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AUSTRALIAN MIDWIVES' ATTITUDES TOWARDS CARE FOR WOMEN WITH EMOTIONAL DISTRESS

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Abstract

Objective - To assess Australian midwives' attitudes towards caring for women with emotional distress and their perceptions of the extent to which workplace policies and processes hindered such care.

Design - A postal survey.

Setting - Members of the Australian College of Midwives.

Participants - 815 Australian midwives completed the survey.

Measurements - A modified version of the 17-item REASON questionnaire (McCall et al., 2002) that was originally developed for used by General Practitioners to measure their attitudes towards their role in the management of patients with mental health disorders.

Findings - An exploratory factor analysis with Varimax rotation identified 4 factors that reflected midwives' (1) perceptions of systemic problems that hindered emotional care; (2) attitudes towards working with women experiencing emotional health problems; (3) perceived competence in using treatment techniques; and (4) attitudes and perceived competence towards the referral of women with depression and anxiety to other health professionals.

Key conclusions and implications for practice - Participating midwives indicated their willingness to offer assistance and acknowledged the importance of providing emotional care to women. In practice, emotional care by midwives is impeded by perceived lack of competency rather than a lack of interest. Midwives' competency in the assessment and care of women with conditions such as depression and anxiety may be enhanced through continuing professional education.

Keywords: M*idwives' attitudes; Emotional care; Emotional Distress; Depression; Anxiety*

Introduction

Emotional disorders during pregnancy and the postpartum contribute to negative outcomes for childbearing women, their families and children (Perinatal Mental Health Consortium, 2008). Immediate and long-term consequences of maternal depression include poor mother-infant relationships (Priest and Barnett, 2008); attachment insecurity (Hammen and Brennan, 2003); and increased risk of affective disorders (Halligan et al., 2007), cognitive delays (Grace et al., 2003; Milgrom et al., 2004) and social-behavioural problems (Talge et al., 2007) in young children. Despite these adverse consequences, many women with depression during pregnancy and postpartum remain undetected and under-treated (Gaynes et al., 2005; Buist et al., 2007; Priest and Barnett, 2008).

In response to this need, the Australian Government established the National Perinatal Depression Initiative 2008-09 to 2012-13 as part of maternity services reform (Australian Health Ministers' Advisory Council, 2010). The five-year framework for the National Perinatal Depression Initiative focuses on preventing and improving the early detection of perinatal depression as well as enhancing the provision of care, support and treatment for expectant and new mothers susceptible to or diagnosed with antenatal and/or postnatal depression. Concurrently, the National Health and Medical Research Council in Australia is supporting the development of the Clinical Practice Guidelines for Depression and Related Disorders in the Perinatal Period (*beyondblue*, 2010). These guidelines (expected to be finalised and released in 2011) will identify best practice in the detection, treatment and management of affective and mental disorders (e.g. depression, anxiety disorders, bipolar disorder and postpartum psychosis) experienced by expectant and new mothers. It will also inform the development of national screening guidelines for perinatal depression and provide advice specific to marginalised groups such as the culturally and linguistically diverse communities and Aboriginal and Torres Strait Islander communities.

As indicated in Australia's National Perinatal Depression Initiative, midwives are expected to assume greater responsibility in providing routine screening, treatment, management and follow-up care for perinatal women (i.e. once during pregnancy and repeated between four to six weeks postpartum). Midwives are well placed to conduct timely and appropriate mental health assessment; provide health information and psychosocial support (Gamble et al., 2005); and assist women to make informed choices

about treatment, resources and options (Schneider, 2002). Such care requires excellent communication skills, sound knowledge of midwifery, and the ability to be receptive to feedback from women and acknowledge their concerns (Homer et al., 2009). In particular, midwives need to provide opportunities for women to discuss their childbirth-related experiences and feelings (Cooke and Stacey, 2003; Gamble et al., 2005).

Although women have indicated general satisfaction with antenatal care provided by midwives (Hildingsson and Radestad, 2005; Janssen and Wiegers, 2006), dissatisfaction with the provision of emotional care during labour and the postpartum for women in fragmented models of care has been reported (Gamble et al., 2004a; Brown et al., 2005; Rudman et al., 2007a, 2007b). The perceived lack of emotional care may be associated with negative attitudes by midwives towards the provision of emotional care to distressed women (Gamble and Creedy, 2009). While midwives are aware that providing emotional support is important for women's psychological adjustment to motherhood, they may be concerned about possibly aggravating women's distress (Hammett, 1997). This hesitancy to assist may be a reflection of midwives' anxiety and uncertainty about their ability to provide emotional support (Gamble et al., 2004b).

The concept of self-efficacy is an individual's belief that he/she is capable of performing in a certain manner to attain certain goals (Ormrod, 2006). It is plausible that midwives with high self-efficacy are likely to perceive themselves as possessing the required skills to impact positively on the emotional well-being of childbearing women and therefore, may be more motivated and inclined to engage in emotional care. These midwives may also perceive emotional care as a challenging yet fulfilling and empowering role of midwifery practice.

Midwives' attitudes in relation to their perceived competence and self-efficacy of emotional care and support may affect their recognition, assessment and management of depressive symptoms and other psychosocial problems for childbearing women. A search of the published literature did not reveal any research papers that specifically examined the attitudes of midwives towards the provision of emotional care. Therefore, this study aimed to investigate midwives' (1) attitudes towards their role in caring for women with emotional distress; and (2) perceptions of the extent to which workplace policies and processes hinder their care for women with emotional distress.

Methods

Sample

Current practising midwives, who are members of the Australian College of Midwives, were invited to participate in the study. The Australian College of Midwives aims to achieve professional excellence in midwifery by striving to "maximize the quality of midwifery and maternity care for Australian women and their families" (Australian College of Midwives, 2008). The Australian College of Midwives has experienced strong membership growth over recent years. During the period of data collection (late 2006) there were 3000 members and an estimated one-third were current practising midwives. The remaining members comprise of (a) student midwives; (b) people who support the objectives of the College; (c) midwives who are working in non-clinical capacities such as academics; and (d) midwives who are neither working nor currently in the paid workforce (e.g. retired, on maternity leave, undertaking post-registration studies). Therefore, the target group for this survey was approximately 1000 midwives.

Data collection – survey

Demographic information relating to respondents' age, gender, average weekly work hours, nature of midwifery practice and place of work was collected. Respondents' attitudes towards caring for women with symptoms of emotional distress, and perceptions of the extent to which workplace policies and processes hindered such care were examined using a standardised measure (refer to Table 1).

The 17-item scale was based on a modified version of the original REASON questionnaire designed to assess General Practitioners' (McCall et al., 2002) attitudes towards their role in the management of patients with mental health disorders. It should be noted that the name of the questionnaire is not an acronym. Instead, it reflects the assessment of the reasons provided by General Practitioners or midwives, in our case, for the way they purported to feel and behave. Respondents' confidence to assess and manage emotional distress was assessed using the 12-item "Professional Comfort and Competence" subscale of REASON (Cronbach's alpha of 0.82). Wording on this subscale was modified for midwifery practice and the maternity context. For example, "I feel I cannot make a difference to patients with mental disorders" became "I feel I cannot make a difference to women with emotional problems". Respondents' perceptions of the workplace and their care of women with emotional distress were assessed using the 5-item "Perception of Systemic Problems" subscale of REASON (Cronbach's alpha of 0.73). This subscale was also

adapted for midwifery and the maternity context. For example, "I find emotional problems are too time-consuming to deal with in general practice" became "I find women's emotional problems too time consuming to deal with". All items were measured on a seven-point Likert scale (i.e. 1 = strongly disagree to 7 = strongly agree). Following an expert review by two maternity researchers, pilot testing of the scale was conducted with a group of Master of Midwifery students (*n* = 13) where initial reliability and face validity of the modified scale were established.

INSERT TABLE 1

Procedure

All members of the Australian College of Midwives were sent the survey and a reply-paid envelope through the College's quarterly newsletter (i.e. the Spring (September) 2006 issue of the Australian Midwifery News). A reminder notice was placed in the following issue and completed surveys received prior to June 2007 were included for data analysis. Informed consent was implied by their return of the completed survey. Ethical approval was obtained from the Griffith University Human Research Ethics Committee.

Data Analysis

The Statistical Package for Social Science Version 13.0 program was used to analyse the survey data. Data were checked for completeness and consistency, and a 10% random comparison between the computerised data and the original data was undertaken to ensure the accuracy of data coding and entry. Each variable was reviewed for skewed and kurtotic distributions. An exploratory factor analysis (i.e. principal components extraction with varimax rotation) was conducted to reduce items in the scale to a few small meaningful factors for interpretation. An inter-item correlation matrix, which demonstrates the associations between items, was also computed to determine the appropriateness of the factor analytic model. Items with factor loadings (i.e. the correlation co-efficient between individual items and the factor) of ±0.3 and above were considered to be adequate for identifying the item with the factor. The higher the factor loading, the stronger the relationship between the item and the factor. The internal consistency of the each factor and the overall scale were measured using Cronbach's alpha coefficient. Finally, respondents' attitudes towards their role in the provision of emotional care for childbearing women were examined using basic descriptive statistics.

Findings

A total of 815 completed postal surveys (804 females and 11 males) were received from members of the Australian College of Midwives. This achieved a response rate of 74.3% (i.e. based on 743 of the surveyed respondents engaging in direct client care and the Australian College of Midwives' estimated membership figure of 1000 in 2006/2007 meeting the inclusion criteria). Table 2 presents comparisons between characteristics of respondents and available national midwifery workforce data in Australia (Australian Health Workforce Advisory Committee, 2002). It should be noted that, in the national data, a midwife is defined as a registered nurse clinician with midwifery qualifications who has indicated midwifery as his/her principal area of activity. It is acknowledged that the national data may not be fully reflective of the midwifery workforce in Australia as it did not take into account registered midwives who are neither a registered nurse nor practising midwifery as their principal area of activity. Nevertheless, this is presently the only available national data of the Australian midwifery workforce. Respondents' age, gender, average weekly work hours and extent of direct client care, as well as the type of workplace setting (either the private or public sector) were comparable to the national data. The percentage of respondents working in hospitals was 14.7 percent lower than the national average.

INSERT TABLE 2

Factor Analysis of the 17-Item Revised REASON Scale

Examination of the exploratory factor analysis outlined four factors, each with an eigenvalue greater than 1.00, which accounted for 58.1% of the total variance. Bartlett's test of sphericity was significant ($\chi^2 = 4443.81$, $p < .0001$) and the Kasier-Meyer-Olkin measure of sampling adequacy was equal to 0.88, suggesting viability of the four-factor model. Table 3 reflects the analogous eigenvalues for these four factors, percentage of variance explained, and cumulative percentage of variance explained by the four factors.

INSERT TABLE 3

A relatively straightforward definition was obtained for each of these four emergent factors due to the prominent themes among items with similar factor loadings. All 17 items entered as variables in the factor analysis had a factor loading of 0.50 and above for at least one factor except item C16 which had a factor loading of -0.36 (refer to Table 4). Additionally, using 0.50 as a lower limit, item C4 loaded on more than two factors.

INSERT TABLE 4

Factor 1 (5 items) accounted for 31% of common variance and reflected perceptions of systemic problems hindering emotional care of women. High internal reliability of this sub-scale was indicated by the coefficient alpha (*r* = .85). Items that loaded highly on this factor (>.5) included: "My workload prevents me from addressing women's problems with depression and/or anxiety" (I1); and "I am too pressed for time to routinely assess women's emotional health" (I3). Around 42% of respondents reported that their workload prevented them from addressing women's problems with depression and/or anxiety. Less than half of respondents found that the organisation of maternity services hindered their ability to get to know women well enough to give adequate emotional care (42.6%) and that current organisational priorities encourage them to focus only on problems presented by women rather than exploring underlying issues (42.5%). Respondents reported having time to routinely assess women's emotional health (55.9%) and did not find emotional problems too time consuming (75.2%).

Factor 2 (6 items) accounted for an additional 12.8% of the common variance and examined respondents' attitudes towards working with women experiencing emotional health problems. There was satisfactory internal reliability for this sub-scale (*r* = .61). Items that loaded on this factor (>.3) included: "I feel I cannot make a difference to women with emotional problems" (I5); and "Women find it intrusive for midwives to routinely / regularly inquire about their emotional health" (I6). Over half the respondents reported that midwives should have a primary role in the treatment of women with anxiety disorders (56.4%). The majority perceived that midwives can make a difference to women with emotional problems (84.1%). Around half the respondents did not feel frustrated in counselling women with emotional disorders (56.9%) and were comfortable treating physical and emotional problems (45.8%). Most importantly, respondents felt comfortable in questioning women about emotional disorders (72.4%) and did not think that women found it intrusive for midwives to routinely/regularly inquire about their emotional health (82.1%).

Factor 3 (4 items) accounted for a further 7.4% of common variance and reflected respondents' perceived competence in the use of treatment techniques" (i.e. counselling and relaxation) with women. The coefficient alpha of the current sample (*r* = .79) revealed good internal reliability for this sub-scale. Items that loaded highly on this factor (>.5) included: "I feel competent in the use of counselling techniques" (I10); and "I feel

competent in teaching relaxation techniques" (I12). Around a third of respondents perceived themselves to be competent in counselling women with anxiety (35.8%) or depression (27.3%). Furthermore, only 33.5% of respondents reported feeling competent in the use of counselling techniques and teaching relaxation techniques (39.8%).

Factor 4 (2 items) accounted for an additional 7.0% of common variance and reflected respondents' attitudes and perceived competence towards the referral of women with depression and anxiety to other health professionals. There was low internal reliability for this sub-scale (r = .36). Items that loaded on this factor (>.5) included: "Women with anxiety disorders should be referred to a counsellor, psychiatrist or psychologist" (I11); and "I feel competent in knowing which women need to be referred to another health professional" (I13). The majority of respondents believed that women with anxiety disorders should be referred to a counsellor, psychiatrist or psychologist (83.7%) and felt competent in the identification of women who need to be referred to another health professional (81.5%).

Although the ideal internal consistency (i.e. Cronbach's coefficient alpha) of a scale is generally 0.7 or greater, a minimum alpha of 0.6 has also been considered to be acceptable for new or modified scales (Nunnally, 1978; Robinson et al., 1991; Jones et al., 1999). Hence, no item was dropped from the original set of 17 variables where adequate internal consistency was found (r = .60).

Discussion

Prior to the establishment of the National Perinatal Depression Initiative in Australia and the development of the Clinical Practice Guidelines for Depression and Related Disorders in the Perinatal Period by *beyondblue*, the Australian College of Midwives in 2004 published the National Midwifery Guidelines for Consultation and Referral which highlighted the need to address the emotional aspects for women as part of best practice standards in maternity care. Consequently, this study attempted to discern the attitudes of practising midwives towards the care of women with emotional distress as well as workplace factors affecting this care. A revised 17-item scale, which consisted of two subscales (i.e. the 12-item "Professional Comfort and Competence, and 5-item "Perception of Systemic Problems), originally developed for use with General Practitioners were administered.

Limitations of the study are associated with sampling, congruency between attitudes and actual behaviour as well as validity of the revised tool. It is plausible that midwives who completed the survey had a particular interest in the emotional aspects of care, perceived themselves to be competent in the provision of such care or possessed positive attitudes towards women experiencing emotional distress. Moreover, the authenticity of attitudes by means of a self-reported survey as a reflection of actual behaviour is difficult to establish. As such, the potential sampling bias and lack of congruency between attitudes and actual behaviour may limit the generalisability of conclusions from this study. However, this is offset by the recruitment of a relatively large representative sample and comparisons of findings with reported attitudes of other health professional groups (i.e. General Practitioners). As noted by McCall et al. (2002), General Practitioners' attitudes were influenced by their perceived comfort and competency with the care of patients with mental health problems. General Practitioners also noted systemic problems in practice and likewise, midwives in this study were concerned about systemic problems in practice. However, besides being influenced by their perceived comfort in working with women suffering emotional health problems; midwives' attitudes also appeared to be subjected to their perceived competence in the use of treatment techniques such as counselling; and competence in the referral of women with depression and anxiety to other health professionals. Although the revised REASON scale has not been used previously with midwives, outcomes seem promising. The identification of two additional factors was not anticipated, but the four constructs have clinical validity (i.e. items within each construct have moderate to strong factor loadings ranging from 0.4 to 0.85 (Garson, 2007)) and a satisfactory Cronbach's alpha with the exception of Factor Four which was low. Taking into consideration that Factor Four had an eigenvalue of well over 1 and explained a further 7% of variance in midwives' responses, the significance of this factor cannot be ignored. The low alpha may be due to only having two items in the factor (Peterson, 1994; Streiner and Norman, 2003). The identification of four factors can be viewed as an indication that midwives' attitudes towards their role in emotional care are more complex than originally conceived.

Participating midwives' acknowledged the importance of perinatal mental healthcare and this may reflect a positive change in attitudes of midwives. However, their willingness to offer assistance and provide emotional care to women in practice was

compromised by their perceived lack of competence. Midwives' perceived inability to offer care and support may have an adverse influence on their motivation, and likelihood of engaging in emotional care in practice (Ormrod, 2006). Midwives may find emotional care overwhelming and as such be less motivated to care and support emotionally distressed women. This may explain why midwives have continued to be criticised for their provision of poor intrapartum and postpartum emotional care to childbearing women reported (Gamble et al., 2004a; Brown et al., 2005; Rudman et al., 2007a, 2007b). Even though providing midwives with the necessary knowledge and skills is important in enhancing their abilities to engage in perinatal mental healthcare, midwives' self-efficacy or confidence to provide such care should also be addressed. Ways to enhance midwives' self-efficacy could include the use of role models as well as encouraging and acknowledging the importance of emotional care in workplaces. Moreover, midwives may need to be reassured of the positive impact of emotional care to address their fear of exacerbating women's distress.

Although there is a wide variety of emotional care and support strategies that can be offered, common psychological interventions such as basic counselling, interpersonal psychotherapy treatment and cognitive behavioural therapy (Bledsoe and Grote, 2006; Dennis and Hodnett, 2007; Cuijpers et al., 2008; Rahman et al., 2008) could be offered by midwives. While the majority of midwives are not trained specifically in the application of interpersonal psychotherapy treatment and cognitive behavioural therapy, it is nevertheless still appropriate for midwives to consider offering women opportunities to discuss their childbearing-related experience (Rowan et al., 2007). Recent mental health service developments in the UK routinely offer CBT training to all health professionals (especially nurses) to enhance service provision (Williams and Martinez, 2008). Skills in basic counselling also need to be developed and assessed during continuing professional training sessions and observed in practice.

It is encouraging that more than half of the participating midwives did not perceive systemic problems such as workload, organisational priorities, and time factors as hindering their care for women with emotional distress. Nevertheless, there are still a considerable number of midwives who indicated otherwise. Midwives' concerns about the systemic problems in health care services accounted for over 30% of variance in their attitudes and perceptions of emotional care highlighting the need to address models of service delivery. The potential of midwives to identify, care and assist childbearing women suffering from

emotional disorders is underutilised (Ross-Davie et al., 2006; Elliott et al., 2007) as they often have limited contact during pregnancy and are unable to maintain continuity of care during labour and postpartum. In order for midwives to be effective and supportive of the delivery of emotional care to childbearing women, contemporary, evidence based models of service delivery such as caseload practice, need to be expanded to ensure midwives have the necessary time, resources and continuity of relationship with women to provide such care.

Conclusions & Implications

Women are vulnerable to emotional distress during the perinatal period. Research regarding adverse effects of untreated perinatal emotional disorders highlights the importance of preventing, detecting and treating emotional distress in childbearing women (Perinatal Mental Health Consortium, 2008). Furthermore, evidence indicates that continuity of care provided by midwives not only enhance maternity care satisfaction, but also improve childbearing women's emotional health and well-being (Homer, Brodie & Leap, 2008). In Australia, midwives are well positioned to provide holistic maternity care including the identification, management and support of childbearing women who are experiencing perinatal emotional distress. However, several studies have reported a general neglect of emotional aspects of care by midwives and other health professionals (Gamble et al., 2005; Gamble and Creedy, 2009). Limited attention has been given to understanding midwives' attitudes to the provision of care and support to women suffering from emotional disorders during pregnancy and the postpartum (Buist, 2006).

This study found that although many current practicing midwives report positive attitudes towards working with women with emotional problems and believe they could make a difference, they do not feel competent in the provision of emotional care and support. This is further affected by the presence of systemic problems in health care services. Continuing professional education, directed at increasing midwives' competency in the assessment and care of women with conditions such as depression and anxiety, should be introduced and models of service delivery reoriented to provide women with improved access to continuity of midwifery care.

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Tables

Table 1. 17-Items Revised REASON scale for measuring midwives' attitudes towards care for women with depression and anxiety.

Item (I)	Descriptions
1	My workload prevents me from addressing women's problems with depression and/or anxiety.
2	Where I work the organisation of maternity services hinders midwives ability to get to know women well enough to give adequate emotional care.
3	I am too pressed for time to routinely assess women's emotional health.
4	I find emotional problems too time consuming to deal with.
5	I feel I cannot make a difference to women with emotional problems.
6	Women find it intrusive for midwives to routinely / regularly inquire about their emotional health.
7	I feel competent in counselling patients with anxiety.
8	Current organisational priorities encourage me to focus only on problems presented by the woman rather than exploring underlying issues.
9	I am more comfortable treating physical problems than emotional problems.
10	I feel competent in the use of counselling techniques.
11	Women with anxiety disorders should be referred to a counsellor, psychiatrist or psychologist.
12	I feel competent in teaching relaxation techniques.
13	I feel competent in knowing which women need to be referred to another health professional.
14	I feel frustrated counselling women with emotional disorders.
15	I feel uncomfortable questioning women about emotional disorders.
16	Midwives should have a primary role in the treatment of women with anxiety disorders.
17	I feel competent in counselling women with depression.

Table 2. Demographic Characteristics of Respondents (N = 815)

Demographic characteristics	**Study Values***	**AHWAC Values†**
Age, y mean (SD)	44.38 (8.82)	40.7
Gender		
Female	804 (98.6)	99.0
Male	11 (1.4)	1.0
Work hours, per wk average (SD)	30.42 (11.98)	27.0
Nature of midwifery practice areas:		
Direct Client Care	743 (91.2)	92.0
Non-Direct Client Care (i.e. not in clinical practice but working primarily as a/an educator, research or manager)	72 (8.8)	8.0
Working in the:		
Public sector	618 (75.8)	75.3
Private sector	197 (24.2)	24.7
Hospitals	684 (83.9)	97.2

** Data are reported as n(%) unless otherwise noted.*

† *Data are reported as % and obtained from Australian Health Workforce Advisory Committee (2002).*

Note: Respondents in the study include current practising registered midwives in Australia while the Australian Health Workforce Advisory Committee's (2002) national midwifery workforce data include registered nurse clinicians with midwifery qualifications who indicated midwifery as his/her principal area of activity. This difference in the definition of a midwife needs to be taken into consideration when comparing and interpreting data.

Table 3. *Eigenvalues, percentage of variance explained and cumulative percentage of variance explained by Factors 1, 2, 3 & 4 of the REASON scale*

Factor variance	Eigenvalues*	Variance (%)	Cumulative (%)
1	5.27	31.0	31.0
2	2.17	12.8	43.7
3	1.26	7.4	51.1
4	1.19	7.0	58.1

**Eigenvalue reflects the amount of variance accounted by the factor. In principal components analysis, each item has a standardised variance of 1.00 which corresponds to an eigenvalue of 1.00. Therefore, the total eigenvalues for the revised REASON scale is equal to the total numbers of items which is 17.00.*

Table 4. *Factor loadings for REASON scale items on Factor 1, 2, 3 & 4*

Items	Factor 1[a]	Factor 2[b]	Factor 3[c]	Factor 4[d]
I3	.85			
I2	.82			
I1	.82			
I8	.74			
I4	.56	.51		
I15		.69		
I14		.69		
I9		.67		
I6		.64		
I5	.37	.56		
I16		-.36		
I10			.79	
I7			.76	
I17			.74	
I12			.70	
I11				.85
I13			.37	.60

[a] *Perceptions of systemic problems that hindered emotional care*

[b] *Attitudes towards working with women experiencing emotional health problems*

[c] *Perceived competence in using treatment techniques*

[d] *Attitudes and perceived competence towards the referral of women with depression and anxiety to other health professionals.*