient centeredness theory (Balint, 1969; Mead & Bower, 2000), for example, has been proposed to help improve doctor-patient dyadic communication, and advice and guidelines are available for doctors at all levels (Kurtz & Silverman, 1996; Silverman et al., 2016) to ensure that the best communication takes place, as effective communication is necessary to ensure optimal healthcare provision.

There are, however, alternatives to the clinical dyad. With antenatal group consultations (AGCs), groups of pregnant women meet in a consultation with one or more trained healthcare professionals (Nisbeth Jensen & Fage-Butler, 2016). AGCs bring groups of pregnant women and healthcare professionals together in transitory social constellations. AGCs are structured around pregnant women (and possibly their partners) attending their midwife for a health check individually, while also meeting other pregnant women (or couples) informally. AGCs differ to antenatal classes in Denmark, the context of this article. At antenatal classes, couples often attend the classes together and meet other couples, but the focus is on learning: about what one should and should not do during pregnancy, about what to expect about birth and pain relief, and about what to anticipate from those first days as a family (Borger, 2021). Also, in Denmark, pregnant women can choose either a combination of AGCs and individual consultations with their midwives, or individual consultations with their midwives only (Brot & Poulsen, 2013).

Many women opt for AGCs because of their social aspect. For example, a qualitative interview study showed that pregnant women chose AGCs “to share pregnancy-related issues, benefit from peer support, and share experiences with others” (Andersson et al., 2012, p. 507). Novick et al. (2011) found that women connected with each other in the AGC setting, and pregnant women in McDonald et al.’s (2014) study of AGCs expressed that “having people who are at the same stage as you is really important” (p. 4 of 12). Meeting others in the same situation in AGCs may help to normalise the experience of pregnancy (McDonald et al., 2014; Novick et al., 2011; Teate et al., 2011). Indeed, AGC participants have stated that pregnant women in AGCs are better at normalising the experience of pregnancy than midwives (Andersson, Christensson, & Hildingsson, 2012).

There are strong indications that group consultations, where groups of patients with similar conditions meet with a healthcare practitioner, may support patients’ wellbeing (Lavoie et al., 2013; Thompson-Lastad, 2018). Lavoie et al. (2013), for example, state that, far from detracting from consultation quality, the format of group consultations “rather adds value to the encounter by providing opportunities for peer learning and mutual support” (p. 8). However, the *processes* that underpin group settings are poorly understood (Ickovics et al., 2007; Ljungdalh & Møller, 2012).

The shortage of research about the processes that underpin group settings extends to the area of antenatal care. Rising, Kennedy, and Klima (2004) have highlighted that “it is imperative to explore the effects of the change [from individual consultations to AGCs] on healthcare outcomes, satisfaction with care, and family health and wellbeing” (p. 403). Gagnon and Sandall (2007), who produced the Cochrane Review on group antenatal care, concluded that wellbeing may be generated in AGCs through increased social capital, while highlighting a dearth of research in this area (pp. 3-4).

Given the indications in the literature just described, the aim of this article is to investigate how the social setting of AGCs may promote wellbeing, focusing on the narrated experiences of the participants of AGCs. Using a phenomenological lens, we analysed semi-structured individual interviews undertaken with 16 pregnant women about how they experienced the presence of other pregnant women in AGCs in order to explore social and interpersonal aspects of the setting of AGCs that may support wellbeing.

## Wellbeing in the context of pregnancy

Although all pregnant women experience pregnancy uniquely (Schetter, 2011), research indicates that gestation is a demanding time for many pregnant women (Rising, 1998). Studies indicate that pregnant women have higher rates of depression and anxiety than corresponding groups of non-pregnant women (McLeish & Redshaw, 2017, p. 1). The emotional challenges of pregnancy are particularly evident in first-time mothers (McLeish & Redshaw, 2017; Seefat-van Teeffelen, Nieuwenhuijze, & Korstjens, 2011). Given the emotional challenges that pregnant women may face, providing emotional support has been described as “self-evidently a necessary part of midwifery” (Seefat-van Teeffelen et al., 2011, e123).

Significantly, pregnant women have highlighted that their own and their baby’s *wellbeing* should be the main priority of antenatal health care, rather than biomedical checks for potential health problems (Downe, Finlayson, Tunçalp, & Metin Gülmezoglu, 2016; Liederman & Morefield, 2003). Greater attention has also been paid to pregnant women’s wellbeing in antenatal care in recent years (Brot & Poulsen, 2013; Coxon, Scamell, & Alaszewski, 2012; McDonald, Sword, Eryuzlu, & Biringler, 2014), in line with midwives adopting a more collaborative style with pregnant women (Koushede et al., 2013).

The initial rationale behind the AGC concept was that AGCs should further a patient-centered approach for women at a vulnerable time in their lives. The CenteringPregnancy initiative, established in the U.S. in 1995, pioneered AGCs (Ickovics et al., 2007) on the basis that “more group interaction, more peer support, and less scheduled individual time would allow both the care provider and clients to identify pregnancy needs and to develop plans to address those needs” (Baldwin, 2006, p. 267). AGCs are increasingly available as part of antenatal care in the U.S., Australia and Europe (Baldwin, 2006; Manant & Dodgson, 2011; Novick, Sadler, Knafl, Groce, & Kennedy, 2013; Teate, Leap, Rising, & Homer, 2011; Wedin, Molin, & Crang Svalenius, 2010), though mainly as a supplement to the more mainstream dyadic consultations. Centering Healthcare Institute’s (2021) website highlights that AGCs facilitate better relationships with healthcare providers as well as valuable peer support: “Providing care in this way allows moms and providers to relax and get to know each other on a much

deeper and meaningful level. Members of the group form lasting friendships and are connected in ways not possible in traditional care.”

## Wellbeing in a healthcare setting

Wellbeing has a long-established relationship with health. In its first constitution, the World Health Organization (WHO), established in 1948, defined “health” as wellbeing: health was a “state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” (WHO, 2003). This definition rejects the characterisation of health in purely biomedical (physiological) terms; health is instead defined with respect to holistic, subjective and intersubjective aspects of wellbeing. Although the WHO (2013) has since primarily reported on biological health matters due to the availability of biological data and the shortage of wellbeing data, wellbeing has from time to time been a core policy focus of the WHO. In 1986, for example, the Ottawa Charter defined the aims of public health in terms of wellbeing (WHO, 1986), and one of the WHO’s (2013) key aims for Europe was enhancing the wellbeing of Europeans.

Although health has been defined in relation to wellbeing, their distinct though not completely dissociated status persists, among other things in the expression “health and wellbeing”. However, there has been growing interest in health-as-wellbeing, evident in applications as diverse as health policies that explicitly redirect attention to wellbeing in the UK, for example, (Department of Health, 2014), community health initiatives that prioritise wellbeing (e.g. Kingsley, Townsend, & Henderson-Wilson, 2009) and wellbeing apps and platforms as part of mHealth (mobile technology healthcare) (Gaggioli & Riva, 2013; Parks et al., 2018).

Promoting patients’ wellbeing in institutional healthcare settings has proven to be challenging, however. Some reasons for this can be traced to the term “wellbeing” itself. Scholars have described ‘wellbeing’ as lacking “cogency” (Jones-Devitt, 2011, p. 25), and as an emergent or “embryonic” concept (Knight & McNaught, 2011, p. 256). Former British prime minister David Cameron who promoted wellbeing-related policies in the UK admitted: “There is a suspicion that, frankly, the whole thing is a bit woolly, a bit impractical, [...] insubstantial and candyfloss-like” (Cameron, 2010). Besides wellbeing lacking clear definitions (Dodge, Daly, Huyton, & Sanders, 2012), another problem is its complexity. Although wellbeing is primarily characterised as a matter of subjective or psychological experience, it also involves objective aspects relating to family, community and society, and access to resources (McNaught, 2011, p. 9). The complexity of wellbeing is reflected in increasingly multifaceted models of wellbeing (e.g., McNaught, 2011, p. 11). Thus, a combination of semantic under-determination (Laclau & Mouffe, 1985) and conceptual complexity makes it difficult to operationalise, integrate and assess wellbeing initiatives in healthcare settings.

Another challenge to promoting wellbeing in institutional healthcare settings has to do with the fact that *biomedical* procedures, forms of knowledge and identities are prioritised in healthcare settings. This is likely due to the expectation that healthcare professionals offer biomedical interventions and services rather than activities that might support an individual’s wellbeing (Groll, 2016). Another problem highlighted by Veatch (2009) is that clinicians may be ill-equipped to promote wellbeing due to lack of relevant training. A different issue is that when wellbeing is discussed in relation to healthcare settings, it is often framed in relation to

the practitioner-patient dyad, and thus is conceived as an individual matter that can be promoted using a patient-centred approach (Groll, 2016, p. 505). However, this is at odds with interpretations of wellbeing as being generated in broader social contexts and settings (McNaught, 2011).

Another inhibiting factor is the shortage of empirical research on how wellbeing can be promoted in healthcare settings. The WHO (2013) has also highlighted the need for research into wellbeing, particularly in relation to “how wellbeing can be defined and measured in the context of health” (p. 40). Also, Spigner and Moreno-Leguizamon (2011) have called for qualitative research into wellbeing in health contexts in ways that capture people’s experiences (p. 182), which is the approach adopted in this article.

Given the aforementioned complexity of the concept, it is important to be explicit about how “wellbeing” is understood in this article. We draw specifically on McNaught’s (2011) framework of wellbeing as dynamic, multi-dimensional and involving multiple social formations and settings. Wellbeing, according to McNaught (2011) is “a dynamic process that gives people a sense of how their lives are going, through the interaction between their circumstances, activities and psychological resources, and includes their interpersonal interactions with significant social formations (the family and their community) within society” (p. 11). Moreover, this article rests on the assumption that culture inflects meanings of wellbeing (Lomas, 2019), a point also emphasized in a recent WHO publication (Napier et al., 2017).

Such understandings of wellbeing as dynamic, interactive and cultural processes help to indicate why wellbeing may be promoted through the peer support that is available at AGCs. Forgeard, Jayawickreme, Kern, and Seligman (2011) explain that: “Social support – the belief that one is cared for, loved, esteemed and valued – has been recognised as one of the most (if not the most) influential determinants of wellbeing for people of all ages and cultures” (p. 86). The relevance of examining the social setting of AGCs in relation to wellbeing is also highlighted by the importance attributed to relationships in Seligman’s (2011) work on flourishing.

## Methods

Phenomenology provides the overarching research framework for this article, as phenomenologists are “typically interested in charting how subjects experience life” (Brinkmann & Kvale, 2015, p. 18), including their visceral responses, and this was clearly relevant for exploring pregnant women’s experiences of AGCs. Specifically, we take a post-intentional phenomenological (PIP) approach (Vagle, 2018), focusing on participants’ accounts of encountering and being with each other in order to shed light on how social and interpersonal aspects of AGCs may have promoted wellbeing. Also, as noted above, we understand wellbeing as culturally and contextually sensitive (La Placa et al., 2013; Lomas, 2019), and PIP accommodates this.

PIP rejects Husserl’s (1983/1913) conceptualisation of phenomena as stable essences, instead drawing from poststructuralism the idea that phenomena are “unstable, contextualized, and historicized” (Vagle, 2018, p. 124). Vagle (2018) emphasises the situatedness of phenomenological objects in contexts that are not only situational and material, but also

sociocultural and historical. Thus, for Vagle (2018), the body is “cultured and gendered” (p. 130). To date, PIP has featured more prominently in fields such as pedagogy and psychology, but it is increasingly evident in healthcare research (e.g., Araten-Bergman, Avieli, Mushkin, & Band-Winterstein, 2016).

According to Vagle (2018), post-intentional phenomenologists should adopt a “bridled” attitude to the object of study, focusing on the object of study and being sensitive to meanings generated by the speaker. However, this does not mean a complete “bracketing” or *epoché* (Husserl, 1983/1913) where researchers strive to set aside all of their preconceptions, as it encourages the inclusion of theoretical concepts that might relate to the phenomenon in question (Vagle, 2018, p. 143). Bringing theories to bear on the objects of phenomenological research reflects Vagle’s (2018) perspective that phenomenological objects are unavoidably entangled in abstract constructs (p. 82). We chose PIP as we understand wellbeing as being generated in and refracted through the contexts in which it is experienced, by participants who are discursively entangled and whose bodies are encultured.

## Phenomenological theories supporting interpretation of wellbeing

As theories are considered part of PIP’s interpretive apparatus, we summarise here phenomenological theories relating to interpersonal encounters that helped us interpret relevant aspects in the interview transcripts, and therefore appear in our Results section:

- 1) The “Other” is someone for whom one is *de facto* responsible (Levinas, 2006).
- 2) Presence is mediated through the body, as we experience the world through our bodies and senses (Merleau-Ponty, 2017/1962). In later work, Merleau-Ponty (1968/1964) grounded his ontology of medicine more solidly on bodiliness, positing a notion of the reflexive self that co-extends with and is intertwined with the body (Brannigan, 1992). This means that our sense of self changes as our body changes (Brannigan, 2001).
- 3) We exist in an intercorporeal relation to others, because “being embodied is never a private affair, but is always already mediated by our continual interactions with other human and nonhuman bodies” (Weiss, 1999, p. 5).
- 4) Eye contact is a form of touching and meeting (van Manen, 2017).
- 5) Empathy in encounters derives from embodiment (Carel, 2016).
- 6) Co-presence has healing potential (Brannigan, 2012).

## Ethical considerations

Danish legislation does not require ethical approval for a study of this type because it did not influence the usual treatment of the participants or include any biological material. In keeping with the Declaration of Helsinki, participants completed written statements of consent prior to the interviews where they were informed about the project, that they could withdraw at any point and that they would be anonymised in any publications. Names and other personal details have been omitted to preserve confidentiality.



## Data generation

The data consist of interview scripts of 16 interviewees, aged between 25 and 36 years, who had previously participated in a study of pregnant women's experiences of AGCs (see Nisbeth Jensen & Fage-Butler, 2016; see Acknowledgements). For 12 of the interviewees, it was their first baby; for the remaining four, it was their second. Recruiting took place via midwives who presented AGC participants with written information about the study. The interviews took place after the women's normally second and final AGC at around week 38 and before they gave birth. The study employed semi-structured interviews and open-ended questions which are widely used in phenomenologically based interview research (Brinkmann & Kvale, 2015).

This article explores participants' responses to the following interview questions:

- "What was it like being with other pregnant women in the antenatal group consultations?"
- "What, if anything, do you feel you got out of being with other pregnant women in the antenatal group consultations?"

The first interview question focused on the participants' *experiences* of being with other pregnant women in AGCs, while the second related to participants' views on the *perceived value* of being with other pregnant women in AGCs. Both of these questions could shed light on wellbeing in relation to AGCs.

## Data analysis

Phenomenological research can involve close textual analysis of written material. Using van Manen's (1990) line-by-line approach, relevant statements were identified in the interview transcripts using the question: "What does this sentence or sentence cluster reveal about the phenomenon or experience being described?" (p. 93). The focus here was on identifying content that related to the experience of wellbeing; interpreting the transcripts was informed both by an openness to the meanings within the transcripts themselves and theoretical insights from the literature on phenomenological aspects of wellbeing, in line with the methodology of PIP. Similar codes were combined to derive broader themes, where themes were understood as "meaningful patterns in the data, which researchers use to interpret that data for an audience" (Morgan, 2018, p. 340). The first author conducted the initial coding, and both of the authors discussed, refined and finalized the themes which are presented below.

## Results

The themes reflect two overarching categories that related to participants' experiences of being with peers in AGCs (interview question 1), and what the participants said they got out of the experience of being together in the AGCs in terms of benefits and drawbacks (interview question 2). The numbers of the interviewees appear in brackets after each quotation below.

## The experience of the interpersonal encounter with other AGC participants

The following five themes were identified under this heading.

### *Encountering others “in the same boat”*

Five of the women, unprompted, characterised their experience of encountering others in AGCs as realising they were “in the same boat” as the other women, for example:

It’s a bit funny – being together with other pregnant women when you are pregnant yourself, you suddenly understand something – you think, “Of course! We are in the same boat.” (14)

Physically encountering other pregnant women seemed to heighten an awareness of their shared existential condition of pregnancy. This reflects Weiss’s (1999) point that one’s experience of being embodied (here, as a pregnant woman) is always mediated in relation to other bodies in one’s environment.

### *Shared common ground with “strangers” offered a safe space for honest communication*

The women stated that not knowing others in the group made it easier for them to open up about their experiences and concerns:

It can be liberating not knowing people, so you can just say what you want. (14)

We’re all in the same situation. I feel it doesn’t really matter. [...] It was not a problem to sit and talk. (7)

One of the participants contrasted her intuitive sense of having common ground with other pregnant women with her home situation, as her male partner had different expectations and could not relate to her perspectives on pregnancy and birth, hence the perceived value of being with other pregnant women, which she described as “relaxing”:

It is very nice being with others who are just as preoccupied about the birth. [...] It is very relaxing being with them. And it probably has to do with the fact that when you are at home with your boyfriend who thinks it [the pregnancy] is really exciting and wants to talk about it, it is hard sometimes, because you are in two different places. I can feel it [the pregnancy] on my body and I don’t always think it’s fun, and I am a little afraid of the forthcoming birth and maybe have more worries than he has about that. He is just really looking forward. (14)

This reflects the phenomenological perspective that as the body changes, so too does one’s sense of self (Brannigan, 2001). As such, it seems that the women’s pregnant bodies help to impart a similar sense of self across the group.

### *Identifying with other pregnant women because of physical similarities*

Encountering other pregnant women in AGCs involved women observing physical similarities between their bodies and those of others; one woman described identifying particularly with those in the group who appeared to be at a similar stage in their pregnancy as her:

It [being pregnant] can look very different from woman to woman. Still, there were a couple of them that had the same kind of belly as me. That was actually very nice. The fact that you can identify with each other because you're just as "far gone", that is very nice. (15)

Visual similarities thus helped to engender a sense of shared experience, reminiscent of van Manen's (2017) perspective on eye contact as meeting.

### *A pleasant, cordial atmosphere*

Nine of the women, unprompted, described the social setting of AGCs as cosy, intimate, convivial – "*hyggeligt*" in Danish:

And then there was the atmosphere. It was actually really relaxed and cosy, or what you might call it. Very peaceful and calm. (8)

The *hygge* – a "Danish quality of 'coziness and comfortable conviviality'" (Altman, 2016) – generated in the social setting of AGCs promoted a sense of togetherness and relaxation among the participants.

### *A respectful space*

Because of a sense of commonality due to the women's shared stage in their lives and their experiences of pregnancy, the women experienced AGCs as a safe space for the exchange of narratives and concerns that they felt they could not share elsewhere:

Just a bit of space to say things that not many others would want to hear about. (3)

It seems that the AGC setting facilitated empathy, reflecting Carel's (2016) characterisation of empathy as being linked to embodiment.

Summing up, the social setting of AGCs provided the basis for open exchanges. The fact that the women could see that they were at roughly the same stage in their pregnancies helped them to think that they may have been through similar experiences and that their narratives might be of interest to others in the group. The metaphor of being in the same boat, travelling towards the same endpoint (birth and motherhood) was important in the pregnant women's characterisation of their experiences of AGCs. The social aspect of AGCs was described by many of the women as *hyggeligt* – it was a positive, social and cosy experience, and was valuable as their partners did not understand how it felt to be pregnant. The women described feeling that they had little to "lose" in encountering other participants in AGCs, as they did not know each other beforehand which also helped them to engage openly with each other.

## **Benefits and drawbacks associated with the experience of the interpersonal encounter**

In order to understand how wellbeing might be generated, we also explored women's judgements on the AGCs they had experienced. Seven themes relating to the women's

characterisations of what they had gained (or not) from encountering each other were identified in the interview data.

### *Solidarity*

Encountering other pregnant women in AGCs engendered feelings of solidarity, a sense of “all for one and one for all” (Laitinen & Pessi, 2015, p. 1) and an orientation towards “we-thinking” (Laitinen & Pessi, 2015, p. 2). This led to an ability to trust one another, even though they did not know each other very well:

It’s funny, being together for such a short time and yet sharing things with each other. That’s what we said about solidarity: it creates a bond. (14)

### *Mutual interest*

Being together with other pregnant women in AGCs created mutual interest and curiosity. This led to the desire to engage with other pregnant women and share deliberations and preoccupations:

But because it [pregnancy] takes up so much head space, because it is so new and so big, I think it’s good to meet others and it can be – it is very hard to put words on it, but one has this desire to share; that’s how I feel: “How are you?”, and “How far are you?”, and “Is it a boy or a girl?” It fills up your world, but maybe not your friend’s, if she isn’t pregnant. So, in that sense, coming into a forum where... – yeah, it’s very hard to say, but I, in any case, want to talk about it a lot. (16)

The AGC forum, in other words, helped to create a space where people were interested in each other and felt responsibility towards the “Other” (Levinas, 2006).

### *Comfort*

The women found it comforting speaking to others whom they felt might understand what they were going through. Speaking with other pregnant women helped them feel less overwhelmed by aspects of their pregnancy and less isolated with their own thoughts:

It is, of course, always nice, when one is pregnant for the first time in such a completely new world, just to talk to others who are going through the same thing. (2)

You can focus on talking a bit about how they are doing. I think it is really nice because you have so much in your head, but you can’t... it isn’t everyone that understands how you feel. (4)

You don’t feel so alone. You have others who are at the same stage and all that. (7)

This reflects the phenomenological perspective that co-presence, including sharing perspectives and listening to others, has healing potential (Brannigan, 2012), and can support wellbeing.

### *Emotional relief and support*

The women found it reassuring to hear from others in the group about positive birth experiences, as these narratives helped to address their concerns about the forthcoming birth. It was also nice having a forum where they could openly share their complaints about the effects of pregnancy on their bodies:

Also, when she said, “you’ll be just fine and it was a good experience”, although she was taken to the emergency ward and all that. I think that made me more relaxed about it. Also, when they say: “I remember, I felt like that too.” It is always nice knowing that one isn’t alone with those feelings. (4)

Sometimes it’s just really nice to hear how others feel and realise that one maybe feels the same in relation to “Oh, it’s really annoying being pregnant!” and (laughing) “All those bothers you can have.” (3)

Being with other pregnant women at a similar point in their pregnancies allowed them to vent some of their frustrations with their pregnancies, and to feel safe in doing so.

### *Emotional encounters could also be negative*

Women attending AGCs could also be negatively affected by the anxiety of other AGC participants, however, as negative emotions could spread to other group members:

But I could feel that she got more and more anxious, and that was a bit contagious. (11)

This reflects an aspect of embodied empathy (Carel, 2016); here, participants found themselves experiencing similar negative feelings to others who were nervous or concerned.

### *Normalisation*

Overall, sharing experiences in AGCs had a powerful normalising effect on pregnancy-related concerns and empowered the participants:

I think when you hear there are others who have also had those thoughts, or find out that it is normal to be worried about it, you can more easily handle it, because, okay, it’s not just me that feels like this, it’s also very common that... there are many who feel like that. (5)

This finding, also identified in previous research (McDonald et al., 2014; Novick et al., 2011; Teate et al., 2011), is an important aspect of the emotional benefits of AGCs. AGCs provided the women with a forum that helped them feel that they were not the only ones who felt that way, and that their feelings were legitimate in relation to their situation, as others who were pregnant felt similarly.

### *Learning*

Encountering others also meant learning from their experiences, which created a sense of greater agency and empowerment:

The fact that you are sitting there with others in the same situation as yourself [...]. And you can also discuss things and take from their experiences. (4)

Learning in AGCs could take place horizontally between the pregnant women who shared experiences, feelings, and practical tips on pregnancy and birth (Nisbeth Jensen & Fage-Butler, 2016).

Summarising the above, the social setting of AGCs provided pregnant women with many mainly positive experiences. Concerns were assuaged, the pregnant women felt less isolated, there was a greater sense of empowerment as they learned from each other, and experiences of pregnancy were normalised. Even the negative effect of finding another's anxiety to be contagious indicates the power of the social setting in engendering empathic and solidaric responses. The findings on normalising effects of being with fellow pregnant women resonated with previous empirical findings (Andersson et al., 2012; Novick et al., 2011).

Comparing these findings to McNaught's (2011) framework of wellbeing, it seems that being together and interacting with other pregnant women in AGCs can enhance AGC participants' positive sense of "how their lives are going" (p. 11), which suggests AGCs' potential to improve pregnant women's sense of wellbeing at a time when they may be feeling vulnerable.

## Discussion

In this article, our aim was to shed light on *attributes of the interpersonal and social setting of AGCs* that may promote women's wellbeing, given existing gaps in the literature. Exploring 16 interviews undertaken in Denmark, we found that pregnant women readily identified with other pregnant women in AGCs, which facilitated the sharing of stories and feelings. Worries were assuaged in the mainly positive, social atmosphere of AGCs, the experience of pregnancy was normalised, and there were moments of learning and empowerment in the *ad hoc* social networks that AGCs facilitated.

This article did not aim to conclude on whether or to what extent wellbeing was generated in the AGCs included in this study. Instead, it focused on what interpersonal and social aspects of the AGC setting may support wellbeing and explored how wellbeing may be generated in the AGC setting by considering the women's statements in relation to sensitising theories. In its orientation to setting, the empirical contribution is quite practical, though the usual caveats apply about the impossibility of generalising from a set of 16 interviews undertaken in a Danish setting. However, follow-up studies could certainly build on the present one, for example, with respect to forming hypotheses or suppositions about wellbeing generation that could be investigated in other healthcare settings where patients attend in groups. Given the shortfall in understanding how wellbeing may be generated in healthcare settings, much more research is needed in this area.

We believe this article offers a valuable methodological contribution to the investigation of wellbeing. Post-intentional phenomenology (PIP) (Vagle, 2018) underpinned the methodological framework; it offered the advantage of supporting an inductive approach that typifies phenomenological research (Reiners, 2012), while acknowledging the role of theory and the impact of culture on wellbeing (Lomas, 2019). PIP works well with interview data that provide a window on personal experiences of wellbeing (e.g. Jongbloed & Andres, 2015). PIP's assumption that experiences are mediated through cultural frames helped us to pick out the

sociocultural aspects of *hygge* and lived aspects of gender (with respect to partners' expectations) in the interview data. Another major source of insight were phenomenological theories that relate to presence and encountering others. These were applied in the analysis, highlighting tacit aspects of meeting and encountering that would otherwise have been hard to spot. We believe that PIP, extended by relevant theories and cultural concepts, could very valuably support other empirical investigations of wellbeing.

Although Rising et al. (2004) have described alternatives to the clinical dyad such as AGCs as reflecting a potential "paradigm shift" in antenatal care (p. 402), the reality is that AGCs and group consultations more generally are still relatively unusual, and the dyadic encounter remains the usual form of medical encounter. However, as wellbeing is contingent on many external factors, Knight and McNaught (2011) have concluded that service providers and policymakers need to take responsibility for "creating the circumstances that affect our wellbeing" (p. 255). In the healthcare setting, this would, among other things, mean reviewing the primacy of the dyad in healthcare encounters and considering the viability of alternative social settings. With growing awareness that wellbeing promotion is poorly served by atomistic conceptualisations of the individual (Taylor, 1992), it is likely that more attention will be paid to identifying the interpersonal and social circumstances that promote wellbeing in healthcare encounters.

Overall, the participants were very positive about AGCs, which raises questions about potential positive skewing. A number of potential limitations can be discussed in that regard. First, a potential source of positive bias is the so-called "halo effect" (Nisbett & Wilson, 1977, p. 250), noted in healthcare situations where patients participating in studies of satisfaction are likely to be positive about their experiences due to gratitude to healthcare professionals. A second aspect is "interviewer effects" (Daymon & Holloway, 2011, p. 20), where interviewees may, for example, wish to please interviewers in their responses. To help counteract these effects, participants were promised anonymity and encouraged to speak freely, and the independence of the study from the team of midwives was emphasised (Nisbeth Jensen & Fage-Butler, 2016). Another potential source of positive bias may be that the women self-selected to participate in the interviews. This means that participants' accounts of meeting others in AGCs and the values they attached to those encounters may reflect positive self-selection bias (Robinson, 2014). However, since the aim of this article is to increase current understandings of AGCs as potential sites of wellbeing generation rather than establish to what extent AGCs led to wellbeing, omission of less positive perspectives does not undermine the validity of our findings, though it may mean that negative points relating to potential 'illbeing' effects were missed.

## Conclusions

This article investigated, from the perspective of pregnant women, how AGCs may further a sense of wellbeing. A post-intentional phenomenological framework supported our exploration of accounts of experiences that accommodated cultural elements, and facilitated the integration of philosophical theories relating to presence and encountering others that brought tacit aspects of wellbeing to the fore.

The article shows the importance of corporeality and co-presence for fostering mutual recognition and interest, providing comfort, allaying fears, making individuals feel less alone, and normalising the experience of pregnancy. The interviewees' positive accounts underlined the importance of identifying attributes of alternative institutional healthcare settings such as AGCs that may enhance the wellbeing of other potentially vulnerable patient groups. In considering how the AGC model could be extended to support the wellbeing of patients with other conditions, it is, of course, important to bear in mind that pregnant women constitute a particular type of "patient". Pregnancy is not an illness. In AGCs, pregnant women can be said to receive 'biopsychosocial' (Engel, 1977, p. 132) care in a group setting, and are monitored for any health issues that maybe impacting themselves or their pregnancies; their situations, needs and experiences can be expected to differ appreciably from patients who have chronic or terminal illnesses. Further research that sensitively explores the needs of other patient groups and how their wellbeing may best be supported via a group setting is needed.

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