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ORIGINAL RESEARCH – QUANTITATIVE

Factors influencing maternal distress among Dutch women with a healthy pregnancy

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ABSTRACT

Background: Maternal distress is a public health concern. Assessment of emotional wellbeing is not integrated in Dutch antenatal care. Midwives need to understand the influencing factors to identify women who are more vulnerable to experience maternal distress.

Objective: To examine levels of maternal distress during pregnancy; and to determine the relationship between maternal distress and aetiological factors.

Methods: A cross-sectional study including 455 Dutch-speaking women with uncomplicated pregnancies during all trimesters of pregnancy. Data were collected with questionnaires between 10 September and 6 November 2012. Demographic characteristics and personal details were obtained. Maternal distress was measured with the Edinburgh Depression Scale (EDS), State-Trait Anxiety Inventory (STAI), and Pregnancy Related Anxiety Questionnaire (PRAQ). Behaviour was measured with Coping Operations Preference Enquiry-Easy (COPE-Easy). Descriptive statistics and multiple linear regression analysis were used.

Results: More than forty percent of the sample (43.3%) showed heightened scores on the EDS, STAI or PRAQ, on one or more measure. History of psychological problems ($B = 1.55$; $p = .005$), miscarriage(s) ($B = 2.30$; $p = .045$), having young children ($B = 2.54$; $p = .004$), avoidant coping, (increased) substance use, somatisation and negative feelings towards the forthcoming birth ($B = 0.583$; $p = .000$) showed a significant positive relationship with maternal distress. Self-disclosure ($B = -0.541$; $p = .017$), acceptance of the situation ($B = -0.377$; $p = .000$), help-seeking ($B = -0.699$; $p = .002$), a previous positive birth experience ($B = -0.331$; $p = .048$), knowledge of maternal distress ($B = -0.378$; $p = .004$) and rapport with the midwife ($B = -0.623$; $p = .018$) showed a significant negative relationship with maternal distress.

Conclusion: Maternal distress among women with a healthy pregnancy is evident and is significantly influenced by various factors. Midwives need to be aware of these factors, in particular the importance of their role and relationship with women.

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1. Introduction

Maternal distress refers to a spectrum of psychological, emotional and behavioural symptoms during pregnancy, birth and the postnatal period.¹ Levels of maternal distress vary, ranging

along a continuum. This continuum extends from daily worries and limited psychosocial disharmony, to major symptoms of emotional tension and mental strains with a considerable disbalanced psychosocial functioning.^{2–4} Depression, stress and anxiety are the most common mentioned constructs of maternal distress^{1,2,4,5} and they often co-occur.^{4,6,7}

There is increasing evidence that maternal distress among otherwise healthy pregnant women can be a predictor for negative birth outcomes, including low birth weight and prematurity.^{8,9}

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Additionally, adverse short and long-term post partum mental health effects have been reported for both mother and child, including post-partum depression and post-traumatic stress,^{6,10–13} psychiatric morbidity¹⁴ and impaired child behavioural, cognitive and emotional development.^{15–17} Maternal distress and its detrimental health effects has therefore been recognised as a worldwide public health concern with rates of maternal distress varying between 10 and 41%.¹⁸ Prevalence rates of maternal distress among Dutch women vary between 2.3% and 33.3%, depending on the constructs of maternal distress being measured (*i.e.* depression, anxiety).^{8,10,19–21}

As about 83% of all pregnant women access maternity services with a healthy pregnancy,^{22,23} it is likely that approximately that proportion of women are healthy with minimal risk factors. Dutch Government policy recommends that women with healthy pregnancies receive routine midwife-led antenatal care.²⁴ During antenatal care midwives have to be alert for the presence or development of (psychosocial) risk factors or complications that need to be adequately addressed.²⁴ This implies that midwives are the lead carers of caseloads of pregnant women, including women with maternal distress.

The Dutch Steering Committee Pregnancy and Birth²⁵ expressed their concerns about the prevalence and the adverse affects of maternal distress with regard to Dutch maternal and child health, seeing prevention and reduction of maternal distress as paramount in maternity care services. In order to provide adequate care, maternity healthcare providers need to be aware of the factors that relate to the prevalence of maternal distress. In response to the concerns of the Dutch Steering Committee Pregnancy and Birth²⁵ the Project 'Promoting Healthy Pregnancy (2011–2015)' has been established. This four-year project aims to develop an antenatal midwife-led intervention to contribute to the reduction of maternal distress. Part of the intervention includes the change of midwives' behaviour with regard to the antenatal management of maternal distress, as earlier research has shown that in particular the majority of Dutch midwives²⁶ do not routinely screen for maternal distress. Other studies confirm that midwives' antenatal assessment of psychological and mental wellbeing and risk factors are not integrated in existing antenatal practice.^{27,28} It is therefore likely that the deficiency of standard assessment of maternal distress limits the identification of women who are experiencing maternal distress and the identification of women who are more vulnerable to develop maternal distress. This might influence adequate further support and care and thus have negative impact on women's and infants' health and wellbeing.

We have conducted this study as part of the project Promoting Healthy Pregnancy in order to bridge the gap in midwives' understanding about the factors that are related to maternal distress. We need to form an understanding of those specific factors that can lead to the identification of women who are more susceptible to experience maternal distress during pregnancy.²⁹ Various studies have looked at factors that influence maternal distress among women with healthy pregnancies from different perspectives, such as personal characteristics,^{30–32} personal history,^{12,13,30,32–38} personal circumstances,^{12,13,30–39} coping styles,^{2,12,38–40,43} income,^{12,34} social support^{12,13,30,35} and positive and negative enhancing factors for maternal distress.^{13,30,31,37,38,40,42–44} Studies have addressed different constructs of maternal distress like antenatal depression,^{12,30,32–35,39,41} childbirth related fear,^{13,31,42,43} anxiety^{32,36,37,40} and antenatal stress.^{37,38,44} This present study maps all possible factors that influence maternal distress and approaches maternal distress as a multi-dimensional conceptualisation of different psychological symptoms and constructs.

For the purpose of this study we want to examine the occurrence of maternal distress in a population of Dutch women with a healthy pregnancy and to identify the explicit factors among this population that might serve as a proxy for midwives to recognise women during antenatal care who are more vulnerable to experience maternal distress. In order to fulfil this purpose, we sought answers to the following questions:

- What are the levels of maternal distress reported by women with a healthy pregnancy?
- What are the aetiological factors influencing the occurrence of maternal distress among these women?

2. Methods

2.1. Design and sample procedure

A cross-sectional study was conducted including a sample of Dutch-speaking pregnant women with uncomplicated pregnancies during any trimesters of pregnancy, receiving midwife-led care in primary care. We included women who were pregnant of a singleton infant, requiring no obstetric-led care as a result from complications or as a result from the threat of complications to arise. Women in secondary and tertiary care were excluded.

The 140 midwife-led care practices that offer primary care based placement to the bachelor students of the Faculty of Midwifery Education & Studies, Maastricht were approached and informed about the content of the study. 31 midwifery practices agreed to recruit a minimum of 30 pregnant women during a routine antenatal appointment between 3 and 28 September 2012. Midwives informed and invited all women in their caseload that attended the clinics in this period, to participate. Explanation about the study for women was also conveyed through a poster at recruiting practices. 950 women expressed interest in the study. They were given additional information by telephone and invited to fill out a questionnaire. Pregnant women appointed suitable dates and times for these telephone calls. 766 women agreed verbally to participate and received a consent form by post including a stamped return envelope. 540 women signed and returned the consent form and subsequently received a digital or paper questionnaire or a telephone interview by a student midwife; depending on women's preference. After two weeks a reminder was sent by mail or e-mail. To raise the response rate, participants could opt to take part in a raffle of mother and baby skincare gift packages.

Data were collected between 10 September and 6 November 2012. The research ethics committee METC-Atrium-Orbis-Zuyd, reviewed and approved the research protocol and confirmed that ethical approval was not necessary according to Dutch guidelines.⁴⁵

2.2. Measures

2.2.1. Maternal distress

We approached maternal distress as a multi-dimensional concept, indicating symptoms of different psychological constructs identified by measurement instruments with established cut-off points. We therefore chose to sum different individual measures, to provide a more complete and clear Picture.⁴⁶ Compiling scores of different measurement instruments measured at the same time provides more stable data.⁴⁶ In this study we used Dutch versions of the *Edinburgh Depression Scale*,⁴⁷ *State-Trait Anxiety Inventory*⁴⁸ and the *Pregnancy Related Anxiety Questionnaire*.⁴⁹

2.2.2. Edinburgh Depression Scale (EDS)

We used the EDS ($\alpha = 0.78$), a 10-item questionnaire developed to screen for antenatal depression.⁵⁰ The Dutch EDS reported a

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