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Polish Baby Boom in United Kingdom – Emotional Determinants of Medical Care Perception by Pregnant Poles in UK

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Abstract

In the year of 2004 United Kingdom experienced the wave of immigration from Poland which was recently admitted to the European Union. In 2010 Poland was one of three countries of origin of non-UK born mothers, and the increase in birth rates among Poles in United Kingdom has started in 2005 (Office for National Statistics, 2010; Hayes *et al.*, 2011). The aim of this paper is to examine the perception of various components of medical care received during the course of pregnancy by Polish women residing in the United Kingdom (N = 106). We took under consideration two aspects of female emotional and cognitive functioning: inclination to depression, and empathy. Depression was measured by the Edinburgh Depression Scale (Cox *et al.*, 1987), and empathy was measured by the Empathic Sensitivity Questionnaire (ESQ) (Kazmierczak *et al.*, 2007). As hypothesized pregnant women who scored higher in depression and emotional contagion were also less satisfied with the information they received from the medical staff. Personal distress was the sole empathic dimension, which was associated with dissatisfaction with: a general gynecological care during pregnancy, emotional support from a gynecologist / a midwife, and the quality of medical care provided by a gynecologist / a midwife. Other-oriented empathic tendencies (empathic concern and perspective taking) facilitated cultural adaptation in our sample in respect of dealing with foreign health system in a highly vulnerable time of pregnancy.

Introduction

In the year of 2004 United Kingdom experienced the wave of immigration from Poland which was recently admitted to the European Union. In consequence, Polish migrants have become involved in the British National Health Service which resulted in the increase of new and complex health interactions (Goodwin, Polek, & Goodwin, 2013). As the Equality and Human Rights Commission (2010) estimates between May 2004 and September 2009 a 1.6 million workers from the EU came to the United Kingdom, and approximately two thirds were from Poland. Recent statistics show that now

there is around 138 490 Polish children in the UK¹. In 2010 Poland was one of three countries of origin (aside to Pakistan and India), of non-UK born mothers, and the increase in birth rates among Poles in UK has started in 2005 (Office for National Statistics, 2010; Hayes, Enohumah, & McCaul, 2011). This implies that there is a significant amount of Polish women involved in British healthcare during pregnancy, which also refers to a recent trend of a systematic increase in use of obstetric British services by women from A8 countries (Bray, Gorman, Dundas, & Sim, 2010).

Such a high immigration rate among Poles implies serious impact on individual experiences and health, especially during such a vulnerable period like pregnancy (Gorman, *et al.*, 2010). As the Polish migration wave to UK is a relatively new phenomenon, there is a lack of research exploring the way Polish pregnant women perceive the British Health Services. Scant studies indicate that Polish women expect a more paternalized, obstetric care (similar to the one in Poland), which is managed by an obstetrician, and often travel back to Poland for additional examinations throughout the course of pregnancy (Gorman, *et al.*, 2010).

Immigration, and emotional and social functioning during pregnancy

Immigration is often described as a critical life event and a time of a serious psychological challenge (Kirkcaldy, Furnham, & Siefen, 2009; Weishaar, 2008, Goodwin, Polek, Goodwin, 2012). It is important to remember that not only cultural but also personal characteristics may seriously influence the way people perceive the medical care and it's quality. Economic conditions, housing conditions, changing work patterns as well as lower level of social support and loosening of the family relationships and friendships make lives more difficult (Kirkcaldy *et al.*, 2009). One of the essential factors of the quality of migrants' functioning is the higher risk of mental problems (Gorman, *et al.*, 2010). Pregnancy is a time, when changes in social roles and in self-definition are especially rapid and meaningful. In connection with other risk factors, like not sufficient social support, more stressful life events, and lower marital satisfaction this could lead to higher vulnerability, and to mental health problems, with special emphasis on depression and anxiety (O'Hara, 1995; Zelkowitz *et al.*, 2004).

Immigrant women are at higher risk of depression in general (Franks & Faux, 1990) and pregnancy increases that risk significantly. It is especially important in time of pregnancy and childbearing as studies show that recent immigrants are at higher risk of antenatal and postnatal depression (Marcelo *et al.* 2012; Teixeira *et al.*, 2009; Zelkowitz *et al.* 2004).

Due to stresses connected with immigration, including social isolation from fami-

¹Source: ONS Annual Population Household Survey January to December 2011, from: <http://www.ons.gov.uk/ons/about-ons/what-we-do/FOI/foi-requests/population/data-on-poleis-people-living-in-the-uk/index.html> [accessed 30.07.2013]

ly and friends, financial worries, unfamiliarity with medical procedures and practices, and language difficulties, physical and emotional wellbeing is being affected (Hyman & Dussault, 1991). The risk of depressive disorder in pregnancy may be related to personal disruption associated with immigrant status (Rogler, 1994). According to this theory migration involves three major transitions: the shift from one cultural system to a new one, followed by the move from one socio-economic system to another resulting in changes in personal ties and reconstruction of social networks. Depression symptoms tend to decrease throughout pregnancy, while anxiety symptoms follow a U pattern (Teixeira *et al.* 2009). Depression symptoms are particularly high during the 1st trimester. Higher anxiety and depression symptoms in 1st trimester may be connected with novelty of the situation and lack of information about possible next steps (*ibidem*).

European comparisons show that Poles generally report lower levels of psychological wellbeing (Kirkcaldy *et al.* 2005) which may negatively affect their predisposition for sociocultural adaptation and psychological health, especially during pregnancy. Abovementioned factors suggest that Polish immigrant women may constitute a high-risk group for anxiety and depressive disorders during pregnancy. In studies conducted in Canada, immigrant women (incl. Poles) displayed higher risk of postpartum depression, which was partly attributed to the absence of female adult relatives, and therefore the feeling of social isolation (Ganann, Sword, Black, & Carpio, 2012; Sword, Watt, & Krueger, 2006). In consequence, those women perceived the Canadian health system less favourably.

Empathy as a factor facilitating cross – cultural interactions

In this paper we are also interested in empathy as an individual difference, because it is associated with a higher quality of interpersonal relationships, also in respect of cross – cultural adaptation. Additionally, empathy is linked to emotional regulation (essential, as we mentioned, in course of pregnancy), and is regarded as a factor required in relations between medical staff and patients (therefore, also pregnant women).

Empathy has been defined as a multidimensional, emotional-cognitive construct (Batson, 2009; Hoffman, 2003). Davis (1980, 1983, 1994) concludes that there are three facets of empathy, which can be observed between people: empathic concern (EC) – ‘other-oriented’ emotional empathy, being interested in others’ emotions and caring for others; personal distress (PD) – ‘self-oriented’ emotional empathy, others’ feelings are experienced as one’s own; and perspective taking (PT) – cognitive empathy, taking others’ point of view in various, social situations. Other-focused, empathic individuals display high abilities of emotional regulation while dealing with stressful situations, and therefore empathy facilitates the adaptation to various life transitions (*e.g.* Malin, Reilly, Quinn, & Moran, 2013), including transition to parenthood (*e.g.* Belsky, 1984; Brandon, *et al.*, 2012). The tendency to analyze others’ emotions, taking the perspective of others to understand their experiences (close by definition to EC and PT), have been also linked to emotional, or more generally, social intelligence (Salovey &

Mayer, 1990), as well as cultural intelligence (Earley, 2002; Earley, & ANG, 2003). Those empathic components are regarded as facilitating social functioning, also in respect of cross-cultural adaptation (lower cultural distance - Suanet, Fons, & van de Vijver, 2009), or even multilingualism (Dewaele, & Stavans, 2012). In contrary, personal distress (emotional contagion) is self-focused (Eisenber & Eggum, 2009), and has been linked to emotional and behavioral disturbances, as aggression (Davis, 1994), depression (Lee, 2009), or personality disorders (Kazmierczak, Pastwa-Wojciechowska, & Blazek, 2013). PD has been also associated with postpartum depression among expectant parents (Kazmierczak, in print), or Couvade Syndrome in expectant fathers (Kazmierczak, Kiełbratowska, Pastwa-Wojciechowska, & Preis, 2013).

Empathy is also a trait that is required from medical staff in their work with patients as it enables to understand better patients' needs and feelings (Ancel, 2006; Pedersen, 2010; Stepien, & Baernstein, 2006), and in consequence promotes awareness of patients' situation and reduce hostile or stereotypic reactions (Bhopal, 2012). The National Health System in UK is viewed as sensitive to cultural differences, where empathy between care providers and care receivers is developed (Cattacin, & Chimienti, 2007). Therefore, taking into consideration abovementioned problems in caring for migrants, it is understandable that empathy is viewed as a key factor in communication between medical staff and pregnant, migrant women (Barragan, Ormond, Strecker, & Weil, 2011). However, there is a lack of research exploring the role of migrant empathy, including pregnant women, in dealing with medical care providers.

Research aim

The perception of British medical care by Polish pregnant immigrant in UK has yet to be analyzed, especially in respect of their psychological functioning. We were interested in perception of various components of medical care received during the course of pregnancy by that specific group of women. Two aspects of female emotional and cognitive functioning were considered: inclination to depression, and empathy. Depression has been identified as a factor negatively associated with adaptation to pregnancy and motherhood, whereas empathy influences the ability to deal with various relational situations, also in respect of parenthood. We focused on emotional and cognitive dimensions of empathy due to their different impact on individual functioning. Empathy is a factor facilitating relations between medical staff and patients. However, patients' empathy, also those experiencing normative life changes as pregnancy, has not been addressed. In this article we define 'adaptation in pregnancy' as positive perception of various components of British medical care received during the course of pregnancy by Polish, immigrant women. We hypothesized that depression and empathic personal distress will be risk factors of lower adaptation of immigrant pregnant women. Empathic concern and perspective taking should be positively associated with adaptation during pregnancy. Empathy should impact to the greatest extent the perception of interpersonal relations

with medical staff, with midwives and gynecologists.

Method

Measures, Participants, and Procedure

A questionnaire has been administered to Polish pregnant women living in the United Kingdom. Data were collected from 159 respondents. However, to make our sample more homogenous, additional inclusion criteria were implemented: 1) residing in UK from the beginning of pregnancy, and 2) being under the medical care in the UK. The final sample consisted of 106 women. All respondents were pregnant at the time of the study and all of them were living in the UK. Data were collected through internet sampling using websites and internet forums for pregnant women. Participants were between 6 and 40 weeks of pregnancy. Based on the data obtained we can state that 60% of respondents were between 22 and 30 years of age, and 36.5% of respondents were between 31 and 40 years of age (35.8% and 21.7% in a whole sample). 61.9% (36.8% in a whole sample) of respondents had a degree of higher education. 52.4% of women were married at the time of the study (31.1% in a whole sample). 36.5% of respondents were unemployed at the time of the study (21.7% in a whole sample), and 50.8% were employed (full time and part time; 20.2% in a whole sample).

To assess depression symptoms the Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden, & Sagovsky, 1987) was used. The EPDS has been used in transcultural research on depression in childbearing women, making it suitable for research with immigrant populations (Cox & Holden, 1994). EPDS was also validated to use in samples of non-postnatal women (Cox, Chapman, Murray, & Jones, 1996), and during pregnancy (Murray & Cox, 1990).

The Empathic Sensitivity Questionnaire (ESQ; Kazmierczak, Plopa, & Retowski, 2007) was used to measure empathy. ESQ measures empathy in three dimensions: cognitive empathy, described as taking someone else's perspective in everyday social situations; and emotional empathy which is distinguished into two elements: emphatic concern (sharing others' feelings, compassion for them) and personal distress (the tendency to take on other people's negative emotions when they experience psychological discomfort). Scale is based on the Interpersonal Reactivity Index (IRI: Davis, 1980; 1983) and consists of 28-items. Respondents marked their answers on a 5-point Likert scale ranging from 1 = *doesn't describe me* to 5 = *definitely describes me*.

Additionally a series of questions evaluating medical care in the United Kingdom and Poland has been administered. Women were asked about their opinion on receiving information and support, medication, availability of prescriptions, and numbers and quality of the appointments with the midwife and GP. To measure the quality of social support we asked participants to assess the level of satisfaction from their romantic relationships.

Results

We conducted statistical analyses with the use of IBM SPSS Statistics 21.0. At the first step of the analyses inter-correlations of the psychological characteristics of participants have been conducted. Rho Spearman correlations indicated that experiencing of the symptoms of depression during pregnancy has been positively associated with empathic personal distress ($r_s = .410, p < .001$), and negatively with the tendency to take the perspective of others ($r_s = -.258, p < .05$). Additionally, women who obtained lower depression and personal distress scores and were more inclined to take the perspective of others, viewed their romantic relationships as more satisfactory (for depression - $r_s = -.278, p < .05$; for personal distress - $r_s = -.350, p < .01$; for perspective taking - $r_s = .245, p < .05$).

Empathy and depressive symptoms, and the perceived quality of medical care during pregnancy

The role of empathy and inclination to depression for the assessment of individual well-being and medical care during pregnancy were assessed. Rho Spearman correlations and U Mann-Whitney's tests were conducted. More depressive participants assessed their general emotional well-being as poorer during the course of pregnancy ($r_s = .218, p < .05$). They also reported more health problems experienced during pregnancy ($z = -3.014, p < .01$). Pregnant women who scored higher in depression and personal distress scales were also less satisfied with the information they received from the medical staff (midwives or gynecologists) (for depression - $z = -2.395, p < .05$; for personal distress - $z = -3.111, p < .01$). Additionally, personal distress was the sole empathic dimension associated with dissatisfaction with: a general gynecological care during pregnancy ($r_s = .256, p < .05$), emotional support from a gynecologist / a midwife ($r_s = .348, p < .01$), and the quality of medical care provided by a gynecologist / a midwife ($r_s = .341, p < .01$).

Comparisons of medical care in Poland and United Kingdom - the role of empathy and depressive symptoms

Participants indicated in which country - Poland or the UK - the particular components of medical care in pregnancy function better according to their knowledge and/or experience. We might conclude that the British medical care is perceived as better (as compared to Polish medical care) in eight out of thirteen assessed components: frequency of visits to a midwife (64.3% of the group; 9.5% indicated Poland; $X^2(1) = 34.129, p < .001$), labor planning with a gynecologist (49.4% of the group; 6% indicated Poland; $X^2(1) = 28.174, p < .001$), cost of prescribed medications (80.7% of the group; 2.4% indicated Poland; $X^2(1) = 61.232, p < .001$), prescription of medications (44.6% of the group; 15.7% indicated Poland; $X^2(1) = 11.520, p < .01$), prenatal classes (27.4% of the group; 9.5% indicated Poland; $X^2(1) = 7.258, p < .01$), breastfeeding classes (39%

of the group; 4.9% indicated Poland; $X^2(1) = 21.778, p < .001$), information about pregnancy and labor (38.6% of the group; 19.3% indicated Poland; $X^2(1) = 5.333, p < .05$), support and information on healthy diet during pregnancy (42% of the group; 6.2% indicated Poland; $X^2(1) = 21.564, p < .001$). Polish medical care was assessed as better only in respect of frequency of visits to a gynecologist (58.3% of the group; 9.5% indicated UK; $X^2(1) = 29.491, p < .001$).

In the last step of the analyses, we examined the role of empathy and depressive symptoms for the perception of Polish and British medical care. U Mann-Whitney's tests were conducted. Polish women who differed in empathy, perceived Polish and British medical care differently in respect of relations with midwives and gynecologists. Females with higher PT as compared to those with lower PT perceived the British medical care as definitely better in respect of frequency of visits to a midwife ($z = -2.088, p < .05$), and breastfeeding classes ($z = -2.067, p < .05$). Emotional empathy (higher EC and lower PD) was associated with a positive perception of labor planning with a gynecologist in UK (EC: $z = -2.069, p < .05$; PD: $z = -2.333, p < .05$), and courses about lactation (higher EC; $z = -2.007, p < .05$).

Discussion

Polish women in general place higher value on specific medical care and examinations received from gynecologist in Poland, whereas informational aspect of medical care, like breastfeeding courses and labor planning is perceived to be better in the UK, what is similar to results obtained by Goodwin *et al* (2012). Although, according to numerous research Polish medical system is in collapse (Goodwin *et al.* 2012; Reibling, 2010), it is valued higher in terms of professionalism and quality of medical procedures. However, when discussed the informational level of medical treatment and the availability of breastfeeding classes, labor planning and contacts with a midwife respondents admit that the British medical system is better.

Our results confirm that individual differences should be taken into account when analyzing the adaptation to such a critical life moment as giving birth. As predicted depression was positively associated with personal distress (and negatively, with perspective taking), and depression and personal distress were correlated with the lower satisfaction from medical care and health information obtained during pregnancy. More depressive women were focused on the negative aspects of their functioning, perceiving their health or intimate relationship as not satisfactory. Additionally, more depressive women reported more health problems during the course of pregnancy.

It might be concluded that disturbances in emotional regulation, especially those associated with interpersonal relations, are risks factors of poorer perception of NHS by Polish pregnant migrants. Both factors, depression and PD, are also linked to lower cognitive abilities of dealing with difficult, stressful situations. Women scoring higher in depression and PD might experience greater isolation as they are focused on their negative

emotions (cf. Cox *et al.*, 1987, 1996; Eisenberg, & Eggum, 2009). They are emotionally sensitive, prone to emotional contagion, not eager to take the perspective of others, and in consequence they might not be satisfied with the care they obtain, also in respect of emotional support from medical staff. In contrary, empathic concern and perspective taking (viewed as components of emotional intelligence) facilitated the interactions with medical staff (labor planning, breastfeeding classes). PT was also positively associated with romantic satisfaction. Other-oriented empathic tendencies might have facilitated cultural adaptation in our sample in respect of dealing with foreign health system in a highly vulnerable time of pregnancy.

Our results emphasize the importance of early detection of depressive symptoms among pregnant immigrants as their might have larger problems with dealing with NHS due to their negative emotional and cognitive bias in perception of themselves and others. Additionally, cognitive empathy and empathic concern might be stimulated during antenatal classes, especially in pairs (Matthey, Kavanagh, Howie, Barnett, & Charles, 2004), in order to facilitate the adaptation to motherhood (*e.g.* developing more supportive attitudes in pairs) and prevent depression, also in respect with cultural factors influencing obstetric care received during pregnancy.

The limitation of the study is that respondents were recruited mostly through internet forums for pregnant women, where participants can share their fears, worries and advices. It might have happened that pregnant Polish women who do not need advice and are not depressed or scared do not look for help in this kind of media, therefore they were not included in the study. It might be also hypothesized that pregnant women who were fully satisfied with the British medical system did not look for help and assistance from their Polish contemporaries on the internet. Additionally, demographic characteristics of the sample was diversified (like the course of pregnancy), which might have influenced the results. However, since the research on Polish pregnant migrants are scarce, and their contacts with British NHS is currently the point of the national debate in UK, we believe that the obtained results shed some light on this problem.

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