Assessing the knowledge of perinatal mental illness among student Midwives

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Introduction

Experiences of emotional distress are common during pregnancy and following childbirth, and there is much reference to the 'baby blues' that occur normally in the few days following birth (Spinelli and Endicott 2003; Evans et al, 2001). Having a child is a major adjustment for a woman that involves major changes in her sense of self, her roles, and relationships with others (McCourt 2006). Many women feel overwhelmed about becoming mothers and express these in a range of ways, such as feeling loss, sadness and ambivalence.

There is strong research evidence that women are at greatest risk of developing a mental illness during the process of having a baby than at any other time in their lives (Dearman et al, 2007). Women are twenty times more likely to be admitted to a psychiatric hospital in the two weeks after childbirth than at any time in the two years before or after (NICE 2007). During pregnancy and up to one year following childbirth, perinatal mental illness (mental illness occurring around the time of pregnancy and birth) is a leading cause of maternal death (Confidential Enquiries into Maternal Deaths 2004; Lewis 2007). The impact of perinatal mental illness on family members has been researched widely (Murray et al, 1996; Poobalan et al, 2007). Research evidence also suggests that perinatal mental illness in the mother has an impact upon the child's emotional, cognitive and physical development (Dearman et al, 2007).

There are very few research studies that focus upon the knowledge of student midwives of perinatal mental illness. In relation to this, it is vital to consider the ways in which midwives are trained, and the attention given to perinatal mental illness in the midwifery curriculum and in placement experiences. This research aims to systematically assess student midwives knowledge of perinatal mental illness and to subsequently inform curriculum development for midwifery students at both undergraduate and postgraduate levels. This study also aims to contribute towards improving the care and support women with perinatal mental illness receive from antenatal services. Consequently, the findings from this study will also be used for the development of an educational web-based resource for student and qualified midwives.

Background/ Literature

The role of the Midwife

The NICE guidelines (2007) 'Antenatal and postnatal mental health: clinical management and service guidance' recommend that all pregnant women need to be screened for mental illness at first contact with a healthcare professional. This first booking appointment is where pregnant women are directly asked by a midwife if they are experiencing symptoms of mental illness, or have a previous or current diagnosis of mental illness (Whooley et al, 1997). Following disclosure of mental illness, an appropriate and relevant plan of care should be devised involving the woman that outlines her treatment and care. Midwives are therefore in a unique and privileged position to assess a woman's well-being and to offer appropriate

support. Therefore, it is vital that midwives are equipped with the necessary skills to ask appropriate questions with regard to the experience of mental illness in order to make an assessment, and to then refer the woman to relevant services, and to work collaboratively with other health professionals.

Midwifery training

To investigate studies that have explored student midwives knowledge of perinatal mental illness, the health literature considered in this literature review was accessed using the Cumulative Index of Nursing and Allied Health Literature (CINAHL) 1990-2012. Keywords 'student midwives'; 'mental health'; 'perinatal'; 'knowledge' and 'training' were used. It was found that previous research has highlighted that qualified midwives often have poor understanding and knowledge of perinatal mental health and require improved training (Ross-Davie et al, 1999). An Australian research study found that student midwives have a limited understanding, or a 'lay-persons' view of perinatal mental illness (McCann and Clark 2010). In addition, research has found that midwives frequently feel unconfident in their role in appropriately assessing and referring women who experience perinatal mental illness to relevant specialist services (Stewart and Henshaw 2002; McCauley et al, 2011). Other research has recommended the need for midwives to receive formal training on post-natal depression as many symptoms overlap with those experienced in pregnancy and following birth (Jomeen et al, 2009). Therefore, a small number of research studies were found relating to midwives awareness and knowledge of perinatal mental illness, but there were none on the knowledge of student midwives specifically.

The Study

Aims

This research aims to systematically assess student midwives knowledge of perinatal mental illness and to subsequently inform curriculum development for midwifery students at both undergraduate and postgraduate levels. This study also aims to contribute towards improving the care and support women with perinatal mental illness receive from antenatal services. Consequently, the findings from this study will also be used for the development of an educational web-based resource for student and qualified midwives.

Design

The researchers decided to use the qualitative method of focus groups to assess student midwives knowledge of perinatal mental illness. The researchers valued the collective nature of the focus group method, and did not wish to reach a consensus but to encourage a range of responses from the group. This method enabled the researchers to enter the world of student midwife group and their experiences which were, as Kitzinger states about the value of focus groups, "articulated through social interaction". The researchers were also able to observe how the group interactions related to peer communication and group norms (Kitzinger 2005: 58.

Setting

The focus groups were conducted at a time when the students were attending their placements. The focus groups took place in an education centre a short walk away

from the students' placement areas. The room had been booked prior to the focus groups and were free of any interruptions and disturbances. The rooms booked allowed adequate time for the focus groups and for any de-briefing needed following the group.

Participants

A purposive sample of nine student midwives was recruited to the study. Those student midwives who were near completion (within six months) of a BSc honours degree in Midwifery (3 year and 78 week cohorts) were asked to participate in the research study consisting of two focus groups. The focus groups lasted for 1 hour, and were not taken out, and did not interfere with, teaching and learning time. To encourage the participation in the research study and to ensure minimal inconvenience to student midwives, the focus groups were conducted at a time when the students were attending their placements. It was made clear that the focus groups were not an exam or a test. Taking part in the study was completely voluntary. The researchers made it clear that if students decided that they did not want to take part in the research study, they did not have to give a reason and there would be no adverse effects on the student or the continuation of their midwifery training course. If after signing the consent form, the students wanted to withdraw some of comments or statements they had made in the focus groups, they were free to do so. The small group discussions were moderated by two researchers.

Due to the potentially sensitive subject of the research topic, students showing any signs of distress during or after the focus groups were to be given additional time to

debrief. If necessary, referral to university based occupational health or counselling services was to be offered. Students could also seek support from their personal tutor. The researchers' contact details were provided on the participant information sheets and students were reminded that they could contact the researchers' if they wished following the focus groups.

The administrator for the 3 year and 78 week cohorts was requested to distribute information about the project to every student midwife who was within six months completion of their degree. Student midwives were given a period of two weeks to consider their participation in the study and were asked to indicate via email to the researchers their intention to participate.

Methods

At the start of the focus groups, ground rules were decided and participants were reminded about support available to them following the focus groups. The students were informed that one researcher would be taking field notes. The researchers reminded the students of the aims of the study. They explained that following introductions, the students would be asked to describe any experiences they had working with women experiencing mental illness, and then the discussion would be directed to a focus upon their knowledge of perinatal mental illness. The researchers found that the discussion flowed easily. They encouraged the participants to speak about their knowledge of perinatal mental illness followed by a discussion of their direct experiences. At times, some quieter members of the group were encouraged to participate.

At the beginning of the focus groups the researchers asked the students to introduce themselves and give details of their training in counselling and psychology or their experience of caring for clients with mental illness. Two of the students in one of the focus groups had either previous training in counselling skills or had cared for patients with mental illness. The student participants were asked to anonymise any patients they were discussing. With the participant's consent, the focus groups were digitally recorded, and the data collected from the focus groups were subsequently transcribed. Time was taken during this process to ensure the views and reflections of respondents were recorded accurately.

Ethical considerations

The researchers followed ethical procedures and all data collected during the process of the research study was handled in confidence. Student's names and any identifying information were not contained in any data collected. The students were informed that the study findings would be written up for a peer reviewed publication and reported at relevant conferences. The data will be stored in anonymised form for 10 years, and no research publication will identify students. Approval to conduct the project was sought from the relevant Research Ethics Committee.

Reflexivity

Prior to conducting the focus groups, the researchers discussed their expectations and assumptions about the research topic, which is referred to as reflexivity (Dowling 2006). As stated in the discussion section, both researchers did not expect

to find the wide knowledge of perinatal mental illness and sensitivity about cultural factors among the student midwives who demonstrated a determination not to repeat some of the less than ideal practices they had observed. The researchers did discuss the impossibility of remaining 'outside' the subject matter being explored. Within the focus groups the students were encouraged to speak freely about their experiences and views of perinatal mental illness, without being influenced with the expectations and assumptions of the researchers.

Data Analysis

Thematic analysis has been described as an accessible method for identifying, analysing and reporting patterns or themes within data. It is considered flexible in terms of its potential to be used within differing theoretical frameworks (Braun and Clarke 2006). It is also used to interpret various aspects of the research topic itself (Boyatzis 1998).

The transcripts consisting of data from the focus groups were read thoroughly by the lead researcher for meaning and sense. Using the method of thematic analysis, the researcher firstly identified and noted relevant issues in the data relating to the participants' awareness of perinatal mental illness. The data was then manually coded. The researcher was then able to identify repeated patterns which were then categorised into specific themes. Key themes and issues which arose from the focus groups will now be discussed one-by-one.

Findings

The themes identified were:

Sensitivity to women experiencing mental health problems	- Knowledge of different forms of mental illness - Knowledge of perinatal mental illness - Awareness of stigma that mother with mental illness face - Observation of practice and the lives of women
Cultural awareness	- Awareness of cultural and ethnicity issues - Understanding that some women do not disclose mental illness because of cultural and family pressures
Perceptions of mothers with mental illness	- Honest discussions about mental illness and difficult responses - Observed that women with mental illness are not always referred appropriately to specialist services
Observations about qualified midwives	- Expressed that qualified midwives who take time to assess a women is perceived as 'slow' by their peers - Midwives do not have time to build a rapport with women in their care
Views on student midwife training	- Very little attention given to mental illness within the midwifery curriculum - Expressed the need for more training on communication skills and referral

The coding system R= respondent will be used within the themes presented.

Sensitivity to women experiencing mental health problems

Overall, there was a great deal of sensitivity towards women with mental illness demonstrated by all the student midwives. Several of the participants spoke of their knowledge about the different categories of mental illness including bi-polar disorder, depression, and schizophrenia. The participants also demonstrated awareness of mental illness at the time of pregnancy:

> "We know that if women have a history of mental illness, they can get worse in pregnancy" (R3).

Many of the participants were aware of the stigma women with mental illness experience, particularly as mothers. The overwhelming view in the focus groups was that midwives do not have adequate time to assess a woman for mental illness, and furthermore as one of the participants stated:

> "Midwives need time to properly assess and build a rapport with a woman" (R1)

Another participant stated:

> "Midwives need more time to look beyond a woman's presentation" (R2).

Many of the participants offered sensitive examples of women they thought could be experiencing mental illness at the time of pregnancy but were never followed up by qualified midwives. One participant, for example, described a woman who was very unkempt and living in a messy environment with a newborn baby. The new mother appeared to be functioning well and caring for her baby, but the flat was very cold:

"The midwife says 'how are you feeling emotionally?' and the woman says yes, but the environment says otherwise".

This participant also stated:

"I was very, very concerned" (R2).

This student raised this issue with her mentor who didn't appear concerned. Another example was a description of a woman who:

"…wore the same pyjamas sitting with a blank face with a baby in her arm".

This participant expressed the need to know more about the mothers:

"Many midwives record in notes that the emotional state is 'good' but what does this mean? - midwives are doing something they are not qualified to do" (R4).

Cultural awareness

Many of the participants in the focus groups demonstrated awareness of ethnicity issues and the cultural pressure on women to be perfect mothers. One stated, for example:

"Women are seen to have a choice, they do not really the minute they are diagnosed…what about consent, they are forced to have medication" (R2).

Another participant (R3) stated that women are "taken over" by mental illness. Several of the participants spoke of cultural pressures on women to be perfect mothers. One participant, for example, spoke about the pressure on women:

"They are expected to be pleased about motherhood. These are women that go home and have post-natal depression" (R6).

Within the focus groups, many participants discussed their perceptions of ethnicity issues and pregnancy, particularly in relation to the disclosure of mental illness. Some participants perceived that there is reluctance in some cultural groups to disclose mental illness. Jewish women, for example, according to one participant:

"…won't tell us about depression - there are pressures on them" (R8).

Another participant spoke about their perception of Caribbean women:

"These women do not talk about or acknowledge depression" (R2).

Several of the participants referred to immigrant and refugee women, and women from low socioeconomic groups being particularly prone to mental illness. Another participant spoke of a woman who was told she could not have any more babies, but experienced pressures from her family to have several children (R2).

Perceptions of mothers with mental illness

Although many of the student participants were sensitive about women with mental illness, some expressed fear and confusion:

"Mental health is very challenging; we are not trained to give mental health care" (R6).

There was a description by a participant of a woman receiving IVF who had an established mental illness and was giving birth to twins conceived through IVF. The participant described how the woman, who had a diagnosis of post-natal depression, anxiety and other issues:

You name it, she had it all. She was very aggressive, smashing things up and assaulting staff - it was like she was doing it for attention".

This participant said she felt sad for the babies:

> "What if she has a breakdown and hurts the twins?"

The participant went on to state the large amount of women desperate to have a baby and where IVF fails. Referring to the woman given IVF who was mentally ill, the participant stated:

> "Why was this woman given IVF…she was given the opportunity and look at how she's carrying on" (R4).

Several of the participants stated that the process of appropriate referral is often unknown and difficult for the midwife and the woman experiencing mental illness:

> "A patient with panic attacks is advised to phone the GP – it's a very long process" (R5).

The participants stated that there are guidelines within antenatal clinics to refer women to Perinatal Mental Health Teams. However, as one participant put it:

> "Some women do not want a referral to a PNMHT" (R6).

The referral process was considered within the focus groups to be the responsibility of the midwife. However, as one participant stated about midwives:

> "We run out of time, we could build a rapport with the woman to persuade her to refer" (R7).

The issue of time was reflected by another participant who stated that for the midwife:

> "Information and knowledge can be there, but there is no time" (R5).

The researchers asked the participants in the focus groups if they were aware of the Woolley questions used in the detection of mental illness in the first antenatal booking appointments. Only one student was aware of these.

Observations about qualified midwives

Several of the participants expressed concern about qualifying as a Midwife and having enough quality time for women. Qualified midwives who take time during their appointments with women are:

"…criticised as slow" (R2).

This view seemed to be familiar to all of the participants. One participant stated:

"Some midwives don't even take off their coats" (R2).

Several participants spoke of the pressure on qualified midwives:

"Women are shared out, there are not enough midwives" (R5).

There was a view expressed by several of the participants that:

"Midwives tend to medicalise women's bodies" (R7).

There was a perception that there is a fear within midwifery practice of going beyond a medical view of pregnancy and labour. Due to limited time that midwives spend with pregnant women in their care, they:

"…cannot open a bag of worms" (R8)

Subsequently, midwives will avoid asking psychological questions. Another participant stated:

"Midwives feel bad if a woman discloses as it takes time and you have to say you will refer her" (R8).

The participants stated that there seemed to be awareness in practice about what should be done with regard to referring women who experience mental illness to specialist services, but this often didn't happen:

"We need to work as a team…key people should be there in the notes". (R2).

This participant described a situation where a qualified midwife did not know a particular woman had a Social Worker, which was a vital piece of information for her care and well-being. With regard to awareness about referrals, one participant stated:

"When we are qualified, we still will not know" (R3).

There was a view expressed that midwives need to be more sensitive: "midwives do ask about mental illness but not always in a sensitive way" (R8). Another participant stated that midwifery is:

"…very psychological, but midwives build up defences and see women in medical ways – they do not go further or deeper"(R9).

Another participant described a visit with a qualified midwife to a woman's home where a woman had pressure on her from her family, but didn't want to have a baby. In this participants' view:

"Midwives just deal with the behaviour. Midwives don't explore further – what is beyond. Sometimes tears do not match up to what a woman wants" (R2).

Several participants stated that both student and qualified midwives need to talk and reflect more, and expressed they enjoyed participating in the focus groups which gave them an opportunity to do this.

Views on student midwife training

All participants stated there was limited mental health teaching within the curriculum:

"There was only one lecture on mental health, no formal training" (R6).

Several participants expressed the importance of covering mental health issues within the training:

"…mental health should be mandatory for all students. Everyone needs knowledge and training; you need that to make a referral" (R3).

It seemed that a majority of the student participants had awareness and knowledge about the different types of mental illness, and as the focus group findings reveal, demonstrated a great deal of sensitivity towards women experiencing mental illness. Several participants expressed that they wanted more in their midwifery training on communication:

"Midwives need to keep assessing women and build a rapport" (R5).

They recognised that they have a "duty of care" towards caring for women with mental illness and referring them to appropriate services:

"We try to assess the women. This is where we pick up issues of women with mental illness" (R6).

Other participants stated they wanted more on referral in their training:

We need a more practical emphasis on how to refer women".

The participants expressed that this is important for their futures as qualified midwives, but at present as one participant stated,

"Midwives are not prepared for women with mental illness" (R4).

Discussion

This small study has achieved its aim to explore student midwives knowledge of perinatal mental illness. The findings from this study revealed the views of dedicated students, who expressed knowledge of perinatal mental illness and the importance of the midwife's role in assessing and referring women appropriately to specialist services. This was a surprise to the researchers conducting the study, who did not expect to find this level of knowledge. The students clearly wished to make a difference to midwifery practice, which is of great benefit to patient care.

The students spoke of the medical model as domineering within midwifery practice. However, a valuable, unexpected and refreshing finding of this research project is that the participants did not adhere fully to a purely medical view of childbirth and women's bodies. They gave many examples of cultural factors that make it difficult for some women to disclose mental illness, and families placing pressure on women to have large amounts of children. The participants in this study stressed the importance of understanding cultural perceptions of motherhood and ethnicity, as well as looking at the ways in which social factors impact upon individuals and increase their susceptibility to mental illness. All the participants expressed the importance of communication and the potential of the unique relationship between the midwife and woman.

The overall finding of this study centres on the lack of time midwives have to think about and act upon the important observations they make in practice. There is no time for qualified midwives to adequately assess mental illness and make timely

referrals. Midwives do not have the time to build the necessary rapport with women. If they do, it is risky and would potentially 'open a can of worms'. Furthermore, all student participants demonstrated both verbally and non-verbally, that the midwives that do take their time with women are perceived as slow and are therefore criticised by their peers. Limited time to care for patients effectively is a recurring issue within health care. There are consistent references in the press about cuts in maternity services. In a recent report, 67% of maternity services in the UK stated that there is not enough staff to run their services effectively. This is particularly difficult as there has been a 19% increase of births that are increasingly complex due to perceived factors such as maternal obesity and age (Royal College of Midwives concern over midwifery cuts, February 2011, The Press Association).

As suggested by several of the participants, the teaching of student midwives in practice is particularly important. The involvement of students in the assessment of perinatal mental illness would provide them with clear examples of communication skills and issues of referral. Students could be encouraged to work within specialist teams. As well as keeping up to date with research developments that inform practice, the student midwife can have rich experiences of work with women with a variety of needs including dual diagnosis (mental health and drug/alcohol misuse), and mental health. The students would also gain valuable experiences of communicating with women from varying ethnic backgrounds who often find challenges in relating their feelings and emotions to midwives and primary care practitioners (Sleath et al, 2005). The introduction of the role of specialist mental health midwife has provided the essential link between antenatal services and

specialist mental health services. Spending time within practice with these specialist practitioners would be particularly beneficial for student midwives. The combination of these experiences would equip students with both communication and referral skills.

As several of the participants stated during the focus groups, mental illness is disturbing and challenging and the fear of 'getting it wrong' must be very acute for midwives. It is understandable that they do not want to risk addressing psychological issues too much. Although it is vital that emphasis is placed upon the therapeutic relationship with women, midwives are faced with decisions about women's safety on a daily basis. Help with making such decisions can be aided by creating a working culture within which midwives are encouraged to think and discuss individual women in a supportive and creative way. This can consist of frequent and supportive supervision to enable midwives to safely articulate their often troubling responses to caring for women. When good therapeutic boundaries are established with patients, staff are less likely to feel overwhelmed and 'burnt out', and plans for the effective care of patients become clearer (Mitchell and Cormack 1998). Time limitations are a major factor preventing midwives from receiving such support. However, as one participant stated, perhaps there is time, it just the way the time is used. Student midwives clearly value their learning experiences on their allocated placement areas. If permanent staff are better supported in their roles, they may be more able to think about and support their allocated students, thus creating a informed and supportive environment for all staff.

This study was conducted with a small number of student midwives in one University. Therefore, there is a danger of making generalisations in relation to data from a small sample. A larger study may be more informative and could adopt a comparative approach between several universities.

Conclusions

Women with a mental health diagnosis require the effective management of their mental illness during pregnancy, alongside obstetric treatment, particularly in relation to medication (Howard et al, 2003; Jablensky et al, 2005). Many women may stop taking their psychiatric medications in pregnancy because they are concerned about the effects psychiatric medication may have on the developing foetus ~~a~~nd may subsequently relapse. Research evidence suggests that the provision of frequent and consistent professional support can be helpful to women who are experiencing perinatal mental illness (Confidential Enquiries into Maternal Deaths 2004).

If a mother experiencing perinatal mental illness is not given appropriate and sensitive support, this may have problematic consequences on her well-being and on the mental health of her developing child (Massie and Szajnberg 2002; O'Connor et al, 2002). Early interventions for perinatal mental illness are therefore essential to reduce risks to the mother and her baby. This research project will contribute towards reducing the likelihood of risks. Although conducted within one university, it has established that there is much sensitivity towards, and awareness of, perinatal mental illness among student midwives who are close to qualification. The participants in this study wished to make a difference to patient care and did not

want to repeat upon qualification some of the less than ideal practice they had observed. Several of the participants had the courage to speak about their uneasy feelings and fear about mental illness, and many demonstrated much knowledge and confidence in their roles as student midwives.

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