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Skills-based childbirth preparation reduces stress for midwives

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ABSTRACT

Objective: to explore the potential benefits of skills-based childbirth preparation on the work related stress levels of midwives.
Design: a questionnaire was sent out to midwives who had clients participating in an RCT of an education package for childbirth preparation (*The Pink Kit (PK) Method for Birthing Better®*) delivered to parents.
Setting: midwives were in private practice and acted as lead maternity carers to New Zealand first time mothers.
Participants: one hundred and four independent midwives participated.
Measurements: a brief questionnaire using a Visual Analogue Scale to portray perceptions of work-related stress and a yes/no question about expected and/or unexpected physical complications.
Findings: midwives working with clients in the intervention group experienced less work-related stress after correction for medical complications compared to the two control groups.
Key conclusions: working with mothers who have used a programme that increased their childbirth self-efficacy decreased the work-related stress experienced by midwives.
Implications for practice: encouraging pregnant women to develop childbirth skills merits further investigation in an effort to reduce the work-related stress experienced by midwives.

Introduction

Childbirth can be an anxious time for new parents. Sometimes a focus on what may go wrong during the pregnancy and birth may create a situation where pregnant women become anxious and rely increasingly on the expertise of their maternity carer (Miller, 2003). Ford et al. (2009) found that British women relied heavily on the support of hospital staff and midwives to assist them to feel in control of their birth processes. Choosing a midwife has been identified in qualitative research to be an important safety consideration and the subsequent relationship with their midwife to be a core predictor of birth satisfaction (Howarth et al., 2010, 2011b, 2013). In a review of the literature, Koniak-Griffin (1993) identified a lack of self-confidence, inadequate preparation, and dependency on professionals, as potential risk factors of mothers for losing personal control during the birthing process. Jones (2012) reported that high anxiety in pregnancy could lead to heightened perception of pain during labour and the establishment of a cycle of behaviours which further heightened anxiety during a birth, resulting in even greater dependency on maternity carers. Miller (2003) claimed that this reliance on expert knowledge and opinion could lead to a culture of dependency on the maternity care provider. In a qualitative study of eight new mothers, Wilkins (2006) reported that women found some of the advice given at British antenatal classes, especially advice that related to early child care, impractical and unhelpful. They too relied heavily on the practical and individualized support given by midwives to cope with their new role. This all places expectations on the midwife which can lead her to experiencing increased work-related stress.

In New Zealand case-loading lead maternity care midwives are expected to be on call 24/7. While midwifery in New Zealand is a challenging occupation, it also has sustaining rewards for those midwives with a passion for midwifery (McAra-Couper et al., 2014). In a qualitative study in which 11 midwives who had practised for at least eight years were interviewed about what sustains them in their work, a number of themes emerged. In particular, McAra-Couper et al. (2014) describe the joy midwives experience in working in partnership with women and their families, assisting women to give birth as the women desire. McAra-Couper et al. (2014) also emphasized the importance of forming boundaries that enabled them to establish professional and personal balance in their lives. While midwives are additionally sustained by their relationships with other midwives and the midwifery community, occupational burnout is a hazard for midwives. It is

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reflected in the following three dimensions: a sense of depersonalization, emotional exhaustion, and a low sense of personal accomplishment (Sandall, 1998). In her doctoral thesis examining burnout in self-employed case loading midwives, Young (2011) interviewed 12 midwives and four of their partners to gain an understanding of what burnout signified for these midwives. While midwives initially tried to hide the high cost of being on call in a demanding profession, they were unable to sustain this, and the high cost of the emotional pain they endured and its impact on their lives and the lives of their families was eventually revealed. Young (2011) concluded midwives needed to be aware of the burnout phenomenon and have boundaries and support systems in place to avoid burnout.

A recent review of midwife stress reported that stress occurs from two major sources. Firstly occupational stress and also organisational stress. Things like dysfunctional workplace culture, bullying and lack of support seem prevalent and should also be considered as sources of stress (Pezaro et al., 2015). The present research will limit the discussion of stress to occupational or work-related stress.

In another qualitative study by Cox and Smythe (2011), three midwives who had recently left their lead maternity carer practices were interviewed. It was concluded that the passion and commitment midwives bring to midwifery could lead to too high an emotional cost for some midwives. An Australian study examining the level of work-related stress experienced by midwives working in two public hospital maternity units found that 60.7% of midwives reported moderate to high levels of emotional exhaustion, 30.3 scored low on personal accomplishment, and 30.3% reported depersonalization (put simply, feeling like a robot), all characteristics identified as related to occupational burnout (Mollart et al., 2013; Sandall, 1998). As the response rate from the target population was low (36.8%) it may be possible that these levels of work related stress and burnout could be higher (Mollart et al., 2013).

While much of this research is qualitative with small numbers of participants, it gives an indication that work-related stress is an issue for midwives. Much recent research on midwife stress has changed in focus to traumatic birth (eg. Leinweber et al., 2016; Wahlberg et al., 2016). The present study instead examines non-medically complicated births, which comprise the majority of a midwifes caseload. The present study observes the stress of midwives while their clients participate in an RCT, where the intervention package has been found to increase self-efficacy of mothers who are expecting their first child. The intervention in the present study is a childbirth preparation programme called *The Pink Kit Method for Birthing Better®* (Common Knowledge Trust, 2001). Midwives who attended participants in this study were asked to comment how work-related stress compared to the work-related stress they generally experienced when working with their clients. It was hypothesized that clients who engaged in this self-efficacy enhancing intervention would reduce stress on their midwives.

Method

Design

This is an observational study of midwives whose clients participated in a Randomised Controlled Trial (RCT) to improve childbirth self-efficacy (see Howarth et al. (2016)). In this trial participants were randomly assigned to one of three groups: an intervention group who were issued the skills-based childbirth preparation programme; an active control group which was issued a booklet of varied birth stories, and a passive control group which was not issued any extra material. Participants in the trial selected their own midwives. Midwives were consequently grouped according to the randomised grouping of the participants for whom they acted as lead maternity carers. A questionnaire asking about stress was sent to midwives after their care of the participant had ended.

Participants

Ethical approval was granted to approach midwives who had been lead maternity carers for participants as informants in this study (reference number: LRS/10/11/052). Only midwives who had acted as the participant's lead maternity carer were eligible. Consent by midwives was implied by the return of the completed questionnaire. One hundred and four midwives elected to participate in the study (70% response rate).

Procedure

Questionnaires asking midwives to rate their work-related stress - along with a brief introductory letter and stamped self-addressed return envelope, were posted out to midwives after their role of lead maternity carer for a particular participant was concluded (at least six weeks post birth). If there was no response, the questionnaire was posted twice more. Those midwives for whom no postal address was available were sent text messages, referred to the study website, and those who agreed to participate supplied their postal addresses.

Measures

Comparative work-related stress was measured on a visual analogue scale (VAS: 0 [much lower level of stress] -100 [much higher level of stress]) in response to the following questions. The questions were:

Comparative work related stress

Please use the following scale to rate how much less stress or how much more stress you experienced when caring for this client/patient and her partner compared to that you usually experience when caring for a client/patient and her partner by putting a stroke through the line.

Complications

Was there any expected physical issue (for example, breech position) or any other unexpected physical issue (only physical) which accounted for the stress you experienced?

Provision was also made for midwives to make comments. Previous experience suggested midwives were resistant to time-consuming and potentially intrusive questionnaires and so a decision was made not collect any demographic or work related detail.

Data analysis

Data for those participants who had withdrawn and those who did not report the birth of their child was removed. Data for those participants under the care of a lead maternity carer other than a midwife and those participants who did not give their permission for their midwives to be contacted was also removed. This left 148 midwives eligible to participate. Of these 104 midwives had their data analysed.

Data from the VAS question asking midwives to compare the work-related stress they experienced when caring for their client in the study with what the work-related stress generally experienced in working with clients their private practices (comparative stress) were tested using a one way Analysis of Variance (ANOVA).

Findings

Demographic characteristics

Midwives who worked as lead maternity carers in private practices located in both rural and urban areas throughout New Zealand acted as informants in this study. All participants were female. No demographic questions were asked of midwives.