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Diagnostic and preventive measures undertaken by midwives regarding mental health among women and men in the perinatal period – analysis of the results of a multicentre cross-sectional study

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ABSTRACT

Introduction: According to the Regulation of Polish Minister of Health of 16 August 2018 on the organisational standard of perinatal care, it is mandatory for the person providing care to the pregnant and postpartum woman to assess the risk and severity of depressive symptoms (at 11-14 and 33-37 weeks of pregnancy) and to assess the mental state of the postpartum woman, including the risk of postpartum depression.

Material and methods: 297 Polish midwives and 90 midwifery students were surveyed by paper or online questionnaire, and 98 Icelandic midwives and 10 midwifery students were surveyed in the same way. The questionnaire consisted of 32 questions on beliefs about difficulties in coping with antenatal health problems, 20 questions exploring participants' knowledge of depression treatment in relation to the general population and pregnant women separately, and 9 questions on participants' views on the stigma caused by the illness.

Results: 28.8% of the professionally active participants declared to examine each pregnant patient for depression. 75% of all participants strongly agreed that they would like to receive additional teaching on antenatal mental health. About 20% of the respondents conducted a standard screening for depression among their pregnant patients, about 30% – among women in the postnatal period. 62% of midwives and midwifery students in Poland and 83% of the Icelandic cohort strongly or partially disagreed with the statement that a psychiatrist or psychologist, rather than a midwife, should do the mood assessment.

Conclusions: Midwives indicate that they do not think that perinatal mental health screening should be addressed exclusively by a psychologist or psychiatrist, but only a part of the care population undergoes a mood assessment performed by midwives. Midwives and midwifery students recognise the need for self-education about screening for perinatal mental health disorders and draw attention to the ever-present stigmatisation of those experiencing depression.

Key words: postnatal depression, mental health assessment scales, midwifery, preventive health care.

INTRODUCTION

Providing care to women in the perinatal period is an integral part of the work of midwives. Among the tasks performed, significant emphasis is placed on antenatal education, defined in the Regulation of Polish Minister of Health of 16 August 2018 on the organisational standard of perinatal care as "practical and theoretical preparation of the pregnant woman and the person close to her to undertake health-promoting behaviours during pregnancy, during labour, postpartum and parenthood, the formation of appropriate health-promoting behaviours and preparation for the care of the newborn and the infant affecting the reduction of the perinatal mortality rate, the reduction of the number of caesarean sections, premature births, medical interventions and the alleviation of fear and anxiety associated with childbirth, the strengthening of the health and well-being of mothers and children" [1]. Therefore, it is possible, to associate with this passage of the regulation the particular guidelines contained in the section of the ordinance indicating the precise scope of preventive services and health promotion activities, as well as diagnostic tests

and medical consultations, performed on women during pregnancy, among which are listed the mandatory assessment of the risk and severity of depressive symptoms (11-14th and 33-37th weeks of pregnancy) and the assessment of the mental state of the obstetrician, including the risk of postpartum depression [1]. While analysing the excerpts cited, we noted that the section describing the tasks to educate the recipients indicates the woman and a close relative, usually the woman's partner. However, it is the woman who undergoes the assessment of the risk of mood disorders.

To assess mood, midwives usually use the scales available to identify women at increased risk of severe mood disorders, including depression [2-4]. This action is intentional and fully justified, as depression during pregnancy affects between 7% and 13% of women up to one year postpartum, and the proportion of women experiencing depression during this period, in individual studies, ranges from 0.5% to up to 60% of women studied [5]. However, in the absence of Polish recommendations and guidelines covering mood assessment in fathers, they experience an educational component rather than screening [1]. Thus, perinatal-related mood disorders among men typically go undiagnosed, resulting in long-term adverse health and social consequences [6]. It is noteworthy that among fathers included in a mood assessment between the first trimester of pregnancy and one year postpartum, depression was found among 8-10% of men [7], while among the partners of women experiencing depression, the proportion rises to as high as 46% [8].

The aim of the study was the assessment of a diagnostic and preventive measures undertaken by midwives regarding mental health among women and men in the perinatal period.

MATERIAL AND METHODS

The study was a mixed-methods, multicentre, cross-sectional study collecting quantitative and qualitative data from 2 partner centres: Poznań University of Medical Sciences in Poland, and in Iceland a research team from the University of Akureyri, University of Iceland and the Parent and Child Centre in Reykjavik, Iceland. The protocol for the study was for a one-time completion of a survey questionnaire by medical midwifery students and active midwives. The survey was conducted between March 2021 and November 2022 in Poland and in Iceland between March and April 2023, using a paper questionnaire and an online survey.

The questionnaire consisted of 5 parts: part A contained the demographic data of the participants; part B contained the author's questionnaire exploring the respondents' attitudes towards 32 statements describing the reasons for difficulties experienced by midwives in diagnosing depression; part C was a modified International Depression Literacy Survey (IDLS) questionnaire [9] (consent for use of the scale was obtained from its authors); part D was a Personal Stigma Items questionnaire Depression Stigma Scale (DSS) [10]; and part E was a *creative box* recording the reflections of the study participants in the form of qualitative data.

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RESULTS

Our cohort comprised 98 Icelandic midwives and 10 Icelandic midwifery students, and 297 Polish midwives and 90 Polish midwifery students. Table 1 summarises the characteristics of the study group. Both cohorts significantly differed regarding distribution of ages and years in the profession, with a significant trend towards younger participants with a shorter period of professional activities, which might be explained by the different composition of the Polish cohort, consisting of both licenced midwives and students.

Two-thirds of midwives and midwifery students in Poland strongly or partially disagreed with the statement that a psychiatrist or psychologist, rather than

Table 1. Characteristics of the study group

Parameter	Participants from Poland (%)	Participants from Iceland (%)	*p*
Age (years)			< 0.001
20-29	57.1	8.3	
30-39	24.0	22.2	
40-49	11.9	26.8	
50-59	6.2	28.7	
60+	0.8	13.9	
Education			< 0.001
Midwifery school	19.4	16.3	
University	80.6	71.4	
Qualifications obtained abroad	–	12.2	
Years in the profession			< 0.001
Below 5	41.3	4.6	
5-9	24.7	25.0	
10-14	10.0	4.6	
15-19	4.4	19.4	
20-24	8.5	13.0	
25+	11.1	33.3	

a midwife, should perform the mood assessment. Midwives practising in Iceland presented a similar standing. Among them, the percentage was even higher, at 83%.

Figure 1 shows the extent and frequency of preventive and diagnostic measures implemented in the study group. Notably, only about 20% of the respondents conducted a standard screening for depression among their pregnant patients, and one-third implemented recommendations to control mood disorders twice during pregnancy – a similar proportion of respondents (30%) conducted standard screening for depression among women in the postnatal period. The heterogeneity of the screening tools used is also noteworthy.

Some of the midwives' and midwifery students' reflections were as follows (the original spelling has been maintained):

Midwife No. 1: *As a primary care midwife, I recognise the need to talk about and monitor each patient's mental state. However, I don't find the questionnaire with the scale helpful. Patients google the answers, they are then insincere. Direct contact is much better. I know that this does not apply to every midwife, but I try to be in "personal" contact with my patients.*

Midwife No. 2: *Many midwives are afraid of mental illness – unfortunately I have met this at work. They stigmatise such patients and this contributes to treating them differently. Education and more education!!! There is a great need for further training in this area.*

Midwife No. 3: *There is a need for courses to prepare medical staff to talk to a patient with depression. What to say and what not to say, how to behave. How to help such patients.*

Midwifery student No. 1: *I believe there is a lack of psychologists and psychiatrists in maternity hospitals who can diagnose depression related to pregnancy and childbirth at an early stage and be a support for postpartum women so that they can feel that they are not alone in their problem and are looked after by a specialist.*

Midwifery student No. 2: *Stigmatisation of women with depression; exclusion/isolation from society of people with depression; double standards in hospital response to people with depression; disregard for depression; use of natural remedies to treat depression.*

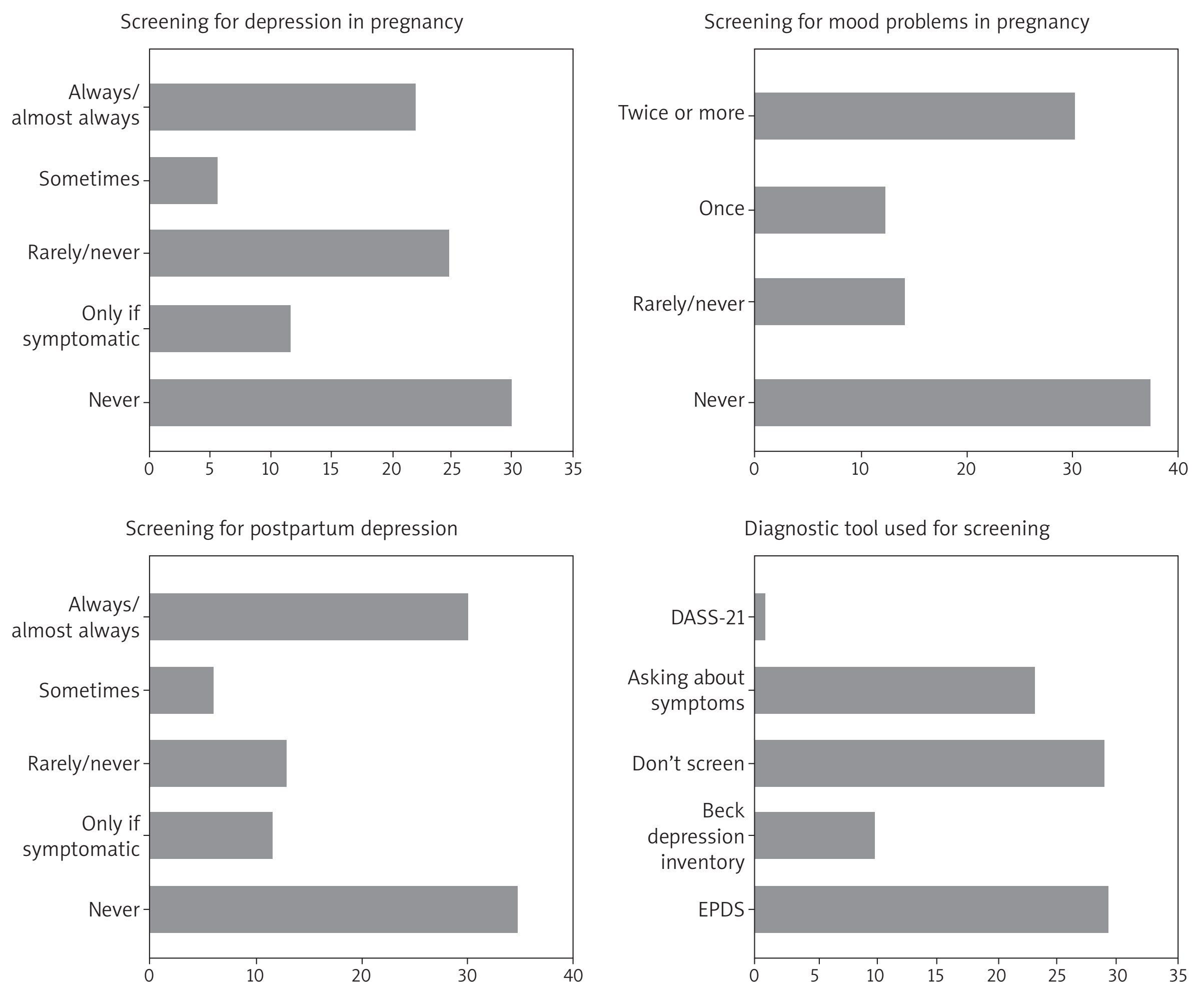

Figure 1. Prevention and diagnostic activities carried out by the study participants

Midwifery student No. 3: *As a midwifery student I attended lectures and seminars on postnatal depression, but today I would not feel confident having such a conversation with a patient due to lack of practical experience. It is a very difficult subject and an incompetent person should not give such a talk, you need to have a great sense of what to say and what not to say, because the patient receives our words much more intensely. I would love to attend more classes on this topic, as I believe that we are the ones who are obliged to help patients with depression in the future and this disease will never go away.*

DISCUSSION

The results indicate a high awareness among midwives (both in Poland and Iceland) of the problem of depression in the perinatal period and of the principles of organising care for pregnant women and women in the postnatal period, and a sense of responsibility on the part of midwives not only in terms of theoretical preparation for childbirth and the puerperium but also of the emotional sphere of the woman in their care. Among the primary interventions undertaken by midwives is education involving the presentation of symptoms of mood disorders, which should prompt the woman and her partner to seek help from a specialist, as well as an assessment of the risk and severity of depression (often referred to as screening), according to current legislation [1]. The importance of familiarising the woman and her partner with symptoms that should be of concern in the postnatal period is to indicate the differentiation of transient lowering of mood, referred to as *baby blues,* from symptoms of postnatal depression [11], but also education on the risks of and symptoms of depression occurring during pregnancy [12]. A crucial element, also highlighted in publications describing the model of care in Scandinavian countries [13], is the establishment of the woman-midwife relationship and the support shown to the woman by midwives at every stage of pregnancy, delivery, and the postpartum period [14, 15].

Therefore, educational activities initiated by midwives should extend beyond isolated messages. Addressing mood disorders and depression should occur at every stage of perinatal care. Building a woman-midwife relationship based on mutual trust must be based on dialogue, responsiveness, and mutual understanding. In this case, the midwife must be well-educated and a reasonable observer of the home life of the family for which she cares. She also should have a high level of sensitivity and empathy. The acquisition of the competencies and skills mentioned above, understood as professionalism in midwifery care, requires both good training programmes for midwifery students (including, among other things, classes with simulated patients) and the conviction of midwives to continue self-education, self-improvement, and the development of acquired competencies and skills throughout their professional life.

An intervention understood as screening is to conduct a mood assessment in the entire population of women in care, using a questionnaire dedicated to this group. Of the questionnaires used for this purpose in the Polish population, the most common seem to be the Edinburgh Postnatal Depression Scale (EPDS), the Beck Depression Inventory (BDI) questionnaire [14], and the Whooley Questions [11, 15]. Further management depends on the score obtained, considering the scale used and the guidelines for summating scores. For an intervention to be considered adequate, in the case of the scores or symptoms presented by the patient, it is necessary to identify where she can get help.

It is important to note that even the best midwifery care will not produce the expected results without procedures to refer a parent at risk of developing a disorder or depression to specialised counselling services. The Regulation of the Minister of Health of 16 August 2018 on the organisational standard of perinatal care cited above does not state that the midwife is to treat the person affected by mood disorders or depression. It also does not state that the midwife is to be involved in providing psychotherapy. Instead, the assumption is that the midwife is to be an outsider who, with objectivity, tools, and perceptiveness, is able to spot the symptoms of mood disorders in the child's parents and point out the optimal treatment path.

Herein, we have referred to several mood disorders in the partners of women during pregnancy, childbirth, and the perinatal period. Evolutionarily and physiologically, these stages are not periods in which a woman should be unattended. The support shown by the partner/family is a condition of stability to maintain appropriate health-promoting behaviours, prepare for the care of the newborn and infant, alleviate the fear and anxiety associated with childbirth, strengthen health, and improve well-being. The abovementioned factors coincide with the ministerial line expressed in the Regulation.

Meanwhile, the assessment of men's mood in the perinatal period in Poland currently needs to be regulated by legislation and recommendations for management. Therefore, it is necessary to conduct further research and strive to include this group in screening, increasing the likelihood of getting help and improving the quality of functioning of the woman's partner and the whole family [16]. Against this background, it has been indicated that the male version of the EPDS questionnaire may find application as a type of screening applied to the partners of pregnant and postpartum women [17].

CONCLUSIONS

The role of the midwife (and the interventions she uses) during pregnancy, labour, and the postnatal period is, among other things, to make decisions and implement actions leading to: 1) the recognition of the state of risk of mood disorders in pregnant women and their partners, 2) the appearance of symptoms of the disorders mentioned above (including depression), and 3) the presentation of a course of action enabling the prevention or reversal of adverse events aimed at intentionally ensuring the stable development of the newborn and infant, as well as safeguarding the health of the child's mother and her partner.

Moreover, midwives and midwifery students notice the need to extend education to the women in their care, including issues related to preparation for labour, the postpartum period, and perinatal mood assessment.

Disclosure

The authors declare no conflict of interest.

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