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Dutch midwives' behavioural intentions of antenatal management of maternal distress and factors influencing these intentions: An exploratory survey

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ABSTRACT

Objective: to explore midwives' behavioural intentions and the determinants of these intentions with regard to the management of antenatal care of women with maternal distress.
Design: an exploratory survey using a questionnaire. Descriptive statistics calculated expanded TPB constructs, demographic information, personal characteristics and work related details. Multiple linear regression analyses were used to examine which factors influence midwives' intention to provide antenatal care of maternal distress.
Setting: midwives working in Dutch primary care.
Participants: 112 midwives completed the survey.
Results: midwives did not report a clear intention to screen for maternal distress (3.46 ± 1.8). On average, midwives expressed a positive intention to support women with maternal distress (4.63 ± 1.57) and to collaborate with other health-care professionals (4.63 ± 1.57). Finding maternal distress an interesting topic was a positive predictor for the intention to screen ($B=0.383$; $p=0.005$), to support ($B=0.637$; $p=<0.000$) and to collaborate ($B=0.455$; $p=0.002$). Other positive predictors for the intention to screen for maternal distress were years of work experience ($B=0.035$; $p=0.028$), attitude about the value of screening ($B=0.326$; $p=0.002$), and self-efficacy ($B=0.248$; $p=0.004$). A positive attitude toward support for women with maternal distress ($B=0.523$; $p=0.017$) predicted the intention to support these women. Number of years of work experience ($B=0.042$; $p=0.017$) was a positive predictor for the intention to collaborate with other health-care professionals.
Key conclusions: the intention to screen for maternal distress was less evident than the intention to support women with maternal distress and the intention to collaborate with other health-care professionals. Important factors predicting the midwife's intention to screen, support and collaborate were finding maternal distress an interesting topic, years of work experience, attitude about the value of screening and support and self-efficacy about screening.
Implications for practice: to provide care involving all three components of antenatal management of maternal distress implies efforts to influence the factors that predict the intention to screen, to support women with maternal distress and the intention to collaborate with other health-care professionals.

Introduction

Maternal distress involves a wide spectrum of different psychological and emotional problems that may manifest during the distinct period of maternal transition, including pregnancy, birth and the postnatal period. These psychological and emotional problems are most commonly referred to as depression, anxiety and stress, worry and fear (Halbreich, 2005; Emanuel and St. John, 2010; Tebbe et al., 2012) and range from a disbalanced emotional and psychological homoeostasis to disturbed psychosocial functioning (Halbreich, 2005; Emanuel and St. John, 2010), but exclude psychiatric pathology (Tebbe et al., 2012). Maternal distress can be

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related to pregnancy and its accompanying maternal role development, or other obstetric related factors such as a previous traumatic birth experience, miscarriage or assisted conception (Leigh and Milgrom, 2008; Emanuel and St. John, 2010). Maternal distress can also be caused by non-pregnancy or birth related factors such as previous or current mental health problems, stressful life events, low self-esteem or inadequate social support (Leigh and Milgrom, 2008).

Worldwide rates of maternal distress during and after pregnancy vary between 10% and 41% depending on definition (WHO, 2008). Maternal distress is an important public health issue as it can have extensive immediate and long-term adverse consequences for women, children, and their families. It can increase the risk of obstetric complications (Mulder et al., 2002; Johnson and Slade, 2003; Matthey, 2010), affect infant and child neurobehavioral and cognitive development (Brouwers et al., 2001; van den Bergh et al., 2005; Davis and Sandman, 2010), contribute to absence of work (Ekkel, 2011), result in severe and/or chronic maternal mental health problems (Grant et al., 2008; Leigh and Milgrom, 2008), and even lead to suicide (Raynor et al., 2003; Schutte et al., 2008).

Maternal distress has been identified as one of the major concerns for perinatal health in the Netherlands (Dutch Steering Committee Pregnancy and Birth, 2009). Midwives have explicitly been appointed as promoters of maternal mental health (KNOV, 2010) as about 80% of pregnant women start their care with midwives in primary care (PRN, 2008). Midwives now have a more extended public health role, but their responsibilities in relation to mental health promotion have not been articulated (KNOV, 2010). When maternal distress is present during pregnancy, follow-on care can be provided by the referral of the woman's General Practitioner to a psychologist or psychiatrist if necessary (Leentjes et al., 2009; Ruiter et al., 2010). The severity of maternal distress and the judgment and advice of the lead medical specialist and the teratogen effect of use of medication during pregnancy, determines whether the midwife will be the woman's lead carer during the childbirth period (CVZ, 2003). Hence the midwife can be faced with various levels of severity of maternal distress.

Currently many women with maternal distress remain ‘under the radar’ and the provision of care is thus often inadequate (Ruiter et al., 2010). The Dutch Royal College of Midwives (KNOV) has published a Quality Standard for antenatal care, including descriptive information for providing psychosocial care (de Boer and Zeeman, 2008). The Quality Standard of the Dutch College of General Practitioners (NHG) for shared maternity care between General Practitioners (GP) and primary care midwives is also available. This Quality Standard includes recommendations for collaboration and consultation between midwife and GP for maternal mental health and well-being (Beentjes et al., 2012). Both Quality Standards describe the elements of management of care: screening and assessment; mental health information and psychosocial support; transfer of information, consultation of, and referral to other health-care professionals (de Boer and Zeeman, 2008; Beentjes et al., 2012), but are by no means best-practice guidelines. Recently an antenatal assessment tool for psychological health to be used by primary care midwives, the Four-Dimensional Symptom Questionnaire (4DSQ), has been validated, but has not been implemented (Tebbe et al., 2012).

Despite the available documents, midwives have reported insufficient understanding of maternal distress and uncertainty about their specific role and responsibilities in providing adequate care for women with maternal distress (SIA, 2011). In response to this the Project ‘Promoting Healthy Pregnancy (2011–2015)’ has been established. This four-year project aims to develop an antenatal intervention for primary care midwives to reduce maternal distress. To achieve a reduction of maternal distress we need to base the intervention on an understanding of the factors that can lead to positive changes in maternal distress, including midwives' behaviour with regard to this aspect of care (Bartholomew et al., 2011). If we want to achieve a change in the behaviour of midwives, firstly we need to look at whether midwives are willing to take on the role and responsibilities in relation to maternal mental health promotion and thus the reduction of maternal distress (Ross-Davie et al., 2006).

There is a breadth of literature about midwives' behaviour in relation to antenatal management of care of maternal distress and underlying factors influencing this care (Buist et al., 2006; Sanders, 2006; Gibb and Hundley, 2007; Yelland et al., 2007; McCauley et al., 2011; McLachlan et al., 2011). We know however, very little about midwives' willingness to provide antenatal management of maternal distress and what factors influence their willingness, as this has never been thoroughly studied. We do have some preliminary insight in the beliefs of Dutch midwives with regard to maternal distress, based on semi-structured interviews with Dutch primary care midwives (Fontein, 2012). The salient belief was that maternal distress is a serious problem and midwives wished to contribute to a positive change for women with regard to this problem. Midwives were not truly convinced if they could or how they could make an effective difference. Beliefs seemed to be affected by practice experience, midwives' interest in maternal distress or finding it an important issue in midwifery care and personal and professional experience with the topic. Midwives also expressed that view of their professional remit, professional identity and their sense of responsibility and competence, and confidence, ability and willingness to address maternal distress affected their beliefs. Barriers to changing practice that were mentioned, included lack of education, perceiving maternal distress as complex, lack of time and resources, lack of guidelines for screening, and limited insight in clinical pathways (Fontein, 2012). Ross-Davie et al. (2006) concluded from their survey, including a sample of 187 hospital-based midwives of the Inner London Trust, that midwives are willing to take on a more developed public health role in relation to mental health but midwives expressed the need for education and involvement of other (mental health) health-care professionals for follow-on care in order to do so.

We conducted this study in order to gain familiarity with, and to increase insight in midwives' willingness for the provision of antenatal care in relation to maternal distress and what factors influence their willingness. With this study we want to begin to develop baseline quantitative data of midwives' antenatal management of maternal distress. Our study aims to explore the behavioural intentions of midwives for antenatal management of maternal distress and examines the factors that influence those intentions. In order to fulfil this purpose indicated above, we sought answers to the following core questions:

- How are midwives' behavioural intentions of antenatal management of maternal distress?
- Which underlying factors influence midwives' intention to provide antenatal care of maternal distress?

Our study uses the Theory of Planned Behaviour (TPB) as a theoretical starting point. TPB has been used to examine a wide variety of different health professionals' behaviours and their intentions (Armitage and Conner, 2001; Bartholomew et al., 2011; Eccles et al., 2012). Behavioural intention has the potential to change clinical behaviour (Walker et al., 2001; McLachlan et al., 2011; Eccles et al., 2012) and has been identified to form the basis for interventions (Walker et al., 2001). Because maternal distress seems to be a fairly new aspect of care and in development (Ross-Davie et al., 2006; Gibb and Hundley, 2007; KNOV, 2010) we have therefore chosen behavioural intention as the focus of our study as intention precedes behaviour (Eccles et al., 2012). Self-reported