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Australian midwives' experience of delivering a counselling intervention for women reporting a traumatic birth

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ABSTRACT

Objective: this paper describes midwives' experiences of learning new counselling skills and delivering a counselling intervention entitled 'Promoting Resilience on Mothers Emotions' (PRIME).
Design: a descriptive exploratory approach was used. Data collected included semi-structured interviews ($n=42$), midwife diary entries (18 pages) and web based postings (169 pages). Data were analysed using manual thematic method.
Setting: the intervention study was conducted in two tertiary maternity hospitals in the Australian states of Queensland (QLD) and Western Australia (WA) during a 17 month period, from August 2008 to December 2009.
Participants: midwives were employed as research assistants and trained to deliver a counselling intervention to women reporting a traumatic birth experience. Eighteen of a possible 20 Australian midwives participated in this study.
Intervention: PRIME is a midwife-led counselling intervention based on cognitive–behavioural principles and designed to ameliorate trauma symptoms. It is offered face-to-face within 72 hours of childbirth and by phone around six weeks post partum.
Findings: participating midwives felt confronted by the level of emotional distress some women suffered as a consequence of their birth experience. Four major themes were extracted: The challenges of learning to change; Working with women in a different way; Making a difference to women and me; and A challenge not about to be overcome.
Key conclusions and implications for practice: the advanced counselling skills the midwives acquired improved their confidence to care for women distressed by their birthing experience and to personally manage stressful situations they encountered in practice.

Introduction

There is a perception that pregnancy and transition to motherhood are a natural and joyous event for all women. It is a time of significant physiological, psycho-social changes to which most will adapt. However for some women, childbirth is traumatic and they require support to reconcile events and regain their psychological equilibrium. Both Australian and international evidence has identified significant rates of perinatal mental health disorders in childbearing women (Gavin et al., 2005; Buist et al., 2008; Austin et al., 2010). Perinatal emotional distress can have a detrimental impact on the health and well-being of the woman, her partner and infant (Perinatal Mental Health Consortium, 2008).

Gamble and Creedy (2009) identified a need for post partum counselling strategies in midwifery practice, to improve the emotional outcomes for women who experienced a traumatic birth. Drawing on a critical review of the literature and focus group discussions with midwives and women, they developed a midwife-led post partum counselling intervention for women

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distressed by their birthing experience (Gamble and Creedy, 2004; Gamble et al., 2004a, 2004b). The effectiveness of the intervention was initially pilot tested by a single midwife in a randomised control trial (RCT) (Gamble et al., 2005). On the basis of these positive results, a larger funded RCT was conducted to determine the effectiveness of the intervention when delievered by a larger number of midwives (Fenwick et al., 2013).

The intervention is known as PRIME, an acronym for 'Promoting resilience in mothers' emotions'. The RCT was conducted in two states of Australia between 2008 and 2010. Some 900 women were recruited in the third trimester of pregnancy and screened within 24–72 hours of birth to determine if they met Criterion A of the American Psychiatric Association, Diagnosis and Statistical Manual of mental health disorders (DSM IV-TR) for posttraumatic stress disorder (American Psychiatric Association, 2000). DSM IV-TR Criterion A for post-traumatic stress disorder seeks information about perceived exposure to a traumatic event and the woman's initial emotional response. Women were asked if during labour/birth they had been fearful for their life or their baby's, or feared serious injury or permanent damage. Mothers screening positive were randomly allocated to receive the counselling intervention or parenting support (active control). PRIME aims to support the expression of feelings and provide a framework for women to identify and work through distressing elements of childbirth. Women are provided with an opportunity to review the birth and gain a realistic perception of events. There is a focus on developing individual situational supports for the present and near future, affirming that negative things can be managed and developing a simple plan for achieving this (Gamble and Creedy, 2009).

A challenge in offering counselling and emotional support to new mothers is the availability of trained staff (right people, at the right place, at the right time) (Watts and Pope, 1998). Gamble and Creedy (2009) argued that midwives were well placed to assess and provide targeted interventions to childbearing women but have been criticised for their lack of attention to emotional care. Furthermore, some midwives have expressed concern about their counselling skill base, time demands to provide emotional support, fear of eliciting emotional responses and not managing these situations (Hammett, 1997; Gamble et al., 2004b). Therefore a potential challenge of PRIME was whether a large group of midwives could learn and deliver the counselling intervention effectively.

Aim

The findings in this paper are part of a large qualitative study that aimed firstly to describe midwives' experiences of participating in a team-based research project and secondly, explore what it was like for them to learn and deliver the PRIME post partum counselling intervention for distressed women. This paper presents the findings focused on the midwives' perceptions of learning the counselling skills and delivering the intervention.

Research design

A qualitative descriptive exploratory research design was employed. Descriptive approaches to research are considered an appropriate choice if the phenomenon is inadequately defined or conceptualised and typically incorporate an eclectic combination of methods in data collection and analysis (Sandelowski, 2000). Participant's subjective descriptions provide insight into understanding the human experience (Schneider et al., 2007; Liamputtong, 2010; Polit and Beck, 2010).

Study setting

The study was conducted in two Australian states from August 2008 to December 2009. Site A was a maternity service in Queensland with an average of 3100 births each year. Site B was a tertiary referral centre in Western Australia with a yearly birth rate of 6000.

The PRIME project: role of midwives

Clinically-based midwives ($n=20$) with an interest in perinatal mental distress and developing counselling skills were recruited as research assistants. These midwives recruited women, administered two questionnaires (first when obtaining consent antenatally and the second within 72 hours of birth), screened women for a distressing birth experience and randomised distressed women into the control or PRIME intervention groups. Women allocated to PRIME were offered counselling at this time and again by telephone six weeks post partum. A detailed description of the key elements of the counselling intervention is published elsewhere (Gamble and Creedy, 2009).

The PRIME midwives received training consisting of workshops, written manuals and digitally recorded counselling vignettes. Midwives demonstrated competence by completing a digitally recorded counselling interview with a volunteer who had self-identified a distressing birth experience. Supportive supervision to gain competence prior to commencing recruitment, and ongoing supervision to assure adherence to the counselling framework, was provided to the midwives throughout PRIME. A tool was developed to determine integrity of the intervention and trigger remedial training and supervision if needed. A clinical psychologist, in collaboration with the research team, developed and implemented the training protocol and provided clinical supervision. To assist with the team cohesiveness, confidentiality and accessibility, a PRIME website was created. This online 'midwifery forum' facilitated access to project information and interaction amongst the research team.

Participants

Purposive sampling was used to recruit midwives into this exploratory study. Open invitations were posted to the 20 midwives along with their confirmation of appointment as a research assistant in PRIME. An additional open invitation and consent was also sent to one midwife who observed the training but did not work in PRIME. Twenty-one midwives consented to participate in this study. Of these, 10 were located at site A and 11 at site B. One withdrew her participation from this study prior to being interviewed citing 'lack of time' but continued on in PRIME. Two midwives did not respond to requests for an interview and also withdrew their participation from PRIME. Eighteen midwives contributed to this study in varying degrees (see Table 1: participant profile and involvement in PRIME).

Data collection

Multiple methods of data collection were used in this study. The main data source consisted of prospective semi-structured interviews conducted at four time points throughout PRIME. The midwives first interviews were attended prior to their PRIME training. Only midwives from Site B were interviewed at this time, as Site A participants had already completed their training when this exploratory study commenced. Their second interview occurred on completion of training and the third while they were simultaneously recruiting pregnant women and implementing the intervention to distressed postnatal women. The fourth interview was held on completion of their participation. Additional data