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Communication study

Clients' psychosocial communication and midwives' verbal and nonverbal communication during prenatal counseling for anomaly screening

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ABSTRACT

Objectives: This study focuses on facilitation of clients' psychosocial communication during prenatal counseling for fetal anomaly screening. We assessed how psychosocial communication by clients is related to midwives' psychosocial and affective communication, client-directed gaze and counseling duration.

Methods: During 184 videotaped prenatal counseling consultations with 20 Dutch midwives, verbal psychosocial and affective behavior was measured by the Roter Interaction Analysis System (RIAS). We rated the duration of client-directed gaze. We performed multilevel analyses to assess the relation between clients' psychosocial communication and midwives' psychosocial and affective communication, client-directed gaze and counseling duration.

Results: Clients' psychosocial communication was higher if midwives' asked more psychosocial questions and showed more affective behavior ($\beta = 0.90$; CI: 0.45–1.35; $p < 0.00$ and $\beta = 1.32$; CI: 0.18–2.47; $p = 0.025$, respectively). Clients "psychosocial communication was not related to midwives" client-directed gaze. Additionally, psychosocial communication by clients was directly, positively related to the counseling duration ($\beta = 0.59$; CI: 0.20–099; $p = 0.004$).

Conclusions: In contrast with our expectations, midwives' client-directed gaze was not related with psychosocial communication of clients.

Practice implications: In addition to asking psychosocial questions, our study shows that midwives' affective behavior and counseling duration is likely to encourage client's psychosocial communication, known to be especially important for facilitating decision-making.

1. Introduction

As in many other countries, Dutch pregnant women are offered prenatal fetal anomaly screening for chromosomal syndromes, e.g., Down syndrome or structural anomalies, e.g., neural tube defects (Appendix A). An opt-in approach is used, to underline the fundamental right of parents to make an autonomous, informed decision whether to accept or decline prenatal anomaly screening [1,2]. However, expectant parents perceive this decision as difficult [3–5]. During the decision-making phase, parents simultaneously hope to be reassured by test results if they choose to opt for screening, and worry, because they might be confronted with an unfortunate test outcome or need to go on to more definitive diagnostic testing which carries iatrogenic consequences [3–5]. Therefore, pregnant women receive prenatal counseling to support them with the decision to have prenatal anomaly screening or not [2,6]. Such counseling comprises: *health education* about, for instance, the available anomaly tests and the anomalies that could be detected, and *decision-making support* by discussing for example clients' values and views on parenthood and disabled life

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(psychological issues), and social influences to opt or decline anomaly screening (social issues). In the Netherlands, for 80% of the pregnancies, primary care midwives are the designated counselors for prenatal anomaly screening [7].

Given that preference-sensitive decisions need to be made, historically, genetic counseling has had much in common with Rogers' client-centered approach to psychotherapy, which is intended to facilitate an autonomous, informed decision using a non-directive counseling attitude and a non-persuasive client-centered communication style [1,8–14]. Within the client-centered approach a good client–counselor relationship is seen as an essential condition for having a dialogue in which the client feels safe enough to express psychosocial issues such as concerns, dilemmas and needs regarding the decision and its eventual consequences. So, a good client–counselors relation is seen as necessary to enable clients to participate in the conversation and therefore to attain autonomous, informed decision-making [14–18].

According to the theory of client-centered psychotherapy, building a good client–counselor relation is primarily established by nonverbal behavior, such as client-directed gaze and affective behavior [14]. Research into the role of gaze in healthcare encounters showed that care providers' client-directed gaze can stimulate the detection of clients' psychosocial concerns and also encourage clients to express these concerns [19,20–24]. Since discussing psychosocial concerns is seen as one of the most important prerequisites for *decision-making support*, nonverbal counseling skills, such as client-directed gaze, are thought to be essential for prenatal counseling for anomaly screening [15,18,25–27]. Affective communication, such as verbal attention, partnership statements and empathy, also enhances the client–counselor relationship and is positively associated with participation of clients for example in negotiations about treatment plans, participation in treatment and moral considerations Thus affective communication can also be seen as a prerequisite for *decision-making support* [16,17,28,29]. In addition, once a good client-counselor relationship is established, clients' participation may be facilitated by asking exploring, client-centered questions, which is another key of the client-centered psychotherapeutic process [14]. Within the context of counseling for prenatal anomaly screening, clients want their counselors to set psychosocial issues on the agenda [30–32]. Apparently, talking about psychosocial topics does not come easy; clients need to be invited e.g., by psychosocial questions. These questions facilitate the process of giving personal meaning to the pros and cons of screening, and are therefore essential during *decision-making support* for clients [15,25].

In daily practice, however, providing *decision-making support* seems to be challenging for several reasons. A significant number of counselors do not fully subscribe to the *decision-making support* function of counseling [18,33,34]. Furthermore, because of a perceived lack of communication skills, many counselors feel incapable of providing *decision-making support* [18]. Midwife counselors in our earlier study, for instance, were more likely to address psychosocial issues by giving psychosocial information and asking rhetorical questions than by using open-ended questions. This might explain the relatively low contribution of clients to the counseling conversation and the largely unmet needs reported by clients regarding decision-support, such as being supported in making a personal decision, and in balancing the pros and cons [15,26,32]. Lastly, appropriate prenatal counseling takes time. This is acknowledged in Dutch healthcare policy by means of a separate fee for prenatal counseling [35]. In daily practice, however, counseling duration appears relatively short, on average 9 min, which is shorter than the allotted, billable time of around 30 min and may hinder a thorough discussion of clients' psychosocial issues and questions [26].

We hypothesize that talking about psychosocial topics does not come easy for clients but relies on prompting from the midwife. Furthermore, we assume that midwives' affective communication, the duration of counseling and midwives' client-directed gaze also help clients to discuss psychosocial topics. As such, gaze can be seen as a nonverbal counseling skill to facilitate decision-making support. The present study aims to examine to what extent psychosocial communication by clients, during prenatal counseling for anomaly screening is related to (1) midwives' psychosocial questions; (2) midwives' affective communication; (3) midwives' client-directed gaze; and (4) the duration of the counseling.

2. Methods

This study is part of the DELIVER study, a multi-center, prospective dynamic cohort study investigating the quality and provision of primary midwifery care in the Netherlands [36]. The current study is part of a series of studies about counseling for prenatal anomaly tests, for which the design was approved by the Institutional Review Board and the Medical Ethical Committee of the VU University Medical Center, Amsterdam, Netherlands. In this series of studies we used different subsets of data from the same group of clients and midwives. Methods of the prenatal counseling for anomaly screening studies have been described in detail elsewhere [15,26] and – with regards to the current study – are briefly summarized here.

2.1. Participants: midwives and clients

For the DELIVER study, twenty midwifery care practices in the Netherlands were purposefully selected to include different-sized practices from all over the country [36]. Twenty midwives from six of these practices also participated in the video-observation study [37]. One practice offered prenatal counseling within a separate consultation, the others as part of the initial intake visit [26]. Clients of the current study were recruited between June 2010 and May 2011 and asked to participate in the study by the practice assistant or the midwife. Eligible clients were: (a) clients new to counseling about prenatal anomaly tests for the current pregnancy; (b) aged 18 years or older; and (c) able to read Dutch or English. Background characteristics of non-responders were recorded by the practice assistant directly after their refusal. The clients who agreed to participate, were asked to complete a questionnaire booklet before and again just after their visit to the midwife [15]. Since client-directed gaze is interpreted differently among cultures we decided to only include native, Dutch clients in the current study [38,39].

2.2. Measures

The pre-visit self-administered questionnaire contained items on background characteristics such as parity, age, ethnicity and familiarity with the midwife.

2.2.1. Psychosocial communication and affective communication

The prenatal counseling visit was video recorded with an unmanned camera, positioned to show the midwives' full face and clients from behind or from the side [37]. We collected a total of 269 videotaped counseling consultations. From these, we excluded videotapes that (1) could not be coded for client-directed gaze, because midwives' faces were not visible enough ($n = 16$); (2) did not match with the data of the pre- and post-visit questionnaire, and/or (3) were of clients from non-Dutch origin ($n = 69$), leaving 184 videotaped prenatal counseling consultations for our analyses. These 184 consultations represent 68% (184/269) of the videotapes [26,37]. Twenty midwives from six practices participated in this