Attitudes of student midwives caring for women with perinatal mental health problems

Abstract

Aims: This study aimed to explore the attitudes of student midwives near completion of their midwifery training, in the care of women with mental health problems in the East end of London.

Method: In this exploratory study using qualitative methods, seven student midwives who were near completion of a BSc in midwifery were interviewed in small groups. The data were analysed using thematic analysis.

Results: Four themes were identified from the interviews: identification and assessment of women, asking women questions about perinatal health, using stereotypes in the care of women, caring for and responding to women with perinatal mental health problems.

Conclusion: These findings are helpful in informing more conclusive research on midwives’ training and practice in the care of women with perinatal mental health problems.

Keywords: Perinatal mental health, Maternal mental health, Student midwives, East London, Qualitative research, Interviews, Stereotypes

Psychiatric illness is one of the leading indirect causes of maternal mortality and maternal morbidity in the UK. A confidential report on the causes of maternal death in the UK suggested a significant number of deaths of women during pregnancy, childbirth and early motherhood, are due to suicide (Centre for Maternal and Child Enquiries (CMACE), 2011).

Despite the number of women who suffer as a result of maternal psychiatric illness, deficiencies in the care that women receive, in particular from midwives, have been widely reported (McCauley et al, 2011; Jones et al, 2012). There is a suggestion that the training and education midwives receive does not adequately prepare them for caring for women with mental health problems (Ross-Davie, 2006; Jones et al, 2012). Jones et al (2012) found that although midwives were comfortable in questioning women about emotional problems, they were not comfortable, nor did they feel competent in offering women simple techniques to alleviate anxiety and depression. Furthermore, midwives’ perceived lack of competence in their ability to care for women often affected their confidence, which in turn influenced motivation and willingness to provide care to women with mental health problems (Jones et al, 2012).

Mental health in East London

For the purposes of this project, the East end of London is defined as those areas which include Tower Hamlets, Newham, Hackney and the City of London. The East end of London is an area of considerable ethnic, cultural and economic diversity as well as an area of high social deprivation. The religious, cultural and social diversity of the area provides challenges to the provision of mental health services. In the cultural and religious mix that is East London, there are a number of paradigms which inform beliefs about the origins of mental health and access to services. Those services developed in the West and deemed acceptable to Western populations are not always acceptable to all women (Cole, 2011). This diversity brings richness, but also adds to the complexity of caring for women with mental health problems.

Aims

The aims of the study were: (1) explore student midwives’ attitudes towards caring for women from diverse cultural, religious and socioeconomic backgrounds who are experiencing perinatal mental health problems; (2) to inform further conclusive research on the educational needs of midwives with regard to perinatal mental health.

Methods

Research design

A small exploratory study using qualitative methods was conducted to provide insight into, and a better understanding of, the perceptions of soon-to-be-qualified students near completion of their training.

Ethical approval

Permission to conduct the study was obtained from the School of Health Sciences Research Governance Committee. Written and informed consent was obtained from all student midwives prior to interview.
Sampling strategy
Convenience sampling was used to recruit student midwives to the study (Polit and Beck, 2009). Student midwives were asked to participate in this study as 60% of their training is spent in clinical practice, placing them in a good position to comment on standards of care.

Two groups of midwifery students, who were approaching completion of a BSc in midwifery programme, were invited to participate in the study. One of the groups comprised students who had no prior nurse training and were completing a 3 year BSc in midwifery degree \( n = 36 \). The second group comprised students who were registered nurses and who were completing a 78-week or shortened BSc in midwifery degree \( n = 24 \). Therefore the total number of students invited to participate in the study was 60 \( n = 60 \). Although both groups of students were invited to attend the interviews, only those students who were registered nurses and who were completing the shortened BSc in midwifery programme agreed. It was unclear why direct-entry students opted not to attend for interview.

Information about the study was distributed via email to students 4–6 weeks before the interviews were due to be conducted. Students were given the option of attending a small group interview on one of 2 days. Interviews with students were conducted in small groups comprising three and four students.

Interviews
The interviews were conducted by the author and a second member of the teaching staff. Both the author and the second interviewer were directly involved in the education of those students participating in the study. The consequences of using researchers who were closely involved with teaching students, for example the affect this might have on students’ responses, were recognised. In order to minimise bias, students were reassured that participation was voluntary, all information was confidential and that there would be no repercussions as a result of non-participation. The interviews lasted between 55 minutes–1 hour 20 minutes and were digitally recorded.

Questions used to generate discussion
The interviews were aimed to be an exploration of student experiences and attitudes regarding caring for women with mental health problems and were intended to be as non-directional as possible. This was in order to establish issues which students themselves believed were pertinent to the care of women with mental health problems.

At the beginning of the interview, students were asked ‘how do you experience caring for women with mental health problems?’ Student responses were further probed using questions such as ‘Can you say a bit more about that?’, ‘How did that make you feel?’, ‘What do you think should have happened?’, ‘What would you have done, if you had been in charge?’

Venue
The interviews were held in one of the teaching rooms at a Medical Education Centre, in an East London Hospital. This venue was chosen because of its convenience for the majority of students.

Data analysis
The interviews were transcribed to produce a verbatim account of students’ discussions (Braun and Clarke, 2006). Thematic analysis was used to analyse the data. Thematic analysis allows the identification, analysis and reporting of patterns or themes within data and minimally organises and describes data in rich detail (Braun and Clarke, 2006). Initially, ‘units’ of data were identified from the transcripts, which were then collated into an initial set of codes. The codes were then grouped into themes and sub-themes in light of how they related to the aims of the research. Analysis of the data was facilitated using NVivo version 9.

Seven student midwives out of a total of 60 agreed to participate in the study. Although many students indicated an interest in participating in the study at the onset, several students subsequently failed to attend for interview and therefore their views were not included in this study. As discussed earlier, the reasons for non-participation of students was unclear. At the beginning of the interview, students were asked to state if they had any prior training in mental health, psychology or psychiatry before commencing the BSc in midwifery programme. All participating students were female and were completing a shortened BSc in midwifery programme.

Results
Four themes were identified from the interviews:

- Identification and assessment of women
- Asking women questions about perinatal health
- Using stereotypes in the care of women
- Caring for and responding to women with perinatal mental health problems.

Identification and assessment of women
Students often used informal or common sense knowledge in their identification of women’s mental health status. For example, a woman’s
environment could provide clues she was experiencing emotional or psychological problems and was not coping well with the transition to motherhood.

'I could see that it must have been stressful for her...she had a newborn living in a place where she couldn't really keep warm. There were boxes everywhere. There was dirt on the floor and to me, she wasn't coping. I just thought she didn't look like she was coping.' (Student midwife A)

Attitude, appearance, behaviour and body language of women were also considered good indicators of mental wellbeing. As such, eye contact, response to questions and behaviour towards the infant were used in the assessment of a woman's mood.

'when you ask that question and she doesn't give eye contact...or she finds it difficult to answer. In fact she might even wait for about a few minutes before...and you might even have to ask her again...and the way that she's interacting with her baby...not bothering if the baby's crying...that would ring alarm bells.' (Student midwife B)

Students often used intuitive responses or 'gut feelings' in their assessment of women.

'and it didn't match up with what was going on...There was something out of the ordinary with what was happening, and her behaviour. I thought this doesn't look right... I just felt so uneasy with it and I thought there's got to be something more.' (Student midwife G)

Asking women questions about perinatal mental health
Students, for the most part, were opposed to the use of standardised questionnaires and screening tools in assessing women's mental health, believing they were not effective. It was felt that questions using the words 'anxiety' or 'depression' alienated women and prevented them disclosing their symptoms. Students believed using simple everyday language such as 'feeling down' was more effective in stimulating open discussion.

'Most midwives say “have you had depression?” “have you had anxiety?”;

“have you had schizophrenia?” and actually those questions are quite harsh...They should make it very simple “Have you been crying?”, “Have you felt down after the baby?” “Did you feel like getting out of bed?” “Did you feel like doing anything yesterday?”' (Student midwife B)

Students were critical of the way they saw questionnaires being used by qualified staff. The 'tick box' approach that students observed qualified midwives using, did not always offer the opportunity to explore women's emotional issues in any detail.

'But what you will find though is some of the midwives ask the question...They'll [women] answer the question, find out, ‘yes, they're [experiencing problems]'... and that's it!...refer them!....but there's no more exploration with the woman to find out a bit more about their condition. It's OK, it's diagnosed, you're taking medication. Oh, that's fine.' (Student midwife B)

'They [qualified midwives] say, “so have you ever had any mental health [problems]?” Then tick the box...I think you're not going to get the answers from the women, the honest answers.' (Student midwife A)

Using stereotypes in the care of women
One of the most important findings from the current study was the assumptions students made about women, based on cultural and illness stereotypes. Students believed that cultural background often dictated a woman's response to mental health, especially with regards to disclosure of mental health issues and acceptability of treatment options. For example, students believed that Black Caribbean women did not acknowledge their symptoms as depression.

'I think most Caribbean women don’t acknowledge that they have depression... it's not something [they] talk about.' (Student midwife A)

Students held similar beliefs about Orthodox Jewish women.

'I think in some cultures it's something that they don’t talk about...it’s not an...
acknowledged thing. You’re meant to have big families and lots of children so it’s [depression] not a thing that would be acknowledged if you’re not feeling [emotionally well], and whenever I’ve asked a Jewish woman how they are postnatally they’re always “fine.” (Student midwife E)

‘...there are so many people out there that can’t have kids, that can’t have the IVF treatment that would make good parents...’ (Student midwife B)

In some cultures there was an expectation that a woman’s role was primarily to marry and have children. Students believed that it was difficult, therefore, for women to express ambivalence or unhappiness about marriage, pregnancy or motherhood. Women who did not conform to normal expectations were under enormous strain and this affected their mental health.

‘...it’s their duty to have babies.’ (Student midwife A)

‘Like the Chinese lady who didn’t want to have this [pregnancy] and the family wanted her to have it...how do you turn round and say, “Well, no, I didn’t want this baby”? ’ (Student midwife C)

‘They feel guilty if they are low...they think that it’s not right [to feel depressed or low] because they are supposed to be happy.’ (Student midwife B)

Students reported feeling frightened by women with serious mental health problems and admitted that they did not always know how to respond, especially if a woman was displaying aggressive behaviour.

‘I’m just scared that maybe with this kind of women, you can say the wrong thing...it was very scary because she was quite aggressive...I felt I didn’t say the correct thing because I don’t know how to...’ (Student midwife F)

Additionally, the behaviour of women was sometimes seen as premeditated and deviant.

‘...but it was just the way she was carrying on...she hit one of the perinatal team...I know I shouldn’t judge, but I just felt that she’d been given this opportunity and look how she’s carrying on and it just didn’t feel fair...’ (Student midwife B)

Discussion

This small exploratory study provided some insights into the attitudes and experiences of student midwives in their care of women living in East London and who are experiencing mental health problems. The findings from this study are not intended to be conclusive; however, they do help inform further exploratory research on midwifery education and training with regard to perinatal mental health with complex and diverse populations.

Caring for and responding to women with perinatal mental health problems

There was considerable concern from one student in relation to women with serious mental health problems being offered assistant conception treatment (ACP) or infertility treatment. One student believed women with serious mental health problems were unable to parent effectively and thus students implied, were less deserving of ACP than other women.

‘...how can she have an IVF pregnancy with this condition?...how on earth are you going to cope with a baby?’ (Student midwife B)

Screening and assessing women for perinatal mental health problems

There were several examples where students referred to the adverse social circumstances experienced by women as indicative of poor mental health. For example, one student suggested a ‘cold and messy’ environment indicating social adversity suggested women weren’t coping. Although socioeconomic status has been recognised as a risk factor for postnatal depression (CMACE, 2011) and poverty and deprivation contribute to mental illness and mental distress (Lewis et al, 1998), cleanliness and home environment are often down to personal preferences and not always good indicators of a woman’s mood. Other factors are recognised as important in predicting a woman’s risk of developing mental health...
problems, however, students made little reference to these. For example, lack of social support, marital relationship difficulties and previous life events are often considered stronger risk factors in estimating the risk of postnatal depression than socioeconomic status (Robertson et al, 2004). Further, a confidential enquiry into the deaths of women due to pregnancy and childbirth found that women who commit suicide are often ‘middle class, employed and in a supportive relationship’ (CMACE, 2011: 141). It would be difficult, therefore, to assume that a woman’s risk of developing mental health problems should be based exclusively on her social and home environment.

One of the students interviewed preferred to use more intuitive methods when identifying a woman’s risk of developing mental health problems and disliked using screening tools. Students also recognised that women disliked a ‘tick box approach’. Although the sensitivity of students to the needs of women was commendable, there is considerable evidence as to the benefits of using screening tools in the identification of perinatal mental health problems in women (Buist et al, 2002; Milgrom et al, 2011; Protopopescu et al, 2012). Many women who commit suicide as a result of pregnancy or childbirth have had a previous psychiatric disorder which has gone undetected (CMACE, 2011). Although women do find re-telling distressing experiences during depression screening uncomfortable (Rollans et al, 2013), without the use of appropriate and validated screening tools it is difficult to correctly assess maternal mental wellbeing and conduct a risk assessment. Additionally, screening tools can help initiate a difficult conversation with a woman about mental health issues, and can open up communication and enable both the health professional and woman to explore her responses and look for solutions (Vik et al, 2009). Despite students concerns about using questionnaires, there is overwhelming evidence to suggest that used correctly screening tools reduce the risk of undetected cases (Buist et al, 2006). Students in the current study, however, failed to recognise this.

Using social and illness stereotypes
One of the most important findings from the interviews concerned assumptions made by students, based on culture and illness stereotypes, largely regarding the causes of women’s mental health problems. Although commendable that cultural and religious differences were recognised as potential contributing factors to a woman’s vulnerability to mental health problems, these links were sometimes communicated by students in a superficial manner. There was often little consideration of the other factors, for example, economic disadvantage or hardship commonly found in ethnic minority groups, and which feasibly could have contributed to women’s depression. Additionally, the use of stereotypes by health professionals to explain illness has been highlighted by others (Burr, 2002; Neale and Wand, 2013). In a study of South Asian women, Burr (2002) found that negative stereotypes of cultural difference were used by health professionals to explain the cause of mental distress and that often where an individual’s mental health problems were attributed to cultural difference, the real causes of illness were missed (Fenton and Sadiq-Sangster, 1996; Burr, 2002).

Other beliefs held by some students were that women from some cultural and religious groups did not always acknowledge mental health problems or recognise the symptoms they were experiencing as depression. The notion that psychosomatic illness is not recognised or given expression to by individuals in certain cultural and religious groups has also been explored in the literature. Fenton and Sadiq-Sangster (1996) found that individuals from diverse cultures may use different terms and language to explain their symptoms. For example, the symptoms experienced by individuals often do not coincide with a medicalised construction of depression or mental illness nor how this experience may be treated. That is, non-Western populations do not experience, express, or treat mental distress in the same way as those in the West. Fenton and Sadiq-Sangster (1996) also found that South Asian women had a specific set of language terms to describe their mood. Women did not use the term ‘depression’, instead they used expressions such as ‘thinking too much...’

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in my heart’ and ‘thinking illness’ to describe their distress (Fenton and Sadiq-Sangster, 1996: 75). As a result, women’s concept of mental health, made it difficult for them to communicate their experiences to health providers.

Similarly, Black Caribbean women’s expression of mental health problems has been explored extensively (Edge, 2008). Black Caribbean women are often unfamiliar with the concept of depression and unable to identify feelings and behaviours that might be described as ‘depressive symptoms’ (Edge 2008: 384). Women may be unable to communicate their feelings to health professionals in a way that can be easily understood and subsequently may not be offered treatment.

Other assumptions about women from cultural minority groups were women’s lack of desire for pregnancy and motherhood. Two students in the current study often believed women from ethnic minority groups were unhappy with being pregnant and becoming mothers, were powerless to express their unhappiness, and unable to assert themselves against the wishes of their partners or families. There is sometimes a presumption that if only women were to adopt a more Western lifestyle, their symptoms of depression would resolve. However, women from Western societies also experience high levels of mental distress, both within, and independent of, repressive relationships (Burr, 2002). It is difficult to support the notion therefore, that depression alone can be attributed to patriarchal and repressive relationships or as a result of cultural background.

Discrimination of women with mental health problems

There was a suggestion that women with mental health problems may be less deserving of being parents and receiving infertility treatment, than other women. Some students expressed reservations about women with mental health problems being able to manage the demands of pregnancy and motherhood. These assumptions were often made without reference to a woman’s individual circumstances or further explanation.

In addition to this, one student midwife appeared insecure in her interactions with women with serious mental health problems and reported being scared of saying the wrong thing and of being frightened when caring for such women. There was a sense that women who were experiencing these problems could be unpredictable, violent or aggressive despite the lack of evidence to support these perceptions (Stuart and Arboleda-Florez, 2001).

The findings from this current project, in tandem with other studies, suggest midwives often feel uncomfortable and unsafe in providing care for women with mental health problems (Mivsek et al, 2008; Jones et al, 2012) and the care of such women is ‘out of their scope of practice’ (McCauley et al, 2011: 793). In their study, McCauley et al (2011) also found that midwives avoided those women in their care experiencing mental illness (McCauley et al, 2011).

Other studies report negative attitudes directed at parents with disabilities, including those with mental health problems, with regards their ability to care for their children (Barber, 2008; Walsh-Gallagher et al, 2012). Students in the current study believed that women with mental health problems tended to be violent and aggressive toward their children. This was despite evidence to suggest that with support, the majority of parents with mental health problems are able to successfully care for their children (Montgomery, 2005; O’Connor, 2012). Women with serious mental health problems often benefit from becoming mothers’ with motherhood often representing the one legitimate role they have in society (Mowbray et al, 1995).

Limitations

There were a number of limitations in carrying out this study. This was a small exploratory study exploring the attitudes of student midwives in caring for women with mental health problems. To begin, the interviews were conducted only with those students who were qualified nurses and were completing a shortened, 78 week, BSc in midwifery programme. Including other students, for example those students completing 3 year, direct-entry BSc in midwifery programmes, might have produced different experiences and perspectives and made an additional contribution to the interviews. Additionally, including midwifery students from other institutions, who had undertaken an alternative emphasis in their training, might have provided further insight.

This study suggests there are gaps in the knowledge and practice of soon-to-be-qualified midwives towards women with emotional and psychological needs during pregnancy and the postpartum period.

Conclusion

These findings from this small exploratory qualitative study have identified some attitudes held by soon-to-be-qualified student midwives, in caring for women with perinatal mental health problems in a diverse population. The findings of this study indicate students use cultural and illness stereotypes in their identification and provision of care of women with perinatal mental health problems. Students were often critical
of evidence-based practice or neglected to use evidence in their care of women with mental health problems. This study has implications for the training of students and in preparing them for clinical practice. A better understanding of the complexity of mental health issues and the importance of evidence-based knowledge among student midwives is needed, especially when caring for diverse groups. In addition, students need a better understanding of the risk factors, which predispose to the development of mental health problems in pregnancy and require training and support in using appropriate screening tools in the identification of women.

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Key points
- Psychiatric illness is one of the leading causes of maternal mortality and morbidity in the UK
- Adverse socio-economic factors and ethnic diversity can add to the complexity of caring for women with perinatal mental health problems
- Interviews with soon-to-be-qualified midwives indicate use of tacit knowledge and intuitive responses predominate in students’ decision making and care of women with perinatal health problems
- Students often neglect to use current research and appeared unconvinced of the value of evidence in the care of women with perinatal mental health problems