Title: Midwives' experiences of caring for women's emotional and mental well-being during pregnancy

Short running title: Midwives and emotional well-being in pregnancy

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Abstract

Aims and Objectives

To explore midwives' experiences of caring for women's emotional and mental well-being during pregnancy.

Background

Pregnancy and childbirth is one of the most life changing transitions a woman can encounter and therefore approximately 15-25% of women will experience a perinatal mental health problem. Providing psychological support to mothers by midwives is acknowledged internationally. The 2016 Irish National Maternity Strategy identifies midwives as being ideally placed to assess women's emotional needs. The research revealed a paucity of qualitative research from an Irish context in this area, therefore this study addressed this gap in the literature.

Design

Qualitative descriptive design.

Methods

Semi-structured interviews were conducted with a purposive sample of 10 midwives' recruited from the Irish midwifery e-group. Data were analysed using Burnard (1991) thematic content analysis. Transcripts were coded, and meanings were formulated to reflect significant statements, which were categorised. Categories then evolved into subthemes and eventually three themes emerged using the COREQ checklist.

Results

Three salient themes emerged from the data: 'awareness of Perinatal Mental Health', 'discussing emotional well-being', and 'the woman has something to divulge'. The themes convey the midwife's awareness, recognition and perceptions of mental well-being during pregnancy. How midwives discuss and assess emotional well-being, the observational skills they utilise, and what they perceive as the barriers and facilitators to discussing mental well-being were all identified.

Conclusions

Midwives reported an awareness and acceptance that women's emotional health was as important as their physical health. Midwives utilised every antenatal opportunity to raise awareness about perinatal mental health, whilst also identifying key challenges in getting women to talk.

Relevance to Clinical Practice

Care pathways for assessing and identifying Perinatal Mental Health issues should be available in all maternity services. More support for midwives is required to debrief, which would assist them in supporting women's emotional well-being.

Keywords: Midwives, mental health, emotional well-being, women, pregnancy, qualitative, Ireland

1. Introduction and Background

Pregnancy is a significant life changing transition which brings joy and fulfilment to many women; however, it can also cause stress and anxiety as women face new challenges (Leahy-Warren, 2007; Howard et al., 2014). It signifies a time when women are susceptible to developing emotional problems (McCauley et al., 2011). For women with a history of mental illness pre-pregnancy, the inherent biological changes in perinatal hormones can have a significant impact on mental illness in the pregnant woman, making women more vulnerable to depression and psychosis (Gilbert et al., 2015). Perinatal Mental Health (PMH) refers to the mental health and well-being of women during pregnancy, and up until the first-year post pregnancy (the perinatal period) (Austin et al., 2008). Perinatal mental health problem is the term used to describe a range of mental health disorders encountered by women during the perinatal period (Austin et al., 2008). It is estimated that between 15-25% of women will experience a mental health problem during this period and may be as a new problem or the recurrence of a pre-existing issue (National Institute for Health and Care Excellence (NICE) 2014, updated 2020). Appropriate care in a timely manner is essential to ensure women with PMH problems have the best outcome (Carroll et al., 2018).

Midwives are uniquely positioned to address the mental health needs of pregnant women due to the frequent contact expectant mothers will have with midwives, allowing a trusting relationship to be built (Sanger et al., 2015; Madden et al., 2018). However, working within a multidisciplinary team to include mental health services has been found to have better outcomes for women (Sanger et al., 2015; Madden et al., 2018). Despite the frequent contact pregnant women have with health professionals, identification of mental health problems is thought to be as low as 50% (NICE, 2014). Midwives are experts in taking a holistic approach to care (Crabbe & Hemingway, 2014), however, normal emotional changes which occur during pregnancy may mask signs of depression or altered mental health (Scottish Intercollegiate Guidelines Network (SIGN), 2012).

Psychological healthcare is now considered a global health issue. The World Health Organisation promotes mental health and well-being through inclusion in their sustainable development goals (World Health Organisation (WHO), 2019), however, there is currently no international agreement on PMH screening (Austin, 2014). Despite this, international guidelines such as NICE (2014, updated 2020) recommend that women be asked about their emotional and mental well-being at the booking appointment, routine antenatal visits, and in the early postnatal period. All maternity staff should have basic training in the identification of risks and referral of mental health problems in pregnancy, and there should be close co-operation between the maternity services and specialist PMH services (Cantwell & Mahmood, 2011). From an Irish context, the Department of Health (DOH) (2016) National Maternity Strategy 2016-2026 recommends that women at risk of PMH problems need to be identified, and plans must be put in place whilst incorporating a multidisciplinary approach.

The Irish National Maternity Strategy implementation plan (Health Service Executive, 2017) aims to expand PMH services throughout the country, by having a clinical midwife specialist in PMH in each hospital setting, with support from multidisciplinary and psychiatric services. The implementation plan also includes the development of a “hub and spoke” system, whereby the hospital in each maternity network with the highest number of births would be the “hub” and have a specialist PMH service with multidisciplinary staff, led by a consultant in perinatal psychiatry. The remaining hospitals in the network will be the “spoke” which means the liaison psychiatry service will continue to provide input in maternity services and will be linked to the “hub” hospital in their particular network (DOH, 2017).

This model of care will set out a mental health referral pathway within the maternity services, ensuring that every pregnant woman is screened for any mental health problems by a midwife at their booking appointment (Shannon, 2019). To date mental health midwife specialists have been recruited for each of the Irish maternity hospitals. These specialist mental health midwives will work with midwives across the maternity services to raise awareness of mental health problems, with the goal of increasing identification and response (Shannon, 2019). Following assessment at booking, women who are suspected of having a mental illness or those with a history of mental illness will be referred to the PMH services. Women with milder problems will be seen by the mental health midwife and those with severe problems by the specialist PMH team (Shannon, 2019).

The advancement of PMH services in the Republic of Ireland (ROI) will be welcomed in light of the 2018 report, Mothers and Babies Reducing Risk through Audits and Confidential Enquiries, United Kingdom (MBRACE –UK) on maternal deaths, which cited suicide as the second largest cause of direct maternal deaths which occur during pregnancy or within 42 days after birth, and the leading cause of direct maternal deaths within a year after pregnancy (Knight et al., 2019). PMH problems are associated with significant morbidity and may adversely affect the mother, infant and the whole family if not identified and the appropriate treatments and support provided (Noonan et al., 2018), and can lead to adverse birth outcomes (Liou et al., 2016).

Undiagnosed and untreated mental health difficulties can have serious consequences including poor antenatal clinic attendance, smoking, alcohol consumption, substance abuse, gestational diabetes and hypertension. Low birth weight, prematurity and poor fetal development may also occur (Stein et al., 2014; Lenze, 2017; Newman et al., 2017). Similarly, maternal depression during pregnancy can cause adverse effects to the developing fetus (Goodman, 2019). The foundations of a child's future mental health can be significantly influenced by the child's earliest environments, including in utero, when rapid brain growth is occurring, and development is particularly open to and affected by the existing environment (Lyons-Ruth et al., 2017; Asis-Cruz et al., 2020). The early identification and effective treatment of perinatal depression, can have a significant impact on maternal mental health and prevent child, adolescent, and adult mental health difficulties (Goodman, 2019).

PMH problems also have wider implications for the maternity services and the economy. Complications including low birth weight, growth retardation and prematurity (Stein et al., 2014; Liou et al., 2016), can place maternity services under increased pressure, as these infants may require specialised postnatal care (NICE 2014, updated 2020). While there continues to be no available figures to date on the economic cost of PMH problems in the ROI, international research, such as that conducted in the UK, reported the long-term cost to society stands at £8.1 billion pounds for each year of births (Bauer et al., 2014).

Studies discussing PMH from the midwives' perspective, found midwives are well placed to assess antenatal mental well-being (McNeill et al., 2012). Various approaches to assess mental well-being were adopted, however no consistent and standardised approach exists (Barber et al., 2017). There was uncertainty about how to support, assess and refer women with PMH needs (Madden et al., 2018). Across international studies, barriers to assessing mental well-being were identified. These included, time constraints (Higgins et al., 2017), inadequate skills (McCauley et al., 2011; Carroll et al., 2018), lack of knowledge and confidence to support women (Hauck et al., 2015; Viveiros et al., 2018), lack of supports for staff (Reilly et al., 2014), and the need for more education/training (Rollans et al., 2013; Reilly et al., 2014; Fontein-Kuipers et al., 2015; Carroll et al., 2018). Midwives also reported being uncomfortable with structured questions, felt they were blunt, would alter terminology to what they felt was appropriate, and felt they needed to justify asking questions around emotional health (Rollans et al., 2013; Williams et al., 2016). Structured care pathways, specialist midwives, and perinatal psychiatrists were recommendations identified to enhance perinatal mental healthcare (Higgins et al., 2017).

In the ROI, midwives are involved in the provision of care to all pregnant women in the antenatal, labour and postnatal period. Therefore, it is important they possess the necessary knowledge and skills to care for vulnerable women (McCauley et al., 2011). For midwives to provide a complete package of antenatal care, incorporating emotional and mental well-being, efforts need to focus on promoting well-being, changing intentions to screen, to support women in distress and to collaborate with other healthcare professionals (Fontein-Kuipers et al., 2015). The NICE guidelines (2014, updated 2020) advocate the use of two depression screening questions (Whooley questions) as well as two questions to explore anxiety, for all women on booking, at routine

antenatal visits, and early in the postnatal period, (Table 1). Higgins et al., (2017) conducted a mixed methods study using surveys and analysis of policies and guidelines of practices, policies, and education needs of midwives and nurses within maternity and primary care services in the ROI. Despite the recommendations from the NICE guidelines, Higgins et al., (2017) found that of the 458 midwives who completed the survey, only 15.4 % reported using a mental health screening tool to assess for mental health concerns. Although the response rate to the survey was low (27.7%) and the location of the study undisclosed, this finding, along with the lack of national guidelines on how midwives should best assess women's emotional and mental well-being in the ROI warrants further research.

Internationally there is a paucity of qualitative research exploring midwives' perceptions and experiences of caring for women's emotional and mental well-being in the antenatal period, and no qualitative studies from the ROI were identified. Given that the Irish maternity strategy has led to the expansion of emotional and mental healthcare for women in the ROI, it is timely that midwives' perceptions and experiences of providing emotional and mental healthcare are explored from an Irish context in the form of a qualitative study, to gain deeper insight, which may ensure educational and professional development opportunities are tailored to the needs of midwives in the future.

2. Methods

2.1 Aim

The aim of the study was to describe midwives' experiences and perceptions of caring for women's emotional and mental well-being during pregnancy.

2.2 Design and rationale for design

A qualitative, descriptive design was employed as it facilitates a comprehensive account of phenomena that both the researchers and participant midwives would agree is accurate (Graneheim & Lundman, 2004). Tong et al., (2017) Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups (Supplementary File 1), was used to report on this study.

2.3 Ethics

Prior to data collection, ethical approval was sought and granted by the local Clinical Research Ethics Committee REF: ECM4 (n) 10/04/18.

2.4 Sample Recruitment

A purposive sample of 10 midwives were recruited. Participants were recruited by posting a participant information leaflet on the Irish midwifery e-group forum, inviting midwives to participate. Midwives who met the inclusion criteria of employment in clinical practice, who spoke English, and who expressed an interest in taking part contacted the researcher via email. All midwives recruited were working in clinical practice. Of the ten midwives recruited, only two were members of the Irish midwifery e-group. The remaining eight midwives were recruited to the study from posters displayed in their clinical settings, by members of the Irish midwifery e-group. A sample size of n=10 midwives was chosen as data analysis occurred after completion of each interview and redundancy, rather than data saturation was considered in the process of data collection and informed the continuing selection of participants for interview.

2.5 Data collection

Data were collected using semi-structured, face-to-face interviews, which were audio recorded. None of the midwives interviewed were known to the researcher. Before commencement of the interview the researcher asked each participant to read an informed consent form, the researcher answered any queries, and if the participant was happy to proceed a consent form was signed. An interview schedule comprising of open questions and generated from the literature was employed. As participants were recruited online, interviews took place throughout the ROI, in locations convenient to the participant, away from the working area, and were conducted when the participants were off duty. The length of interviews ranged from 30-40 minutes. Interviews were transcribed verbatim by the researcher, while data collection was on-going. Redundancy, rather than data saturation was considered in the process of data collection and informed the continuing selection of participants for interview. Redundancy is considered by Cleary et al., (2014) as a preferable concept as it addresses the adequacy and appropriateness of qualitative descriptive analysis, whereas data saturation is more appropriate in theory development. Every effort was made to enhance rigor by being open and transparent in all stages of the research process. The first and last authors checked the development of the themes independently and a reflective diary was maintained by the first author during the course of data collection and analyses.

2.6 Data analysis

Once the data was transcribed it was anonymised and cleaned. Data were analysed using Burnard (1991) thematic content analysis. Transcripts were coded, and meanings were formulated to reflect significant statements, which were categorised. Categories then evolved into subthemes and eventually three themes emerged. A rich and vigorous presentation of the findings together with appropriate quotations also enhances transferability (Graneheim & Lundman, 2004).

3. Results

Of the ten midwives that agreed to take part, 9 participants worked in the public sector and 1 in the private sector. Two of the participants who worked in the public sector, also worked as self-employed community midwives. All participants were Irish, female, educated to degree level, and with a wide variety of ages and experience. Half the participants had more than 11 years' experience. All participants, except one, worked with antenatal women at the time data was being collected. Five maternity services and one GP practice in the ROI were represented. Following analysis of the data, three major themes with seven sub-themes emerged (Table 2).

Table 2. – Subthemes and Themes

3.1 *Midwives Awareness of Perinatal Mental Health*

The first theme was the midwives' awareness of perinatal mental health and it had three subthemes 'not just the physical needs of the mother but also the emotional needs', 'antenatal contact' and 'don't want to talk about it'.

Recognition that the emotional and physical well-being of pregnant women were of equal importance was demonstrated by participants with reports of increased prioritisation of PMH.

> *"…we have developed over the years an acute sense of not just the physical needs of the mother but also the emotional needs of the mother…"* [Bridget].

Participants reported the increasing prioritisation of being aware of PMH.

> *"…I think perinatal mental health is big, and I think it's going to become bigger. There's a lot of women out there struggling with their mental health…"* [Michelle].
>
> *"…were also more focused on the emotional impact of pregnancy and their experience…"* [Lucy].

Furthermore, one participant suggested psychological well-being was priority above all else.

> *"… to have a good outcome, their emotional well-being needs to be, and psychological well-being needs to [pause] be, first and foremost be paramount…"* [Siobhan].

It was evident that participants not only cared for women's physical needs but also their emotional needs. Participants with greater clinical and practical experience had more confidence in their ability to deal with the emotional needs of pregnant women.

> *"…When you are a newly qualified midwife you are so focused on keeping the woman and the baby alive that you kind of you know and the perinatal mental health now as I am that bit older and more mature I can see that that is part of that but I suppose as a new midwife I didn't really see the benefit of it…"* [Claire].

Participants referred to the MBRACE-UK (2017) reporting on the risks of suicide and research as having raised awareness of the importance of discussing emotional well-being.

> *"… I think because perinatal mental health has been in you know the media it's been in you know I suppose like you know the MBRACE and all it has been highlighted I suppose to us as healthcare professionals you know…"* [Claire].

The increasing influence of research evidence in informing practice was also evident.

> *"…Just the research and all that so many women are affected by it…"* [Naomi].

The serious adverse outcomes for mothers and infants was also deemed influential in raising awareness.

"…you know with the MBRACE you know that suicide is one of the highest causes of maternal mortality so that kind of really stuck with me as well and I was like okay this is something that we really need to be serious about…" [Claire].

Participants' awareness of caring for women's emotional as well as physical needs was evident as they reported discussing emotional health regularly throughout the pregnancy at opportunities such as antenatal visits.

"I think the focus was on physically minding the women, but I think we're moving away from that. We're physically minding them, but we're also more focused on the emotional impact of pregnancy and their experience" [Michelle].

Each antenatal contact between participant midwives and women were utilised to discuss and raise awareness around emotional and mental well-being. The initial booking appointment was described as the main opportunity for assessment. However, at the antenatal visits throughout the pregnancy, participant midwives also asked women about their emotional and mental well-being. Rather than using formal structures, such as screening tools, participants took quite a relaxed approach with women.

"…You'd always ask you know when they come in first, 'how are you today?' before I'd even open the chart…" [Alice].

Using open questioning and language such as 'feel' were words used by participants to inquire about well- being.

"…How do you feel about the pregnancy?" [Bridget].

"…How are you feeling? How is this pregnancy been for you? How are you feeling at the moment is there any issues that arises?" [Siobhan].

In contrast, two of the participants felt that emotional health was not revisited or prioritised after the booking appointment.

"…from my experience it's not addressed again no. Unless they come in and they're unwell and something happens and it's acute…" [Michelle].

Although they both felt that emotional health in pregnancy and the midwives' role in emotional well-being was something that should be examined further.

"…that's probably an area identified that maybe it should be looked at a bit closer throughout the rest of the antenatal period, is there something that we can do you know, even just discuss you know how are you looking after your mental health…" [Lisa].

Antenatal classes were also used by participants to raise awareness and highlighted available support services.

"… We'd talk to them after the class, were they ok and we'd tell them about "nurture"

we'd tell them about the possibility of depression happening during pregnancy as well as postnatal depression…" [Linda].

It was seen as an opportune time to get partners involved as they were considered to know the women the best and would be best placed to notice any changes.

"…even to tell the partners when they're at the antenatal visits or at the classes that you know them better than anyone, and you could see a change in their attitude or how they're feeling so to be alert, to get help…" [Linda].

However, one participant disagreed and felt that antenatal classes focused mostly on postnatal depression.

"…we do a bit of an information session in that class about your mental health but its more so focused I suppose about postnatal depression…" [Lisa].

One thing which participants discussed and collectively agreed on was the challenges they experienced in getting women to talk.

"…*Not everybody is ready to talk to somebody because I think its stigma as well…"* [Michelle].

The participants who tried to engage in a discussion on mental well-being encountered some challenges. They felt pregnant women were hesitant in discussing their emotional and/or mental health.

"…I think people are a little more tuned in. You do your best to make sure people are aware. But then, a lot of people don't want to talk about it…" [Linda].

Stigma around mental health was also seen as a factor for women not talking.

"… there is a stigma I suppose and the stigma that I mean is that they know there's mental health issues and they don't want to talk about it, or we don't want there to be a problem" [Siobhan].

Whilst participants reported that women had a fear and misunderstanding about mental well-being, it appears that it is not just the pregnant women that do not want to talk about emotional health. Statements made by the participant midwives demonstrate similar reluctance.

"If someone has high blood pressure or diabetes, they take medication and will say so. When it comes to mental health, none of us like to advertise that our mental health isn't great" [Linda].

The quotes below illustrate how participants were concerned as to how they would be viewed if they disclosed a mental health problem:

"… I know as a midwife if I had a perinatal mental health issue I wouldn't like to go in there because I would be like oh, they all know now" [Naomi].

"…we have a counsellor within the hospital but God if we are seeing to be going in to use her facility it doesn't look great on your name" [Bridget].

To combat the fear and concerns participants felt women experienced, they used a range of approaches in discussing emotional well-being and asking questions.

3.2 *Discussing emotional and mental well-being*

The second theme to emerge was discussing emotional and mental well-being – with the subthemes 'it's how you ask the questions' and 'observing the woman's demeanour'. Participants reported discussing emotional and mental well-being with women during pregnancy. The booking appointment had a more detailed assessment with participants taking a full past and current history as illustrated in this quote:

"…it would be a little bit more detailed in the booking clinic. Because you are looking for history while at the other clinics you have that history… so you are only building from that" [Bridget].

Use of the Whooley questions was described by some participants as a useful guide for identifying which women need referral to support services at the booking appointment as illustrated below:

"…before we used to just take past history of mental health so we would ask them in the past do you have any history of anxiety depression postnatal depression psychosis or any other mental health problems or illnesses, but now we also complete this it's kind of like a referral pathway kind of a form and what we ask them is we ask them the three Whooley questions… [Lisa].

Whilst other participants used past and current history, including family history with no screening tool.

"…we ask them how they feel about their pregnancy. We would ask them had they any history in the past of depression, but no there's no antenatal scoring tool…to check if they are particularly predisposed to antenatal depression…" [Catherine].

Participants used a variety of approaches both at the booking assessment and the antenatal visits to get women to talk about their well-being. Developing a rapport with the woman was deemed essential in being able to ask the more sensitive questions.

"… you can't just come out and blurt these questions out to her, you have to talk and see how the mother is and kind of develop a rapport with her and then indirectly start asking these questions…" [Bridget].

Participants were conscious that they needed to lead into the sensitive questions slowly.

"…when you meet somebody for the first time you are like how are you doing? how is your pregnancy going? and often they might start with oh I am feeling tired or you know I was very sick and that would nearly lead in to a question you know how are you feeling then about the pregnancy [pause], and you know when you build up a relationship with somebody…" [Claire].

Participants used various approaches in discussing well-being. Humour and general conversation were used to relax women.

"…I think ordinary chit chat is the best way to get women to talk to you" [Claire].

Altering the questions so that it didn't appear like a tick box exercise was seen as important.

"You ask the questions you include what is in the questions but you don't make it like a check list question" [Lisa].

One Participant described how she used case studies to get them thinking about what advice they would give to women.

"…I would give case studies this is Mary and you know little things like that and they might see oh I can identify there with Mary…" [Naomi].

The various approaches used were important to obtain information from women as participants felt it was all about how you asked the questions. Open-ended questions elicited more information as closed questions would only achieve yes/no answers.

"…it's down to the fact of how you ask the question, if you ask a question with a yes and no answer you are not going to get information, but if you ask the mother like what do you think? or how do you feel? you might get a more open information…" [Bridget].

The volume of information received was dependent on how you asked women the questions.

Half the participants reported observing a woman's demeanour or changes of personality at the antenatal visits as part of their assessments of well-being.

"…you might have used your intuition a little bit to see, to feel that there might be something not right, there's a different, she's a different demeanour to the last visit, or there's something different about her" [Catherine].

"…just by looking at them, you'd know their general demeanour when they come in, whether they're happy about the pregnancy" [Alice].

Participants reported observing women's' body language.

"…see them looking down towards the ground, or maybe the partner is there and I can see he's watching her and I can see by her shoulder movements or if she looks to be upset in herself. To me that's saying there's something going on somewhere" [Linda].

How they spoke about the baby were also seen as important cues to how the woman might be

coping.

> *"…now I suppose there is gestures even you know with a woman with her hands on her stomach you know that kind of way, or even the way they refer to their baby as well. I suppose women who I might think were at risk were I suppose women who don't talk about the baby"* [Claire].

A poor support network was seen as a risk factor for the development of emotional issues therefore participants observed what social supports were available to women by who accompanied them to antenatal visits.

> *"…if they have a partner or someone with them that's supportive when they come to their visit. If they've someone with that's supportive as well, that tells you a lot about them as well"* [Alice].

One participant worked in a hospital setting and as a home birth midwife. As a homebirth midwife she had the opportunity to observe women in their own environment.

> *"…I always do one visit at least antenatally in a woman's home…you see her in her own environment I suppose you know which lets you know things without asking any questions. I suppose you see how their house is you know I suppose if you walked in to a house and it is absolutely filthy you know and you are wondering is this woman being supported enough…"* [Claire].

Claire appeared to make judgements around how a woman is coping based on her level of social supports and living conditions. Although participants used a variety of approaches and observations in discussing emotional health, they also outlined many challenges and barriers in getting women to divulge information.

3.3 *The woman has something to divulge*

The third theme to emerge 'the woman has something to divulge' had two subthemes 'the environment' and 'more support for staff'. Participants discussed many factors which affected their ability to get women to disclose concerns to them. There were many environmental factors including time, rushed appointments, staffing levels, which influenced participants' ability to encourage women to disclose information.

> *"…There isn't enough staff on the ward. Am you don't get to give them the time that they deserve, to listen to them I suppose…"* [Lucy].
>
> *"…The wards are very busy and sometimes if you need, especially if someone's emotionally upset, you'd need time to sit down and talk to them…"* [Alice].

Due to time constraints participants felt they were unable to give women the time they deserve

and described a hesitance to discuss mental health due to work pressures.

> *"…I am saying this for me personally now but if you had a thousand other things to do and you were under pressure you know are you going to turn around and say let's talk about your mental health and you could be there for a half an hour with the woman talking about mental health…"* [Lisa].

Participants felt that the women themselves could see the challenges midwives encounter and therefore may be hesitant to talk.

> *"…they can see how busy it is, they know that they are not going to get time either to talk about it because they know the midwives are busy…"* [Naomi].

A rushed and tense environment was considered not conducive in getting women to talk freely about concerns.

> *"…if someone is tensed and in a rushed environment, and they know everyone is under pressure, they're not going to come out with what they want to say. They need someone at ease and someone that has time to listen to them"* [Linda].

Continuity of care was viewed as essential to building relationships and developing trust in order to assist women in disclosing their concerns.

> *"…continuity of care I think is so important for building relationships and I think you know people talking openly about mental health really it has to be a relationship and a continuity of care"* [Claire].

Participants felt that continuity of care was deficient in the hospital setting.

> *"…maybe not enough in the Irish health system, in the maternity hospital, is continuity of care, so they are seeing the same person over and over again, you know that trust will definitely build and familiarity you know continuity of care is so, so important and it is something that we probably need to look at…"* [Siobhan].

Half of the participants interviewed worked in the community, midwifery led clinics or GP practice. They reported good continuity of care in comparison to the hospital setting and this was considered an advantage as they could develop a relationship with the woman and really get to know her.

> *"…In the community setting there's no kind of capped time on appointments, you see the women regularly, if something was said in the last appointment you could follow it up at the next appointment, and I guess its midwifery led clinics where you develop a relationship with them over time and give them more time at their appointments they also tend to disclose more…"* [Catherine].

Participants therefore recommended that continuity of care should be promoted by expanding

and further developing midwifery led clinics or case loading/team midwifery.

All of the participants interviewed felt that more supports, education and training were required to support midwives. Of the ten participants, five worked in a hospital setting where a new PMH team and screening tools have been established, whilst the other five worked in smaller units which were linked with the general psychiatric services. The participants working in the smaller units felt a lack of support and clarity about how to support women.

> *"…there's lack of a care pathway…you know the women are struggling, they know they're struggling. You don't know where to send them…"* [Michelle].

Participants who work in units where extra supports are in place stated that they felt more confident in discussing emotional well-being with women.

> *"…since this new perinatal mental health team have started to come up, I feel that bit more confident in myself…"* [Lisa].

This extra confidence related to the fact that they now have a PMH team in place and have somewhere to refer women too if they needed to talk.

> *"…what they are doing is they are asking the Whooley questions and if they get three of them then they are referred on the perinatal mental health team…"* [Naomi].

In fact, participants illustrated in the below quotes how their role has evolved into identifying which women need referral to specialist supports. Participants suggested that if women needed to talk, they were referred onto specialist services.

> *"…basically, I feel our role is now is there is an issue to be able to direct them on to a specialist…"* [Bridget].
>
> *"… I just speak to them and see do they want to speak to anyone…"* [Lucy].

Participants outlined how more education and training was needed for midwives to approach a discussion around mental health with women.

> *"…if midwives were given more training or a bit more teaching or a bit more of an understanding about mental health you know they might be able to approach it differently…"* [Lisa].
>
> *"…unless we've got training a lot of people won't go there…"* [Michelle].

Three of the participants reported completing additional postgraduate training in PMH and felt this had impacted their understanding and gave them tools to assist and guide women.

> *"…I did a level 9 module supporting perinatal mental health in University of Limerick (UL) and that helped an awful lot as well. Just even to understand where the help was, what was the pathway the woman should be taking, that we should be guiding her towards as well…"* [Naomi].

In addition to extra training and structured pathways, staff need other supports in the form of debriefing as well.

> *"…I feel that there isn't enough support for the staff because you know do we want to be taking on problems of other people, you know, it's hard going sometimes within the hospital field…"* [Bridget].

Participants felt that the hospital setting can be quite stressful and that staff's emotional well-being also needs to be endorsed in order for midwives to give empathy and provide emotional care to women.

> *"…I suppose yeah debriefings I suppose for staff, but I think a lot of staff are really just from seeing them, a lot are very much under pressure at the moment and I think their mental health might be suffering a little bit…"* [Claire].
>
> *"…for us as midwives to give enough of that support I suppose we ourselves probably need to get better emotional support…"* [Siobhan].

Consequently, the participants have suggested that in order to get women to divulge concerns to midwives, the staff themselves need training, education and support to have the confidence to discuss any concerns with women.

4. Discussion

Following thematic analysis of the interviews with ten midwives, three main themes emerged: awareness of perinatal mental health, discussing emotional well-being, and the woman has something to divulge. Participants identified the recognition of the equality of emotional and physical health and their use of a variety of approaches at antenatal contacts to raise awareness about emotional and mental well-being. They spoke about the challenges they encountered such as lack of time, continuity of care, education/training, and clear pathways for assessment and referral. Lack of debriefing support for midwives was also highlighted. Four of the five participants involved in teaching antenatal education used the antenatal classes as a platform for raising awareness about emotional and mental well-being. A new finding to emerge was that participants' themselves would be reluctant to discuss and disclose concerns about their own mental well-being, as narrated by the participants.

In the present study participants reported that the emotional needs of pregnant women were as significant as their physical needs and thus included emotional well-being in their holistic assessments. Furthermore, they described using every antenatal opportunity to explore and assess, which predominantly commenced at the booking appointment. The literature also found

that midwives recognised that they had an integral role in the provision of perinatal mental healthcare (Hauck et al., 2015; Noonan et al., 2017). Five of the participants indicated undertaking this assessment by initially enquiring about their current emotional well-being and also moving on to include past, personal and family history. Whilst the remaining participants reported using a combination of enquiry and also a screening tool such as the Whooley questions. The importance of promoting and supporting pregnant women's mental health, was attributed to the MBRACE reports and from research. Previous literature supports these findings as research also reports that midwives use a combination of approaches, including screening tools at booking whilst other midwives use screening tools or clinical interviews (Fontein-Kuipers et al., 2015; Barber et al., 2017).

This study offers greater insight into how midwives support women's well-being throughout pregnancy and not just at the booking appointment. Midwives were aware of the importance of ongoing assessment as women's circumstances can change throughout their pregnancy, which in turn may affect their well-being. Participants reported using informal structures and open language throughout the pregnancy, such as; How are you feeling? How has the pregnancy been for you? They indicated that these open questions in a relaxed manner would help women to open a conversation around concerns rather than a structured format. On the other hand, previous research suggests emotional well-being assessments by midwives predominantly occurs at the booking appointment only (Rollans et al., 2013; McGlone et al., 2016).

Five of the participants were involved in facilitating antenatal classes, and all except one, described using them as a platform for raising awareness about mental health in pregnancy, discussing what is normal and when to seek help. The classes were seen as an opportunity to raise awareness of emotional/mental health issues in pregnancy and particularly for partners who were best placed to observe for signs of stress. This finding is juxtaposed to previous research from the woman's perspective which found a lack of discussion and a veil of secrecy around mental health in antenatal classes, which they attributed to stigma (Higgins et al., 2016).

Participants reported that when trying to engage women in conversation about emotional health there was a reluctance to talk. Indeed, some participants revealed that women were reluctant to engage in conversation which was attributed to fear, misunderstanding and stigma. These findings are supported by research conducted with pregnant women who identified stigma as a barrier and found women were not comfortable talking to healthcare professionals about their

emotional well-being (Jarrett, 2016). However, an unexpected finding which emerged was that some of the participant midwives also stated that they themselves would not want to discuss a mental health concern. This is an issue that may require further investigation to explore greater understanding.

A number of participants reported that they themselves would not seek help if they had a mental health difficulty, as they felt it would not look good on their reputation and would not want colleagues to know, thus suggesting that they may be stigmatised. This is an important finding which illuminates previous quantitative research findings where midwives reported that documenting mental health issues may stigmatise women (Higgins et al., 2017). The finding that midwives may be hesitant in engaging and documenting a pregnant woman's mental health difficulties may be connected to their own mental well-being and thus requires further exploration and may even be associated with their reluctance to discuss mental health with women.

Participants used various approaches to enquire about emotional and mental wellbeing from screening instruments, to enquiring about current and past history to assess well-being. They reported using various techniques to ensure women were comfortable with the questions. They reported that 'how you ask the questions' was key to making women feel comfortable to elicit an opening up of emotions. Developing a rapport with the woman was deemed essential, as participants felt that you can't just blurt out the questions, you need to get to know the woman first, therefore asking questions at the end of the visit was deemed more appropriate.

Previous research also revealed the importance of getting to know women first, with midwives having a general conversation about the pregnancy in a relaxed manner before delving further into the sensitive questions (Rollans et al., 2013). Indeed, other studies also found that midwives reported asking the Whooley questions directly seemed blunt and felt they needed to justify the questions to the women before asking (McGlone et al., 2016; William et al., 2016). Several midwives did not find a prescribed format of questions helpful as they already enquired about emotional well-being, whilst other midwives felt that the questions reassured women that midwives were interested in their well-being (Williams et al., 2016). This finding was also evident in this study as midwives enquired about mental health regardless of using screening tools.

Similar to other studies, the current study shows that participants reported changing the wording

of the questions when using a screening instrument to ensure the use of everyday language and terminology that women would understand, and that would be sensitive to their emotions. They indicated that this was important so that it did not appear to women like they were participating in a tick-box exercise (Rollans et al., 2013; Jarrett 2014). A study by Schmied et al., (2020) to describe midwives' experiences of psychological assessment using two different screening tools in Australia found midwives welcomed a form of structured assessment, as they felt it offered women an opportunity to disclose concerns. The study did however find that midwives recognised the importance of building a rapport with the woman before asking questions, and often altered the wording of the questions to ensure the woman understood what was being asked (Schmied et al., 2020).

Midwives also reported using open-ended questions which they reported would elicit more information. One participant gave an example of using case studies to get women thinking about what they would do if in a similar situation, whilst another participant used humour to relax the atmosphere. Fontein-Kuipers et al., (2015) also found midwives using a variety of approaches which is essential as the woman's individual needs and situation should determine the approach required.

Participants outlined how they observed for changes in a woman's demeanour, body language and personality as indicators of changes in emotional health. A lack of social supports was seen as a risk factor for developing poor emotional health. A participant who worked in the community used her home visits to observe women's living conditions and was cognisant of socio-demographic factors in assessing emotional well-being. Previous research also found student midwives made assumptions about women, based on living conditions and social circumstances (Jarrett, 2014). However, the MBRACK-UK (2017) report states that many of the women who died by suicide had good social supports, were middle class and in employment (Knight et al., 2017). A qualitative study of student midwives' attitudes in the care of women with mental health problem by Jarrett (2014) found student midwives assessed women's demeanour and body language which were also reflected in this study albeit with qualified midwives. Midwives spoke of their use of intuition, to observe if something was not right, as well as experiences from personal life. McGlone et al., (2016) found that midwives relied on previous experience and use of intuition when discussing well-being. Schmied et al., (2020) described the use of clinical judgement as being very important, for example, if the woman scored in the normal range on a screening tool but seemed upset or was crying, midwives considered this a red flag for referral

(Schmied et al., 2020). Furthermore, participants in this study stated how clinical, personal, and life experience had increased their confidence in discussing and identifying women's well-being.

Participants reported many factors which influenced their ability to discuss emotional well-being with pregnant women. Time was considered a major issue mainly due to increased workloads and inadequate staffing levels. Participants reported that to discuss emotional well-being with women they would need extra time to address any concerns disclosed. Participants felt that women were reluctant to 'divulge' emotional issues as they felt women could see how busy midwives were and the lack of time prevented them from building trust and a rapport with the women.

Virtually all of the literature discussing emotional and mental well-being documented inadequate time as a major challenge to discussing and assessing emotional well-being. Time made screening for well-being and identifying risks a challenge at the booking appointment because of overlaps with the physical examination (Rollans et al. 2013; Higgins et al., 2018). Insufficient time also made it challenging for midwives to build a relationship and trust with women, which were seen as essential to ask probing and sensitive questions (Williams et al., 2016) Midwives in a study conducted by McGlone et al., (2016) to explore their experiences of asking the Whooley questions found they did not want to probe too much when asking the Whooley questions in case the woman answered yes to any of the questions. Similarly, participants in the current study also indicated how they hoped women would not 'divulge' concerns due to time constraints. From the women's perspective Jarrett (2014) reported that antenatal appointments were rushed and Higgins et al., (2016) suggested that women perceived midwives to be too busy to engage in conversation.

The current study deemed continuity of care very important in developing relationships, trust and getting women to talk openly. Participants working in maternity hospital settings reported a lack of continuity of care in their work places but felt better continuity existed in the community and midwifery led clinics. Furthermore, they recommended examining the expansion of midwifery led services. The current literature also found service fragmentation and a lack of continuity of care as being one of the main barriers to integrating perinatal mental healthcare into midwifery practice (Bayrampour et al., 2018; Fenwick et al., 2018). A study by Fenwick et al., (2018) exploring perceived barriers and enablers of implementing a midwifery led counselling intervention found continuity of care to be an enabling factor. Barber et al., (2017) found midwives working in the community setting were better able to identify women's emotional well-

being and attributed this to midwives being in a better position to develop a relationship with the woman due to continuity of care. In fact, not seeing women enough to develop a relationship was identified as a barrier to assessing emotional/mental well-being (Higgins et al., 2017; Higgins et al., 2018).

All of the participants in the current study indicated that more support and further education and training were required. Previous research also identified a requirement for further education and training to enhance confidence and skills in providing PMH to pregnant women (McCauley et al., 2011; Rollans et al., 2013; Reilly et al., 2014; Fontein-Kuiper et al., 2015; Madden et al., 2018). Many studies have demonstrated that educational interventions in combination with the appropriate clinical experience can increase midwives' knowledge and skills required to further develop confidence and competence (Fenwick et al., 2018; Higgins et al., 2016). In 2016, Higgins et al., using a pre/post survey design explored student midwives' experiences of a perinatal mental health module. The study identified that this educational input improved student midwives' knowledge, skills and attitude (Higgins et al., 2016). Interestingly, Fenwick et al., (2018) also found the same with qualified midwives. The study found that a counselling training intervention for midwives' lead to significant improvement in midwives' knowledge, skills and confidence to counsel women (Fenwick et al., 2018). This supports findings from the current study, as participants who completed extra training through continuous professional development and postgraduate courses felt an increased confidence in discussing and assessing emotional health. Five of the participants worked in units where specialist PMH services existed, and reported being more confident. The remaining five participants worked in smaller units whom at the time of this study had no specialist supports, and reported uncertainty about how and where to refer women to if needed, and stated that there was a lack of care pathways and support. Clear referral pathways, policies and guidelines, and pathways of care, such as specialist midwives and perinatal psychiatrists are all recommendations identified in the literature from an Irish context as a result of the national maternity strategy to enhance emotional and mental healthcare in pregnancy (Higgins et al., 2017). Clear care pathways were seen as very important particularly for women without a diagnosis (Madden et al., 2018). It is clear however from the participants interviewed in this study that these recommendations were not implemented in all Irish maternity services at the time the study was conducted.

Participants in the present study spoke about their need for debriefing. The hospital setting was seen to be quite stressful and staff reported being under a lot of pressure. Debriefing for

midwives was deemed to be very important in order for midwives to be able to pass on empathy to women. Mollart et al., (2009) qualitative research from 2005-2006 on the impact of conducting psychological assessments on midwives' emotional health also identified a need for midwives to debrief. Mollart et al., (2009) also found that midwives who accessed clinical supervision, that is a support service with an independent professional to discuss concerns, greatly benefited, and it gave them an opportunity to reflect and become more self-aware. Twelve years later and this Irish study has also found that despite improvements in PMH services with the introduction of PMH midwives/teams, midwives still require debriefing opportunities. To the best of the author's knowledge this is the first Irish study to identify this requirement for midwives working in the antenatal setting.

5. Limitations

To the best of the authors' knowledge this is the first Irish study to explore, in-depth, midwives' experiences and perceptions of caring for women's emotional well-being during pregnancy. Participants self-selected, and it may be that those with a greater interest or experience in caring for women's emotional well-being volunteered. In keeping with qualitative studies, the goal was not statistical representation but a rich understanding of the behaviour and experiences of participants, therefore the findings cannot be generalised to all midwives.

6. Conclusion

This study adds to the existing knowledge with new findings including a reluctance from the participants' themselves to talk about their own mental health which they attributed to stigma. Four of the five participants in this study who were involved in the provision of antenatal classes stated that they would use the classes as a forum for raising awareness of mental health concerns in pregnancy, a finding which requires further exploring. This study recommends more assistance for midwives in the form of clinical support, a process of debriefing with an independent professional, to assist midwives in supporting women. A holistic focus to midwifery education, to ensure care includes emotional as well as physical well-being, along with continuous professional development opportunities for qualified midwives to update their knowledge should be made available.

Midwives use various approaches to assess antenatal emotional well-being including clinical interviews and screening tools, as well as observing women's demeanour and using their own life experiences. Participants outlined many challenges which hindered their assessments and ability to discuss emotional well-being with women, including inadequate time, lack of continuity of

care, as well as a requirement for care pathways, education, training and debriefing opportunities for midwives. This is in keeping with previous research.

Further research is required to explore how midwives care for women's emotional health, in the form of a large quantitative study, to identify how midwives can be further supported to support women.

7. **Relevance to Clinical Practice**

This study has significant implications for midwifery practice. If midwives are to incorporate PMH within their scope of practice they need care pathways available in all maternity services for assessing and identifying PMH issues. More support for midwives is also required for discussion and debriefing to assist them in supporting women.

What does this paper contribute to the wider global clinical community?

- Albeit a small study, participants were recruited from a number of clinical settings across the ROI, and of those interviewed, nine were providing care to women in the antenatal period. The study identified a need for more support for midwives, to give midwives an opportunity to debrief, in order to be better prepared to support women.
- The findings also identified a need for continued education to enhance confidence, as well as having available care pathways for identification and assessment of PMH issues.

Conflict of Interest

None

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Tables

Table 1 – NICE Guidelines (2014, updated 2020) Whooley Depression identification questions:

During the past month, have you often been bothered by feeling down, depressed or hopeless?
During the past month, have you often been bothered by having little interest or pleasure in doing things?
Also consider asking about anxiety using the 2-item Generalized Anxiety Disorder scale (GAD-2):
Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious or on edge?
Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?

Table 2 – Subthemes and Themes

Theme One – Midwives Awareness of Perinatal Mental Health	Theme Two – Discussing Emotional Well-being	Theme Three – The Woman has Something to Divulge
• Not just the physical needs of the mother but also the emotional needs • Antenatal contact • Don't want to talk about it	• It's how you ask the questions • Observing the woman's demeanour	• The environment • More support for staff