

Midwives' experiences of asking the Whooley questions to assess current mental health: a qualitative interpretive study

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ABSTRACT

Background: Perinatal Mental Illness (PMI) is a key cause of maternal mortality and morbidity in the UK, with one goal of midwives to identify those at risk during pregnancy. At present, the system of preliminary identification of existing PMI in the UK involves the midwife asking pregnant women the Whooley questions at the antenatal booking interview. **Aim:** To explore midwives experiences of asking the Whooley questions with pregnant women. **Method:** A qualitative interpretive study explored midwives' ($n = 8$) experiences of asking the Whooley questions in one maternity unit in England (UK). Data were gathered through semistructured interviews and analysed using Framework Analysis (FWA). **Findings:** Themes and subthemes identified included: (1) no clear understanding of purpose, (1a) discomfort when disclosure occurs, (2) feeling pressurised for time, (3) resultant dissatisfaction and frustration; (3a) lack of knowledge and how to refer, (3b) lack of training around PMI, (3c) relying on experience and use of intuition. **Discussion:** The development and evaluation of an education curriculum to prepare midwives to effectively use case-finding instruments such as the Whooley questions to identify pregnant women at risk is required.

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Introduction

Perinatal Mental Illness (PMI) refers to mental health problems that occur during pregnancy and up to one year post-birth (O'Hara, Wisner, Asher, & Asher, 2014), with depression and anxiety disorders most prevalent (Le Strat, Dubertret, & Le Foll, 2011; Melville, Gavin, Guo, Fan, & Katon, 2010). The incidence of antenatal depression is reported to be around 10%–15% and post-natal depression (PND) 13%–21% (Boots Family Trust, Netmums Institute of Health Visiting, Tommy's & the Royal College of Midwives's, 2013; Evans, Heron, & Francomb, 2001; Gavin, Gaynes, & Lohr, 2005; O'Hara et al., 2014), which indicates that between 100 and 150 per 1000 women may develop mental health issues during and post childbearing (Scottish Intercollegiate Guidelines Network (SIGN), 2012). Furthermore, identification of PMI has been reported to precede 12% of maternal deaths, with suicide the chief cause in westernised countries (Gavin et al., 2011; Howard, Flach, Mehay, Sharp, & Tylee, 2011; MBRRACE-UK, 2014). Given there is approximately 600,000–700,000 births per year in England and Wales (ONS,

2014), this equates to around 60,000–90,000 women who may require support for PMI. These figures make recognition of PMI a very important issue.

Evidence also supports that anxiety and depression during pregnancy can result in detrimental health effects for the woman, baby and family in terms of low birthweight, preterm labour, behavioural problems in children, and problematic family relationships (Glover, 2013; Goodyer & Cooper, 2011; O'Connor, Heron, Golding, Beveridge, & Glover, 2002). Hence, it is important that maternity care experts find an effective system for predicting and detecting PMI (Wylie, Hollins Martin, Marland, Martin, & Rankin, 2011).

At present, all pregnant women in the UK are screened for PMI during the antenatal period using the Whooley questions (Whooley, Avins, & Miranda, 1997) recommended by the National Institute for Health and Clinical Excellence (NICE) (2007, 2014), who proposed this help question be asked to strengthen the sensitivity and specificity of the Whooley questions.

(3) Is this something you feel you need or want help with?

National Institute of Clinical Excellence (NICE)(UK) (2007) recommends that the Whooley questions are repeated again at 4–6 post-natal weeks and 3–4 post-natal months.

The Whooley questions originated from the Primary Care Evaluation of Medical Disorders Procedure (PRIME-MD) questionnaire, which has been validated for screening for depression in primary care settings (Spitzer et al., 2000), and more recently within the pregnant population (Mann, Adamson, & Gilbody, 2012). Acknowledging that it is the midwives' role to ask childbearing women the Whooley questions, and that there is a dearth of research to explore confidence and self-efficacy in relation to this task, the aim of this study was to explore midwives' experiences of asking the Whooley questions.

There is little existing literature which has examined midwives' experiences of screening for depression and anxiety during the antenatal period. Nearly all of the research in this area has been done in Australia, where an antenatal psychosocial assessment has been implemented whereby all women are screened during the antenatal period by midwives. The assessment tool is a comprehensive list of questions, which include ones about present and previous mental health (Rollans, Schmied, Kemp, & Meade, 2013). Mollart, Newing and Foureur (2009) conducted a study assessing the impact of structured antenatal psychosocial assessments (SAPSA) on midwives' emotional well-being. The authors found that midwives felt frustrated at the lack of referral pathways when women disclosed the need for help. Jones, Creedy and Gamble (2012) conducted a study on the Australian midwives' awareness and management of antenatal and postnatal depression. The main findings revealed that midwives lack competency in identifying depression and its appropriate subsequent management. The midwives in this study used the Edinburgh Postnatal Depression Scale to screen women.

Method

A qualitative interpretive study explored midwives' experiences of asking the Whooley questions. This method was selected because the aim of interpretative research is to attempt to understand the world from the viewpoint of the participant, as opposed to explaining their world (Green & Thorogood, 2006). Our objective was to gain knowledge and understanding of the participating midwives' experiences of asking the Whooley questions, to inform how this may affect levels of detection of PMI. Ethical approval for this study was gained from the NHS Research Ethics Committee (REC) (Reference number 08/H1008/192).

Table 1. Demographic information of participants ($n = 8$).

Age range = 21–60 years old
Years of experience in midwifery = 1–35 years
Area of clinical work:
• Antenatal clinic (1)
• Community (4)
• Rotational post (3)
Registered midwives (8)
• Educated to degree level (4)
• Additional registration as a general nurse (5)
• Additional registration as a children's nurse (1)

Participants

A purposive sample of midwives ($n = 8$) was recruited via posters and an invitation issued at a team meeting held in the maternity unit. One inclusion criterion was that the midwife had to regularly conduct antenatal booking visits, which is the first point at which the Whooley questions are asked. An overview of participants' demographic details can be viewed in Table 1.

Data collection

The study was conducted in a large maternity unit in the northwest of England (UK). Data were collected using semistructured interviews that took place in a quiet side room at the maternity unit. Interviews were digitally audio-recorded and lasted around 60 min. During the interviews, participants were encouraged to express their thoughts, attitudes towards, and experiences of asking the Whooley questions. The interview schedule is presented in Table 2.

Data analysis

Framework Analysis (FWA) was used to analyse the data (Ritchie & Lewis, 2007), which is considered a suitable approach for use in applied social policy research (Green & Thorogood, 2006). The interviews were transcribed verbatim and analysed as follows.

- (1) *Familiarization*
The data were repeatedly read to identify emergent themes. This included listening to the audio tapes and reading the transcripts thoroughly.
- (2) *Identifying a thematic framework*
By sifting and sorting through data, a thematic framework emerged.
- (3) *Indexing*
Emerging themes were classified and listed.
- (4) *Charting*
Core themes were tabulated, with associated participant responses listed and cross-referenced.
- (5) *Mapping and interpretation*
Concepts and themes were defined and typologies created.

To exemplify the coding process, in the case of MA, the 'M' stands for the Midwife (participant) and A for the unique identifier attached to their stored transcript (A, B, C, D, E,

Table 2. Questions on the semistructured interview schedule.

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- (1) Who usually conducts the booking interview with women where you work?
 - (2) Where do you normally conduct the booking interview?
 - (3) How do you feel about conducting the booking interview?
 - (4) How do you feel when asking the women the Whooley questions during the booking interview?
 - (5) During the booking interview, do you ask women about any mental health problems that they might have now or have had in the past?
 - (6) What do you know about some of the mental health problems women might have during the ante and postnatal period?
 - (7) Are you aware of the ante and postnatal mental health guidelines published by NICE in 2007?
 - (8) If you have read them, have you heard about the questions that the NICE guidelines are suggesting that midwives ask women at the booking interview?
 - (9) What do you think about these questions?
 - (10) When are the Whooley questions asked?
 - (11) Have there been times when you have had to ask women the third question?
 - (12) Have you had any training on how to ask the questions recommended by NICE, 2007?
 - (13) If you do not use the NICE questions, how do you ask women about their present or previous mental health problems?
 - (14) Is there anything that you feel makes it difficult for you to ask women questions during the booking interview?
 - (15) How do you feel/respond if a woman discloses mental health problems?
 - (16) How do you document responses from women?
 - (17) What is the most important thing that you want me to hear from talking with you today, or is there anything else you would like to say?
 - (18) How do you feel after talking with me today?
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Table 3. Themes and subthemes identified in the data.

Themes	Subthemes
(1) No clear understanding of purpose	(1a) Discomfort when disclosure occurs
(2) Feeling pressurised for time	
(3) Resultant dissatisfaction and frustration	(3a) Lack of knowledge and how to refer (3b) Lack of training around Perinatal Mental Illness (PMI) (3c) Relying on experience and use of intuition

F, G and H). As a validity check, a second academic read the transcript and provided feedback for accuracy of meaning of quotes and their relationship to the identified themes and subthemes.

Findings

A summary of the themes and subthemes that emerged from the data is presented in Table 3.

(1) No clear understanding of purpose

Some participants did not fully understand the purpose of asking the Whooley questions at the initial booking visit, with little explanation specified of their relevance or appropriateness:

I do think sometimes we ask slightly inappropriate questions, erm. I do wonder sometimes what the relevance of some of the questions are, and I sometimes think that maybe some of our ladies tend to wonder what the relevance of the details that we ask about them. (MD)

A further difficulty was the subsequent participant's perception that asking the Whooley questions in the current way was inappropriate:

I have a lot of mixed feelings about asking these questions in, in the booking interview. Erm, I, I you know, think there are better ways that we could approach mental health than just form filling. I think it's, it's, it's insensitive and erm, and, and a minefield for, for both midwives and for women in our care. It's inappropriate. (ME)

(1a) Discomfort when disclosure occurs

Some participants expressed trepidation compounded by lack of expertise when mental health problems were raised by women. Powerful words exemplified the challenge presented to midwives who were underconfident in their ability to manage a disclosure:

Well what the *hell* am I going to do if they disclose something? (ME)

You are praying please don't say yes because what can I do? (MC)

I feel completely out on a limb. I don't know what I should and shouldn't be doing? But it's really difficult and I feel like I am completely out of my comfort zone when that (disclosure) happens. (MD)

Increasing midwives' knowledge about asking the Whooley questions and their associations with PMI would assist the questioner to understand their appropriateness, purpose and pathway. Being effectively prepared could reduce the further difficulty of midwives' discomfort when a disclosure occurs.

(2) Feeling pressurised for time

Constraints about having enough time to manage ensuing events were also raised as a problem. Concern about midwives having enough time to adequately conduct the booking interview is a common complaint (McCourt, 2006; Elliott, Ross-Davie, & Sarkar Green, 2007). Some participants felt that the pressure of time meant they did not want to probe when asking the Whooley questions in case the woman answered yes. The following quote captures this point:

God, I have not got time for this and who can I get to who can help me. (MC)

The following midwife perceived that time constraints were also a problem for some women:

There is a limit to how much the women will take in, and often they are looking at their watches. (MA)

The following midwife expressed that there were too many questions to ask within the allocated time frame for a 'booking visit' (1 h), which resulted in a tick-box exercise:

In the case of women that I see, I don't think it even addresses some of their particular needs. Um, so it strikes me there's a lot of tick boxing, which is a bit sad. (MF)

To compound the matter of time constraint, the following participant viewed that when an interpreter was involved, the booking interview took considerably more time:

Because with an interpreter it seems to take twice as long. (MF)

(3) Resultant dissatisfaction and frustration

Some midwives felt dissatisfied and frustrated due to lack of time to be able to fulfil their role. Dissatisfaction and frustration was associated by the participants in relation to lack of

knowledge surrounding PMI and appropriate referral pathways when a woman answered 'yes' to a Whooley question.

(3a) Lack of knowledge and how to refer

The first difficulty to be acknowledged is that all eight participants were unaware that the Whooley questions incorporated into the National Pregnancy Notes (Perinatal Institute, 2009) were recommended by NICE (2007, 2014). This point was the first to alert us that midwives require more education about PMI and that some lack understanding of why the Whooley questions are asked. The following quotes illustrate some midwives' vexations surrounding lack of knowledge about the Whooley questions and how to refer women post-disclosure.

I suppose it's about listening to the women isn't it? But in order for midwives to listen effectively, um, you have to have some basic understanding of mental health. And you have to have the appropriate skills to ask the question. Um, and then once having asked the question, they have to know how to deal with the information. (MF)

I feel completely out on a limb. I don't know what I should and shouldn't be doing. (MD)

Having a clear pathway of referral and appropriate support is patently important:

Have got a flow chart for smoking ... you know what to do with breastfeeding, because you have got standardized guidelines for baby friendly. (MH)

The aforementioned quotes illustrate that some midwives would like more preparation and require a well-defined referral pathway when a disclosure occurs.

(3b) Lack of training around Perinatal Mental Illness (PMI)

Only one participant had received training in relation to asking the Whooley questions, and understood their role in referral and management of PMI. This education had been sought out independent of the organisation and consisted of one day. The other seven participants presented vague details about PMI and its referral processes. They recollected education from their pre-registration/undergraduate midwifery programme, which for the majority was some time ago. Most of this recall related to PND and not information that underpins the Whooley questions. The following quotes emphasise participant belief in their own lack of knowledge:

Questions open a can of worms. When you ask a question the woman will then want to talk about what you have asked her about, and if then you are completely flummoxed and don't know where to go, then erm you are a little stuck. (MG)

I feel that the midwives could be better equipped to support women and if they knew ... If they had had the education. (MH)

Patently, some midwives are reliant upon self-acquired knowledge and their own experiences of assessing women for PMI through use of the Whooley questions.

(3c) Relying on experience and use of intuition

The following participant commented that she drew upon her personal and family members experiences of having mental health problems:

Even though I've got 14 years midwifery experience, I've got a lot of life experience and professional experience. Though I don't particularly feel I have expertise, um, in the way that they might need it. (ME)

For this participant, prior experience of working in a mental health setting proved helpful:

When I was very young I worked on a psychiatric ward and I try sometimes to draw from that. (MD)

These quotations inform us that some midwives use their personal prior encounters for comparison and listen to their 'inner voice' when considering a woman's mental state:

You are relying on your own intuition you know. (MC)

I think purely you learn in a situation that something is inappropriate. This is beyond my remit as a midwife, and it would be unsafe to leave the woman. (MB)

The results of the data analysis unmistakably indicate that some midwives lack knowledge in relation to asking and responding to the Whooley questions.

Limitations

Acknowledging that reflexivity is important in qualitative research; in this instance, the participants knew the interviewer to be an academic midwife, which could have swayed them to be more guarded with their comments.

Other limitations of this study include its lack of applicability to all maternity units in the UK. Data were collected in just one maternity unit, where the care pathway for maternal mental health is not clear. The sample size of participants was small and therefore can only provide a snapshot into how some midwives approach and manage the Whooley questions. To support this point, the Boots Family Trust et al. (2013) also surveyed midwives ($n = 365$) and reported lack of knowledge and confidence surrounding recognition of PMI and lack of support services as a hindrance.

General discussion

This study demonstrates that some midwives find asking the Whooley questions (Whooley et al., 1997) recommended by National Institute of Clinical Excellence (NICE)(UK) (2007) challenging. Also, when a childbearing woman answers 'yes' to a Whooley question, some midwives are unaware of the referral pathway or how to transfer the woman for a further diagnostic interview (Gilbody, Sheldon, & House, 2008; Bennett et al., 2008). All eight participants were unaware that a subsequent interview to further investigate PMI was recommended. In essence, the data reveal that some midwives struggle to use their professional knowledge and clinical judgement when asking the Whooley questions, which is a sentiment echoed in the wider literature (Boots Family Trust et al., 2013). Lack of midwives' confidence in managing disclosures of PMI and their dearth of comprehension of referral pathways may in addition be compounded by women's fear of consequences from exposure. These fears may include:

- fear of repercussions from not being seen as a fit mother and having the baby removed;
- fear of being judged by health care professionals;
- having to repeat their story over and over again

To assist women with disclosure, midwives are required to build sensitive relationships with women (Raymond, 2007), provide continuity of care (Renfrew, McFadden, & Baston, 2014) and create a safe environment (Raymond, 2007), in which they can feel comfortable and safe to reveal their problems.

Constraints upon time when PMI symptoms are raised also requires redress. Clearly, the nominal one-hour time slot allocated to conduct the 'booking interview' and effectively manage emergent problems that arise from both the Whooley questions and others is an insufficient window of time when a problem is acknowledged (Methven, 1989; McCourt, 2006; Boots Family Trust et al., 2013). What constitutes a reasonable time slot for the midwife to be effective in this role still needs to be determined. It should be noted that subsequent to undertaking this study, NICE has introduced two further questions specifically to detect anxiety (National Institute of Health & Clinical Excellence (NICE), 2014). These are:

'feeling nervous or on edge'

'not able to stop or control worrying'

Having further questions to ask in the same allotted time can only compound the problem of time pressure.

Whether or not the Whooley questions are the most valid method for initial detection of PMI may require further investigation. Hewitt et al. (2009) found no evidence across four systematic reviews of validity, acceptability and cost-effectiveness of using the Whooley questions. Dennis and Creedy (2004) also found no psychological interventions for preventing PND, with no detectable treatment effect across 15 studies. These findings indicate that approaches used are a 'mixed bag', and creates room for developing a new strategy for collecting relevant information on the mental state of childbearing women. There is scope to develop a modern conceptualised system to effectively detect and monitor PMI over key longitudinal intervals and when risk is elevated.

Living in a multicultural society can complicate difficulties with identifying PMI, and may compromise the midwives' ability to appreciate and appropriately manage events when a disclosure occurs. Time restrictions may also impede midwives from providing information about PMI that inform women's choices and the person-centred element of care that is advocated in social policy documents (Nursing Midwifery Council (NMC), 2012; National Institute of Health & Clinical Excellence (NICE), 2014). Quite clearly, when features indicative of PMI present, the avenues for referral must be made transparent. To aid development, recent literature has provided information about implementation of appropriate care pathways that midwives can use to support their practice (National Institute of Health & Clinical Excellence (NICE), 2014; NHS Greater Glasgow & Clyde, 2012; Boots Family Trust et al., 2013).

To improve delivery, the Maternal Mental Health Alliance and the Royal College of Midwives (2014) have called for the implementation of specialist mental health midwives in all maternity units in the UK. Part of this role is to ensure midwives have adequate training surrounding PMI and that appropriate care pathways are developed. As the lead professional in maternity care provision, midwives are in a prime position to identify and support allied health care professionals and women themselves coping with mental health issues (Nursing Midwifery Council (NMC), 2012). To be effective in this role, midwives need to be equipped with appropriate evidence-based education and provided with support services to facilitate them with appropriate referral when a woman answers 'yes' to the Whooley questions.

This study indicates that an education programme to extend midwives' knowledge surrounding the Whooley questions and recognition of PMI is required. In response, we propose that a training session be developed and delivered within the maternity unit, which is evaluated post-delivery for effectiveness at improving midwives knowledge surrounding initial recognition of PMI. Delivering high-quality training about how to effectively ask the Whooley questions could profoundly improve levels of detection and referral of childbearing women with PMI.

Conclusion

The aim of this study was to interpret participants' experiences of asking the Whooley questions. Findings have shown that some midwives feel pressurised by time, feel that they lack knowledge, and have PMI training needs in how to effectively ask the Whooley questions. In response, there is an acknowledged need to develop and deliver undergraduate and postgraduate curricula that directly embrace:

- what a midwife needs to know about PMI;
- how to manage asking the Whooley questions and other case-finding instruments suggested by National Institute of Health and Clinical Excellence (NICE) (2014);
- how to develop effective pathways of care when referral is required.

Future research should explore whether delivering this training could improve levels of detection and referral of childbearing women with PMI or if a new system for detecting PMI is needed in the UK.

Disclosure statement

No potential conflict of interest was reported by the authors.

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