

Knowledge and Attitudes of Postpartum Hospital and Public Health
Nurses Regarding Postpartum Depression: An Exploratory
Study

by

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DALHOUSIE UNIVERSITY

SCHOOL OF NURSING

The undersigned hereby certify that they have read and recommend to the Faculty of Graduate Studies for acceptance a thesis entitled “Knowledge and Attitudes of Postpartum Hospital and Public Health Nurses Regarding Postpartum Depression: An Exploratory Study” by Cynthia Mann in partial fulfilment of the requirements for the degree of Master of Nursing.

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Dedication

I dedicate this to those I love and who have loved me; the people who have made this a reality. To my husband, Bob, this work is as much yours as mine. You have been my support in every way possible. More importantly you are my biggest fan. You always believe in me and remind me that I can do anything. I know we say this all the time, but I want it to be in print: We are so lucky. I do not know what I would do without you.

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Abstract

The purpose of this study was to explore the knowledge and attitudes of hospital postpartum and public health nurses towards postpartum depression (PPD) using interpretive description. Postpartum depression is the leading complication after childbirth and impacts negatively on the health of the mother and her child. The nurses in this study participated in focus groups and/or participant observation. The five patterns that describe participants experiences related to PPD were: “Nurses understand PPD in different ways”, “Nurses recognize that women need support”, “Nurses reported that teaching about PPD makes a difference”, “Strong relationships with a primary care provider is essential in the post partum period”, and “a key role of the nurse is to listen”. The nurses in this study revealed a rich understanding of PPD leading to recommendations for practice by hospital and public health nurses related to PPD contributing to better care for women experiencing PPD.

List of Abbreviations Used

PPD	Postpartum Depression
APA	American Psychiatric Association
DSM-IV-TR	Diagnostic and Statistical Manual – Text Revision IV
CHNAC	Community Health Nurses Association of Canada
TPB	Theory of Planned Behavior
GP	General Practitioner
CNA	Canadian Nurses Association
UK	United Kingdom
EPDS	Edinburgh Postnatal Depression Scale
PHN	Public Health Nurse
PNG	Postnatal Guarantee
CHNC	Community Health Nurses of Canada
CPHA	Canadian Public Health Association

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Chapter One

Introduction

Postpartum Depression

In a meta-analysis of 59 studies performed in many countries, the overall prevalence of postpartum depression (PPD) was 13% (O'Hara & Swain, 1996). More recently, Gavin et al. (2005) performed a systematic review and found the prevalence rate of depression in the first three months postpartum to be 19.2% for women in developed countries. This makes PPD the predominant complication following childbirth. According to the 2008 census, there were 9,134 live births in Nova Scotia (Vital Statistics, 2008). This would mean that over 1750 women each year could potentially suffer from PPD. Despite this, there is a lack of Canadian data on the prevalence of PPD and PPD is no longer included in the list of perinatal health indicators for Canada (Public Health Agency of Canada, 2008).

The Diagnostic and Statistical Manual – Text Revision IV (DSM-IV-TR) (American Psychiatric Association [APA], 2000) provides one definition of PPD and categorizes it as a major depressive episode with postpartum onset. The essential features of a major depressive episode include at least two weeks of a depressed mood or the loss of pleasure and interest in activities. Along with the above symptoms at least four additional symptoms must be present such as; “changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts” (APA, 2000, p. 349). The depressive episode must also

include impairment in functioning and symptoms must be present most days in the two-week period (APA, 2000).

The DSM-IV-TR (APA, 2000) specifies that if the depressive episode occurs within four weeks postpartum it is defined as a major depressive episode with postpartum onset. Many researchers and clinicians agree that the criteria of onset within four weeks is too limiting and some suggest that PPD can begin any time during the first year postpartum (Beck, 2006; Leahy-Warren & McCarthy, 2007; Stewart, Robertson, Dennis, Grace, & Wallington, 2003). There is agreement that the symptoms do not differ substantially regardless of the timing of the onset, however, depression in the postpartum period does have special implications for the woman and for her family, including impact on relationships, infant feeding patterns, attachment patterns with offspring, and future childbearing (APA, 2000; O'Hara, 2009).

Despite clear diagnostic criteria for PPD, it remains difficult for nurses and other health care professionals to understand and distinguish the variety of emotional changes and potential mental illnesses that can affect women in the postpartum period. For example it is important to differentiate between PPD and postpartum blues. Postpartum blues occurs in the first week to ten days, generally only lasts a few days, and resolves on its own (O'Hara, 2009). One of the potential reasons PPD remains difficult to understand is that there has not always been consensus on the definition of PPD. It has also been reported that women with PPD can also present with wide variations in symptoms. For example, a woman may first identify anxiety and irritability instead of sadness and hopelessness (Beck & Indman, 2005). Another difficulty in identifying women with PPD

is that symptoms such as fatigue, low libido, and changes in appetite can easily be confused with normal adjustments to motherhood (Stewart et al., 2003).

Women's Experiences with PPD. There have been several studies that attempt to better understand PPD by exploring the experiences of women with PPD. In 1992, Beck published her research on women's experience of PPD. She used a phenomenological approach and identified 11 themes to describe the experience of having PPD. The themes included; unbearable loneliness due to people not understanding their feelings, grief over loss of self, loss of interest in all activities, fogginess and lack of concentration, feeling stripped of all emotion, obsessive thoughts, uncontrollable anxiety, loss of control of thoughts and emotions and besieged with insecurity. Many women at different points talked about being suicidal and every participant contemplated death as a way out of suffering. The women also had enormous fear and guilt over thoughts of harming their babies (Beck).

Hall (2006) also used interpretive phenomenology to study the experience of women who had experienced PPD. In this study, ten women were interviewed. The four major themes identified were; feeling like a bad mother, discrepancies between expectations and reality, fear about lack of attachment to infant and difficulty in disclosing feelings. Women felt embarrassed and were afraid of the consequences of disclosing. At the same time, many women stated they wished for help, both physical help and emotional help in the recognition of how bad they were feeling (Hall, 2006).

Edhborg, Friberg, Lundh, & Widstrom (2005) used a grounded theory approach and the overarching theory that was developed was "struggling with life". Edhborg et al.'s theory described women's struggles related to the self, the infant, and the partner.

Many of the themes in Edhborg et al. (2005) resembled those of Hall (2006). The women participating in both studies described feeling like a bad mother and having to deal with unexpected changes to their life.

Beck (2002) performed the first metasynthesis one decade after her original research on women's experience of PPD. She found four overarching themes. First, women experienced incongruence's between reality and their expectations. This mismatch led women to believe that no one else understood their experiences. Secondly, women experienced pervasive loss, for example loss of control, loss of self, and loss of relationship. The third theme was a spiraling downward. Beck described women's mounting feelings of anger, anxiety, insecurity, guilt, and fear (2002). Some women experienced losses of cognitive abilities and obsessive thoughts, including harming themselves or their infants.

The last theme in this metasynthesis was making gains. This occurred when women made the difficult decision to seek help and began to feel better. Beck (2002) described this as women "struggling to survive" (p. 469). Women had difficulties in accessing treatment and some women needed to surrender to the illness in order to get better. Women described being humiliated, ignored, and their concerns being minimized. Difficulty in seeking help and accessing treatment is described again in more recent literature (Hall, 2006) and remains essential for nurses to keep in mind in working with postpartum women. Beck also stated that nurses must take a role in dispelling the myths of motherhood in order to help women feel less isolated by negative feelings during the transition to motherhood (2002).

Knudson-Martin and Silverstein (2009) also performed a metasynthesis using nine articles published between 1999 and 2005. The researchers found six themes; feelings of progressive despair and isolation, fear of reactions of others, inability to express negative emotions, distress over incongruence in perceptions of motherhood versus reality, healing effects of validation and the need to reconnect to others (Knudson-Martin & Silverstein, 2009).

Knudson-Martin and Silverstein (2009) pointed out that many of the themes were similar to those in an earlier metasynthesis by (Beck, 2002). For example, the difference between women's expectation of motherhood and their reality, the overwhelming negative emotions, and the need for help in healing. Knudson-Martin and Silverstein (2009) reiterated the need for health care professionals to help dispel the myths of motherhood and help women create more accurate expectations. They also noted that one of the ways that women received the support they needed was by seeking professional help with their depression (Knudson-Martin & Silverstein, 2009).

Summary

Much of what I have learned about women's experiences of PPD came from talking with my patients, many of whom admitted to not seeking help for depression, or not understanding what was happening to them until much later. In reading the literature, several researchers confirmed my observations of this illness. As a practitioner, and as a woman and mother, I continue to want to better understand why women with PPD are not receiving the help they need.

Getting help for any mental illness is challenging for a variety of reasons, some of which were identified in the work of (Beck, 2002; Hall, 2006) for example the fear of the

reactions of others. New mothers face additional and unique fears. For example, fear of being considered a bad mother and fear of losing their infants (Hall, 2006). Postpartum women are also unique in that they have frequent and routine contact with health care professionals, such as nurses. This contact provides repeated opportunities for health care professionals to provide education, assessment, treatment, and support in regards to PPD.

As part of an in-depth review of the PPD literature, I noted that a gap exists. That is, there is currently very little published literature on health care professionals' knowledge of and attitudes towards PPD. More specifically, only one published study was located that explored nurses' knowledge of and attitudes towards PPD (Sofronas, Feeley, Zelkowitz, & Sabbagh, 2011). There are however studies that include nurses with other professionals (Lees, Mills, & McCalmont, 2009; Lepper, DiMatteo & Tinsley, 1994; Skocir & Hundley, 2006). In each of these four studies, the researchers identified gaps in health care professionals' knowledge towards PPD (Lees et al., 2009; Lepper et al., 1994; Skocir & Hundley, 2006; Sofronas et al., 2011).

Nurses provide care for postpartum women, yet their role in caring for this population is often not clearly articulated (Holopainen, 2002). In order to improve the care that postpartum women get related to PPD, I believe there is a need to explore nurses' knowledge of and attitudes towards PPD.

Purpose of the Study

The purpose of this study was to explore a) hospital postpartum nurses and public health nurses knowledge of and attitudes towards PPD, b) the role that hospital postpartum nurses and public health nurses have in caring for women related to PPD, and

c) to understand the context in which the nurses in both setting provide this care. This knowledge has the potential to influence nursing education, policy, and practice in relation to PPD.

The methodology that I chose to use for this study is interpretive description. Interpretive description is a non-categorical qualitative methodology that is aligned with other interpretive, naturalistic methods of inquiry (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004). Thorne et al. (2004) described the philosophical underpinning of interpretive description as similar to that of other naturalistic methodologies and include a) there are multiple and constructed realities; b) the researcher and the object of study are interrelated and inseparable; and c) that the findings must be grounded in the data (Thorne et al., 2004). The second assumption leads to a need for the researcher to spend time during the planning stages of a study to reflecting and document any prior knowledge and assumptions about the subject of the study.

Positioning of the Researcher

As this study began, I felt it was important to reflect on my own interest in the topic of PPD and how that interest has evolved to ensure that I am aware of and reflect upon my beliefs and values and how these may influence the study. In May of 2001, I graduated from Dalhousie University with a Bachelor of Science in Nursing. My first job was as a registered nurse on a postpartum inpatient unit. In reflecting back, I remember being highly influenced by an event in the media. Andrea Yates was a mother of five children in Texas and suffered from depression, PPD, and postpartum psychosis. In June 2001, Andrea Yates drowned her children and was charged with their murder (O'Malley, 2004).

At the same time that I was beginning my nursing career, I was also a young mother with a toddler. I knew that the postpartum period could be a challenging time emotionally; however, I am not sure I had previously understood just how difficult the postpartum period could be for some women and families. This extreme and tragic case made me want to know more about mental illness in the postpartum period so that I could provide the best care and education to women and their families. This was the beginning of my interest in PPD.

While I worked as a postpartum nurse, I gathered as much information as I could on PPD. I read both academic literature and personal accounts on this illness. I listened carefully to the comments that I heard from other staff on what they felt was “normal” or “not normal” emotions after having a baby. I also learned a great deal by spending time talking with patients about PPD. I heard many stories from patients. The more I talked with women the more I learned. One of the things that I noticed was that many women told me stories of having PPD but not receiving treatment. As my career continued and I made the decision to pursue graduate studies I knew that I wanted to learn more about PPD. I was fortunate through my graduate studies to be able to focus both my clinical and academic work around the mental health of childbearing women. The wealth of research on PPD added to my curiosity as to why women were not getting the help they needed and what the role of the nurse was in the care of postpartum women related to PPD.

Chapter Two

Literature Review

The literature review is divided into three sections: knowledge and attitudes, postpartum depression (PPD), and health care professionals' knowledge and attitudes toward PPD. In the first section, the concepts knowledge and attitudes are explored, and definitions of both are provided. The literature on PPD is vast, therefore in the second section I provide a review of the PPD literature that is limited to the following two areas; women's experiences in the health care system and the nurses' role in caring for women with PPD. These two areas have the greatest relevance to this study. In the final section, I review what is currently known about the knowledge and attitudes of health care professionals toward PPD.

Knowledge and Attitudes

The terms knowledge and attitudes are used frequently in research. They are both complex concepts that are rarely defined. In this section, I review the literature on both knowledge and attitudes in order to provide a clear and logical understanding of how the concepts were used in this study. I also provide definitions of each concept used in this study.

Knowledge. In the current health care context, knowledge is considered highly valuable (Thompson, Estabrooks, & Dagner, 2004). Thompson et al. (2004) reported that a common assumption was that an increase in the availability of information will result in changes in the behavior of clinicians. Despite the assumptions around the value of knowledge in clinical settings, the meaning of knowledge is rarely clearly articulated in research literature.

The definition of knowledge is complex in part because it varies across disciplines and changes throughout history. For the purposes of this study, I will limit my discussion of knowledge to the discipline of nursing. I provide a brief historical overview of how the understanding of nursing knowledge has changed over time and then place this understanding in the context of current nursing practice. I conclude by providing a definition of nursing knowledge that is informed by the writings of a variety of nursing researchers and theorists.

Patterns of knowing have formed the foundation for knowledge in nursing. Barbara Carper (1978) was the first nursing theorist to name the various patterns of knowing in nursing with the publication of her doctoral work. Understanding the various patterns of knowing in nursing is essential for both learning and teaching within nursing (Carper, 1978). Her work formally recognized that nurses' ways of knowing extended beyond the medical model and the pure empirical knowledge.

Carper, 1978, described four fundamental patterns of knowing: (a) empirics, the science of nursing; (b) aesthetics, the art of nursing; (c) personal knowledge; and (d) ethics or moral knowledge. The first pattern, empirical knowledge represented the objective, verifiable facts. This type of knowledge was considered highly valuable (Carper) and I would suggest it is still considered highly valuable in our current health care context. The next pattern of nursing knowledge, aesthetics, is holistic and creative and occurred through nurses working to understand and meet the specific needs of individual patients (Carper).

Personal knowledge, the third pattern, is the most difficult pattern of knowing to articulate (Carper, 1978). It is even more difficult to teach and master. Personal

knowledge in nursing is developed through engaging with individuals and learning about oneself through the encounter and what you bring to the relationship (Carper, 1978). The last pattern of knowing identified was that of ethical knowledge (Carper, 1978). She suggested that ethical knowledge goes beyond knowing the code of ethics of the profession and that nurses must consider their ethical obligations with every action. The complexity of health care frequently results in moral dilemmas and ethical principles can conflict with personal values, thus challenging nurses to apply their ethical knowledge in practice.

Carper (1978) asserted that it is essential for nurses to consider all patterns of knowing in order to benefit from all aspects of nurses knowledge and to be aware of the interconnectedness of the patterns. I believe that Carper's work (1978) has informed my own and many nurses, understanding of the multifaceted nature of nursing knowledge, as well as, the interconnectedness of the various types of knowledge that are applied in nursing practice. I have also observed that Carper's work (1978) provided a language in which nurses can articulate the various ways of knowing that they use in practice and as such it validates ways of knowing that were not previously well articulated and were not traditionally given high value.

Silva, Sorrell, and Sorrell (1995) provided a critique of Carper's 1978 article. These authors suggested that Carper's description of the variety of patterns of knowing in nursing has been very influential, but has not been examined in relation to the philosophical shifts in nursing. Silva et al. (1995) identified several strengths of Carper's patterns of knowing. For example, one of the strengths of Carper's work is that she liberated nurses to use the broad range of their knowledge and extend beyond the widely

accepted empirical knowledge. Silva et al. (1995) also stated that the strength of Carper's work is that she validated the use of nurses' creativity and pushed for the development and advancement of nursing knowledge, separate from medical knowledge. By identifying the variety of patterns in how nurses know there was room to expand nursing knowledge to include complex and diverse types of knowledge (Silva et al., 1995).

Silva et al. (1995) asserted that one of the limitations of Carper's patterns of knowing was that, although Carper claimed that these patterns were not exhaustive, the patterns have been treated as such by future authors. Silva et al. also asserted that Carper did not describe how nurses come to know but merely labeled the patterns of knowing, limiting the potential of this work to guide nurses' knowledge development (1995). The third limitation was that although Carper clearly stated that all four patterns are necessary and interrelated, the presentation of four distinct entities left the reader to see them separately (Silva et al., 1995). Silva et al. (1995) maintained that the lack of further development of the patterns of knowing led to Carper's work being misinterpreted and the richness of the original work being lost. I am suggesting that these limitations could have been more accurately addressed as critiques of the limited development of the ways of knowing in nursing and resultant lack of further research on nursing knowledge. They may not actually be true limitations to Carper's initial 1978 work.

A second influential nurse theorist on nursing knowledge is Patricia Benner. She described how knowledge was developed and how individual nurses built on their own knowledge. Benner (1982) used a model called the Dreyfus Model of Skill Acquisition. She studied the knowledge of nurses in a variety of hospital settings and in a variety of roles. Benner described nurses' knowledge as existing on a continuum from novice to

expert (1982). She claimed that with little to no clinical experience novice nurses rely on rules to guide their actions. Without any context, Benner described a novice as being unable to exercise judgment and needing the assistance of a mentor to help them make sense of clinical situations as they occur (1982). As a nurse encounters more real life situations, they begin to incorporate these experiences along with the rules progressing to the advanced beginner and then to competent. This progression can take years of clinical practice (Benner, 1982).

On the next two levels of the continuum, proficient and expert, a nurse provides care in a more holistic way that is highly individualized and contextual (Benner, 1982). Benner (1982) described the progression to these levels as not based solely on the passing of time in a clinical setting but on the nurses' reflections on their clinical experiences. I agree with Benner's conclusion that in order to refine and build on a nurse's knowledge, the clinical context is necessary. I also support Benner's description that in order to maximize the learning that occurs during these clinical experiences, a nurse must go beyond the concrete experience and reflect on what occurred and how it is relevant to her practice.

One critique of Benner's work is her description of the expert nurse. She gave the impression that the nurse is acting instinctively and stated that it is nearly impossible to articulate the process used to guide an expert nurse's decision making (Mantzoukas & Jasper, 2008). Benner (1982) described the expert nurse as "having an intuitive grasp of the situation" (p.405) and as unable to describe why they acted in the way they did. In addition, Manzoukas and Jasper (2008) reported that Benner's work provides a limited understanding of what knowledge is. I agree with Manzoukas and Jasper. Benner's

(1992)description of the expert nurse is vague and open to misunderstanding around the knowledge that an expert nurse applies in practice. I am suggesting Benner's (1982) description of the expert nurse has the potential to promote a stereotype of relying on gut feelings or intuition instead of a highly refined combination of both empirical and practice knowledge. However, Benner (1982) did add to the understanding of nursing knowledge with her description of nurses as relying on a variety of amounts and types of knowledge. Benner (1982) also added the important insight that nurses must incorporate clinical experiences and reflection in order to refine their knowledge.

Since the work of these early nursing theorists, very little work was published on nursing knowledge until very recently. Mantzoukas and Jasper, 2008, described the changes in the types of knowledge used by nurses throughout history. These authors organized the changes into three distinct periods (Mantzoukas & Jasper, 2008). In the first time period, from the 19th century to the mid-20th century, nurses were trained to follow rules and carry out activities dictated by an authority. This was a time when nursing knowledge had no power to explain or control its own activities (Mantzoukas & Jasper, 2008).

Mantzoukas and Jasper (2008) described the second time period as dominated by the use of nursing theory to explain the how and why of nursing activities. This period continues to some degree into the current time period. It was during this second time period that nursing began to develop its own unique body of knowledge and was defined by the work of nursing theorists such as Carper and Benner. The second time period also highlighted a division between two distinct types of knowledge in nursing. The first type of knowledge was made up of objective, generalizable truths. This type of knowledge

was emphasized in the use of evidence to guide practice. The second is knowledge that was subjective, had multiple realities, and was context dependent. This can be seen in the emphasis on reflective practice as a way for nurses to further develop their knowledge (Mantzoukas & Jasper, 2008).

In the third time period, beginning in the mid 1990's and continuing up to the present, there has been an effort to critically reflect on the divisions, gaps, and contradictions in nursing knowledge (Mantzoukas & Jasper, 2008). Individual practitioners were expected to be curious and be aware of the role of language, power, and authority in forming knowledge. There was also awareness that knowledge was formed based on the context in which it was created. In this period, less emphasis was placed on certainty and final resolutions. Knowledge development was based on the process involved in its creation. Mantzoukas and Jasper (2008) asserted that there was a lack of research on changes in nursing knowledge over time and that our understanding of what types of knowledge nurses apply in caring for patients in this recent time period was limited.

Mantzoukas and Jasper (2008), in their secondary analysis of qualitative data identified the types of knowledge that nurses used in providing care to hospitalized patients. The researchers reported five discrete types of knowledge used by nurses on medical wards. Two of these 5 types of knowledge closely resembled two of the patterns of knowing described by Carper in 1978, personal and theoretical. Personal knowledge is created by each nurse in each encounter with a patient. It is highly individualized and created during a specific interaction. Personal knowledge is what allows a nurse to create a personalized approach to each patient. The second type of knowledge is theoretical

knowledge. Theoretical knowledge is acquired in a very different way than personal knowledge. It is knowledge acquired in formal settings such as nursing schools; it can also be found in books and journals. It is often memorized and is considered quantifiable and measurable (Manzoukas & Jasper, 2008). Similarly, Carper (1978) described personal knowledge as being based on individual encounters with patients and empirical knowledge as being quantifiable, measurable and nurses often acquired it in nursing schools.

Manzoukas and Jasper (2008) introduced three additional types of knowledge that had not been previously identified. Procedural knowledge is the recognition of patterns; it is often unconscious and formed through doing tasks. This type of knowledge often predominates in routine actions that are unique to a specific ward and are often related to common situations. The next type of knowledge identified was ward cultural knowledge which is related to written and unwritten rules and norms of the ward. Manzoukas and Jasper found these rules can relate to nurses keeping busy and always doing something (2008). This type of knowledge had no cognitive aspect and did not aim toward further development of knowledge.

The last type of knowledge was reflexive knowledge (Manzoukas & Jasper, 2008) Reflexive knowledge allows a nurse to access and use all other types of knowledge efficiently and in the right sequence. This type of knowledge requires experience and is congruent with the writings of Benner (1982) where, as a nurse gains experience she would be able to more easily use all of the knowledge gained from her experience to guide actions. Manzoukas and Jasper (2008) provided a recent look at the types of knowledge used by nurses in hospital and confirmed some of the previous theories on

nursing knowledge while adding additional insights on the types of knowledge used by nurses.

The recent research of Manzoukas and Jasper (2008), as well as the earlier work of Carper (1978) and Benner (1982), was based on the types of knowledge used by nurses in hospital settings. The Community Health Nurses Association of Canada (CHNAC) (2008) described what knowledge means for community health nurses, including public health nurses, in the Canadian community health nursing standards of practice. The CHNAC (2008) describes community health nurses as using multiple ways of knowing. Their publication asserts that each different way of knowing is necessary to understand and work with the diversity found in both individuals and communities. The five ways of knowing described in the standards of practice included Carper's 1978 four patterns of knowing and an additional pattern, socio-political knowledge (CHNAC, 2008). The most recent CHNAC (2011) standards of practice continue to endorse community health nurses use of the multiple ways of knowing.

Two additional authors have added a fifth pattern to Carper's original patterns of knowing in nursing. White (1995) critiqued the work of Carper (1978) and added a new pattern of knowledge, socio-political knowledge. Socio-political knowledge is described as an understanding of both the socio-political context of nurse-client interactions and the socio-political context in which nursing as a profession exists (White, 1995). Chinn and Kramer (2008) also made an attempt to add to the work of Carper through the description of an additional pattern of knowledge described as emancipatory knowing, the capacity to take notice of social injustices, critically examine why these injustices exist, and take action to correct social and institutional wrongs. It requires both reflection and action,

and is the pattern of knowing that “makes social structural change possible” (Chinn & Kramer, 2008, p.77). This pattern of knowledge is similar to both the writings of White and the description of knowledge in the CHNAC standards of practice (2008) requiring nurses to understand the socio-political environment and use multiple sources of knowledge to question the status quo and move toward action.

Bonis (2009) used a different approach to clarify what constitutes nursing knowledge by using Rogers’ evolutionary method of concept analysis to perform a concept analysis on nursing knowledge. Rogers’ method involves an in-depth exploration of the literature and an iterative process to identify antecedents, consequences, an exemplar, and areas for potential further research. Roger’s evolutionary method is also highly useful in this case as concepts that often change over time are recognized. The 134 papers that were reviewed by Bonis (2009) spanned from 1978 to 2001 and concluded that:

The concept of knowing in nursing involves a uniquely personal type of knowledge, constructed of objective knowledge interfaced with the individual’s awareness and subjective perspective on personal experience; it is a dynamic process and result of personal reflection and transformation. (p. 1330)

Bonis (2009) described knowing in nursing as highly personal and influenced by both personal and professional experiences. Knowing is influenced by awareness, reflection, and perspective so that no two nurses may have the same knowledge even if they have the same experiences. The consequences of knowing are understanding, finding meaning, and transformation (Bonis, 2009).

Although other nursing theorists discussed the role of professionals' experiences and reflection in influencing the knowledge of an individual nurse, the role of nurses' personal experiences in the development of nurses' knowledge has not often been described. Previous descriptions of personal knowledge have referred to the knowledge nurses gain from individual interactions with patients (Caper, 1978; Manzoukas & Jasper, 2008). Bonis (2009) however, referred to the influence of a nurse's personal knowledge as being formed by their experiences outside of interactions with patients. This description of personal knowledge is similar to the conclusions of Aston (2008) in her research with community health nurses in which she reported that the nurses used a wide range of sources of information when working with new mothers including personal parenting experiences.

Porter (2010) challenged the reliance on Carper's patterns of knowing suggesting they may no longer be acceptable as society changes in its relationship to health care providers. The limitation that Porter identified is that nursing, beginning with Carper's patterns, has continued to be unable to articulate what is meant by knowing, in a time where there is increasing accountability and an expectation for the use of evidence. Although Porter (2010) does not disagree with the notion of multiple ways of knowing the question is raised as to how much of Carper's ways of knowing can be justified and advocates for the use of evidence to help provide support for the additional ways of knowing. Porter (2010) suggests that nursing risks facing that the only way of knowing is empirical because it is well understood by society.

In this section, I have focused on knowledge in nursing as described by nursing researchers and nursing theorists. Since nursing knowledge was first described, these

descriptions have been multifaceted and holistic (Carper, 1978). In more recent literature, authors have concluded that the work of Benner and Carper are still applicable (Manzoukas & Jasper, 2008) but may be facing increasing challenges in a time of increasing accountability (Porter, 2010). Nursing knowledge has been expanded to include knowledge of the socio-political environment. Nurses must use this additional means to knowledge of context in order to advocate for change (Chinn & Kramer, 2008; CHNAC, 2008; White, 1995). Bonis (2009) and Aston (2008) added that nursing knowledge is also informed by experiences that nurses have outside of their professional interactions.

For the purposes of this exploratory study, I will use a broad definition of nursing knowledge that includes all of the various ways that nurses use to form their knowledge. This includes formal, quantifiable, and empirical knowledge but it also relies on subjective forms of knowledge that change based on the individual patient and nurse, and the context in which the knowledge is formed. This definition combines the writings of the above theorists and researchers that describe nurses as using a variety of sources to develop their knowledge base. This study was exploratory and the research questions were purposely broad due to the limited information on this subject. Therefore, an all encompassing definition of nursing knowledge meets the needs of this research.

Attitude. Attitude is a complex concept. There is considerable literature on nurses' attitudes toward specific illnesses or toward specific behaviors. Despite the interest in the attitudes of nurses in nursing, the concept of attitude either lacks a definition or is vaguely defined (Altman, 2008). The concept of attitude is extremely relevant when attempting to understand clinical practice since there is both theoretical

and empirical evidence that supports attitudes as playing a role in predicting behaviors (Ajzen & Gilbert Cote, 2008).

Altman (2008), prior to her own research on the attitudes of nurses toward formal education reported that, in the nursing literature, the term attitude is often used without providing a clear definition. Using the Avant and Walker concept analysis procedure, Altman (2008) performed a concept analysis of attitude in order to provide a definition that she could use in her own research. She described attitude as a “multidimensional construct ... a disposition towards or against a specified phenomenon, person, or thing” (Altman, 2008, p.146).

This two-part definition comes from social psychology. First, attitudes can be either favorable or unfavorable and second, an attitude is a response towards a person, object, or situation (Altman, 2008). The other key characteristics that Altman (2008) reported are that attitudes are a mental state and they can be either conscious or unconscious. Attitudes are characterized as values, feelings, or beliefs and they predispose a person toward behaviors or actions. These three categories of characteristics imply that attitudes have a cognitive, affective, and behavioral component (Altman, 2008). The conclusion put forward was that attitudes cannot be measured directly but can only be inferred through a person’s responses (Altman, 2008). Attitudes are also difficult to measure as the individual may not be conscious of their attitudes or may choose not to reveal it in certain circumstances (Altman, 2008).

Eagly and Chaiken (2007) also explored the definition of attitude. They challenged psychology to review the definition of the term attitude in light of the explosion in attitudinal research. Like Altman, they stated that clear definitions are needed in order to

foster clear measurement and enhance theory development. The definition of attitude provided by Eagly and Chaiken is that attitude is “a psychological tendency that is expressed by evaluating a particular entity with some degree of favorability or unfavorability” (2007, p.598).

Many similarities exist between Eagly and Chaiken’s (2007) description of attitude and Altman’s (2008) concept analysis. In both the description and the concept analysis, attitudes were reported to: (a) be negative or positive; (b) have a cognitive, behavioral, or affective component; and (c) be either conscious or subconscious. The authors also agreed that it was difficult at times to determine an individual’s attitude because an individual can refuse to reveal their attitudes depending on the context (Altman, 2008; Eagly & Chaiken, 2007).

Another researcher who provided a definition of attitude was Ajzen (1991) in his theory of planned behavior (TPB). The TPB has been frequently cited in literature on health care professionals’ clinical behaviors, including nurses, and is one of the more popular social-psychological theories used to predict behavior (Ajzen & Gilbert-Cote, 2008). In the TPB, Ajzen defined attitude as “the degree to which the person has a favorable or unfavorable evaluation or appraisal of a given behavior” (1991, p.10). Attitudes are based on a person’s beliefs and are one of the factors that inform behavioral intentions, the antecedent to behaviors (Ajzen, 1991).

Ajzen’s (1991) theory provided both a theoretical explanation and the empirical evidence to support the contribution of an individual’s attitude when predicting his or her behaviors. Ajzen stated that attitudes toward behaviors are a function of behavioral beliefs, or beliefs about the likely consequences of a behavior(1991). A behavioral belief

is a subjective assessment of the likelihood that certain behaviors will lead to a particular outcome. These beliefs can be inaccurate or biased, but are spontaneous and lead to an attitude toward a behavior. Attitude is one of the factors that form a behavioral intention, which in turn precedes a behavior (Ajzen & Gilbert-Cote, 2008).

According to the TPB, the antecedent to a behavior is a behavioral intention. A behavioral intention is formed based on three separate, although at times interrelated factors; attitudes toward the behavior, subjective norms and behavioral control. These three factors influence the strength of the behavioral intention and therefore will influence the likelihood that a behavior will be performed or not (Ajzen, 1991).

The authors of the TPB also considered the role and importance of context (Ajzen & Gilbert Cote, 2008). The three factors, attitudes towards a behavior, subjective norms, and behavioral control were influenced by a variety of situational and personal factors. These three factors can vary in their relative importance depending on the situation (Ajzen & Gilbert Cote, 2008). Given this understanding of the role of attitudes in influencing behaviors, the TPB supports that attitudes towards a behavior would be one of the factors that helps to explain why a nurse would choose to perform certain behaviors and not others.

The TPB provided a theoretical understanding and framework of factors that influence behavior (Ajzen, 1991). Godin et al. (2008) conducted a systematic review of social cognitive theories in order to better understand what theories have been able to predict the behavior of health care professionals. Of the 76 studies reviewed, Godin et al. identified seven specific to nursing (2008). Godin et al. (2008) reported that the theory most commonly used to predict behaviors or intentions was the theory of reasoned action

or its extension, the TPB. Godin et al. also stated that the TPB appeared to be the most appropriate theory to predict behaviors of individual health care professionals (2008).

I have chosen the definition of attitude as defined by Ajzen (1991) to inform this study for several reasons. First, it provided a clear definition of attitude. Second, the definition of attitude as defined by Ajzen acknowledged that attitudes can be negative or positive (Ajzen, 2008) which is important in an exploratory study. Finally, the TPB has been previously used in studying the attitudes of nurses and has been used to predict the behaviors of health care professionals (Godin et al., 2008). Although this study does not intend to predict behaviors of nurses, I am using interpretive description, which guides the researcher to design a study that will inform the practice or actions of nurses (Thorne, 2008). Given that attitudes, as defined by Ajzen (2008), are presumed to influence one's behaviors and that attitudes are formed by a number of factors, this definition fits both the exploratory nature of the study and the assumptions of the methodology.

Postpartum Depression

Postpartum depression (PPD) is the predominant complication that affects women following childbirth. Gavin et al. (2005) performed a systematic review of the prevalence of depression in the perinatal period and found the prevalence rate of depression in the postpartum period to be 19.2% for women in developed countries. The impact of this illness is significant and PPD creates intense suffering for women and their families. The literature on PPD is vast and extensive. It is outside the scope of this literature review to summarize all of the various aspects of PPD. Therefore, I have chosen to focus on two topics that relate to the purpose of this study, exploring the

knowledge and attitudes of nurses toward PPD. These topics are women's experience with PPD in the health care system and the role of nurses in caring for women with PPD.

Women's Experience with PPD in the Health Care System. Several researchers have explored women's experiences in seeking help and in their treatment preferences. In this section, I will review the literature specific to the experiences of women with PPD in accessing the health care system. I will use this literature to illustrate the expectations of women with PPD and some of the current gaps in the health care system for this population.

Holopainen (2002) aimed to understand the experiences of women who sought help for PPD. She used a phenomenological approach to explore women's experiences with support and treatment. Seven women participated in this study; all of whom currently or recently had PPD. The major source of support for most women was their partners. In addition, all but one woman reported that the maternal health nurse who contacted them after the birth of their baby was a significant source of practical and emotional support. Holopainen stated that the maternal nurse is a nurse contacting women after the birth in the women's homes (2002). The maternal nurse fulfilled a role similar to the role of public health nurses in Nova Scotia. The term "maternal nurse" was not clarified further, making it difficult to discern the role of this nurse.

Holopainen (2002) identified the maternal health nurse as instrumental in facilitating access treatment for women experiencing symptoms of PPD. The women in this study stated that they did not know how or where to access help. They reported that the maternal nurse provided support to the woman and her family. It was also reported that the maternal nurse was often the person who identified that the woman either had or

was at risk for PPD and the maternal nurse made appropriate referrals. In contrast, when women accessed their General Practitioner's (GP) for support with PPD they would find either a lack of time or empathy or both. The most common help they received from their GP was medication and the women in this study felt that this was not appropriate for their situation. Women reported leaving their GP's feeling patronized and dismissed; contributing to their feelings of worthlessness (Holopainen, 2002). Although this study was reported in 2002, the negative experiences with the health care system have been described in subsequent studies (Beck, 2002; Hall, 2006).

Dennis & Chung-Lee (2006) performed a qualitative systematic review of the literature on both treatment preferences and barriers to help seeking for women with PPD. Studies were included if they identified either women's preferences for treatment or barriers for seeking help with PPD. The review included 40 studies published between 1999 and 2005. Facilitators and barriers related to care seeking were grouped into maternal factors, family and friend's factors, as well as, health care professional factors.

Health care professional factors are particularly relevant in relation to this study. Dennis and Chung-Lee (2006) identified that depressed women were high users of health care services and therefore had frequent contact with health care professionals. Health care professionals frequently did not screen women or they used inappropriate methods to screen for PPD. Health care professionals lacked knowledge of PPD. Women reported that health care professionals dismissed or minimized their symptoms leading to the women being even more reluctant to disclose symptoms. Dennis and Chung-Lee reported that women preferred to talk with someone versus the use of pharmacological treatments (2006).

Letourneau et al. (2007) interviewed women in Alberta (n=29) and New Brunswick (n=23) both individually and in groups. In this descriptive exploratory study, the researchers found similar barriers as those reported in Dennis and Chung-Lee (2006). These findings included women wanting health care providers to not only be empathetic and supportive, but also expecting health care providers to ask specific questions to determine if a woman has symptoms of depression. Insufficient time spent with women and language barriers were identified by the authors. This finding had not been identified previously.

Sword, Busser, Ganann, McMillon, and Swinton (2008) used a qualitative descriptive approach to explore women's experiences with care after referral for PPD. Eighteen women were interviewed. The women were recruited through a screening program by public health nurses in Ontario where all new mothers are screened for possible PPD. If a woman met the screening tool's cut off, the nurse told them that they could potentially have PPD and a medical referral was offered. Any woman who met the cut off was also asked if she would participate in this study.

Similar to the findings from Dennis and Chung-Lee (2006), the researchers in this study grouped factors that influenced care into three areas; individual, social network and health system factors that influenced care seeking. The researchers described factors that hindered or facilitated care seeking at each level. One barrier to care seeking was the health care provider's normalization of symptoms. For example, many health care professionals attributed the woman's feelings to lack of sleep and life changes. The second barrier was health care providers offering unacceptable treatment options. Women reported frustration due to the fact that they were often offered medication when

that was not what they wanted. These barriers are similar to the previously identified barriers (Dennis & Chung-Lee, 2006). A third barrier, which was not previously identified was the disconnection in pathways throughout the health care system. The women in this study felt that it was difficult to navigate the health care system. The gaps in communication between providers and long waits also made accessing help difficult (Sword et al., 2008)

The women in a study by Sword et al. (2008) also identified some care seeking facilitators within the health care system. These facilitators included having previously established relationships with supportive health care providers, having health care providers reach out to the woman, and timely responses. The legitimization of PPD provided women with reassurance (Sword et al., 2008). As a result of this finding, Sword et al. emphasized the importance of all health care providers developing strong interpersonal skills in order to develop trusting relationships (2008). These skills would also assist them in determining what treatment options were acceptable to the women they were caring for. Throughout the study, the women often mentioned “the nurse”. Sword et al. did not describe the role the nurse played, but did identify that public health nurses played a key role in the care of the women (2008).

Goodman (2009) studied women’s treatment preferences and barriers to treatment for PPD and used a convenience sample recruited from obstetrics clinics. All women were in the third trimester of their pregnancy and of the 525 women that consented to participate, 509 completed the surveys. Of these women, 22% reported significant depression symptoms and an additional 8.6% were in the range of probable depression.

One hundred twenty one (24%) women felt that they “needed help with sadness or depression or coping emotionally during this current pregnancy” (Goodman, 2009, p.65).

Goodman (2009) asked questions about barriers to treatment. The top three barriers for women included lack of time, stigma, and issues regarding child care. These barriers differed from the barriers found in Sword et al. (2008). Sword et al. described women’s fears and discomfort discussing mental health concerns as a barrier, which may be similar to the concept of stigma identified in this study (2008).

Goodman (2009) asked women to identify how acceptable they felt specific treatment options were for PPD. The majority (92%) stated that individual psychotherapy would be acceptable (Goodman, 2009). Fewer women (62%) responded that group therapy would be acceptable (Goodman, 2009). Only a small number of women felt that medication was an acceptable treatment for depression when pregnant (33%) or breastfeeding (35%) (Goodman, 2009). In contrast, 69% of the women responded that antidepressants were an acceptable treatment option when neither pregnant nor breastfeeding (Goodman, 2009). The reluctance to using antidepressants was related to fear of dependence, potential side effects, and stigma. In addition, the women in this study preferred to receive treatment for PPD at the clinic where they received their obstetrical care and 36.5% preferred to be treated by their obstetrician or midwife (Goodman, 2009).

The findings from Goodman (2009) represent challenges to health care providers caring for this group of women. The preference for individual psychotherapy in treating PPD, in addition to the preference for treatment in the place where they received obstetrical care creates significant challenges for the health care system. Treatment for

PPD is challenging and requires specific knowledge and skills and not all obstetric care providers would be capable of providing treatment for PPD (Stewart et al., 2003). These challenges make it difficult for this preference to be accommodated. The reason for the preference was not explored, but it may be related to the trusting relationship that is built between the woman and her obstetrical care providers. In addition, lack of time or stigma may also play a role. A more in-depth understanding of these barriers could give clinicians and decision maker's information needed to structure treatment in a way that minimizes barriers.

Chew-Graham, Sharp, Chamberlain, Folkes, and Turner (2009) interviewed both women and health care providers to explore disclosure of symptoms of PPD in primary practices. Nineteen GP's, 14 health visitors and 28 women were interviewed and thematic analysis was used to analyze the data. The women in this study had many fears around disclosure. These included fears of judgments about their ability to mother and uncertainty of the role of the health care providers such as were they there for the health of the baby or the mother (Chew-Graham et al., 2009). These findings were similar to the findings from previous studies describing women's experiences of disclosing symptoms of PPD (Sword et al., 2008).

Chew-Graham et al.'s (2009) study was unique in that the researchers also asked the GP's and the health visitors about barriers to diagnosing PPD. The health care providers reported using clinical intuition to determine if there was a possibility of PPD and did not report the use of formal screening tools. Health care providers reported reluctance to diagnose PPD although the different professionals had differing explanations for this reluctance. Health visitors were concerned that it was not their role

to diagnosis PPD and felt that this was the role of the GP. The GP's were reluctant to diagnose PPD for several reasons. Some felt that symptoms would remit on their own, or that women would not accept the diagnosis and in some cases they did not feel they had the skills or resources to manage PPD (Chew-Graham et al., 2009).

An additional barrier to providing care included lack of continuity of care resulting in professionals feeling limited responsibility for the woman. Health visitors were reluctant to refer a woman to the GP if they foresaw that antidepressants would be the only treatment offered. Both GP's and health visitors were reluctant to diagnose a woman if there were limited resources for referral or if they personally felt that they did not have anything to offer. This led the researchers to conclude that there needs to be a system wide approach to improving detection of PPD (Chew-Graham et al., 2009).

Slade et al. (2010) used a qualitative design to provide information on women's experiences with identification, and management of symptoms of postpartum depression by health visitors as part of a bigger trial on primary care models of care for women with PPD. Thirty women participated in in-depth interviews to describe their experiences with the care provided by health visitors. The first theme, "seeking help" described by Slade et al. was about how difficult it was for women to seek help. Women only sought help if urged by family. They also stated that they would not seek help if they did not feel their home visitor was someone with whom they could relate. In the second theme, "roles and relationships", Slade et al. described the role of the health visitors and the relationships women had with the health visitors. Women described being unclear as to the role of the health visitors and that the interpersonal skills of the health visitor made a difference on how the women felt about the treatment provided. The final theme, "experiences of

intervention or support” was where women in the intervention group, that received psychological care by health visitors, reported overwhelmingly positive experiences with the care provided. For the others the care they received was varied and inconsistent (Slade et al., 2010).

The findings from this study confirm findings from previous studies about how difficult it is for women to disclose symptoms of depression (Slade et al., 2010). It also highlights how important it is for health professionals to be empathetic and to form a relationship with the woman. Up to this point many studies provided information on the negative interactions that women had with health care providers, in contrast the researchers in this study appeared to find overall positive interactions. The health visitors in this study were part of a larger study that was focusing on improving care related to PPD and many of them had additional training on how to provide care related to PPD. This may have influenced the differences in findings. Slade et al. (2010) adds to our understanding of the importance of women perceiving that they have a good relationship with their health visitor.

The studies described up to this point suggest that women frequently have negative experiences when they attempt to talk with health care providers about symptoms of PPD (Dennis & Chung-Lee, 2006; Goodman, 2009; Holopainen, 2002; Letourneau et al., 2007; Sword et al., 2008). Women’s experiences of health care providers dismissing their concerns and normalizing their symptoms made it more difficult to access help (Goodman, 2009; Holopainen, 2002; Letourneau et al., 2007; Sword et al., 2008). In contrast, Slade et al. (2010) concluded that women were mostly satisfied with the care provided by the nurses identifying PPD and during home psychological visits. Women

were reluctant to take medication and preferred to talk with someone who would acknowledge their concerns and be empathetic (Dennis & Chung-Lee, 2006; Goodman, 2009; Stewart et al., 2003; Sword et al., 2008).

From these findings, several researchers, recommended empathetic and supportive listening by health care professionals as key to promoting an atmosphere where women were comfortable disclosing feelings (Goodman, 2009; Holopainen, 2002; Letourneau et al., 2007; Slade et al., 2010; Sword et al., 2008). The fact that nurses have frequent contact with women in the postpartum period combined with recent evidence to suggest that with women receiving treatment for PPD were satisfied with the care those nurses provided (Slade et al., 2010) increased the need to ensure that nurses have the skills and opportunities to provide effective care to women. Slade et al. (2010) also adds to our understanding of the importance of ensuring that women understand the role nurses play in promoting the health of both the woman and the child in the postpartum period.

Nurses' Role. The research regarding the role of the nurse in caring for women with PPD or at risk for PPD is sparse. When the nurse is discussed he/she is often included in a list of other health care providers, with the role of the nurse not clearly described. Despite the lack of research in this area, The Canadian Nurses Association (CNA) (2008) competencies for perinatal nurses included that the perinatal nurse must be able to assess for and select interventions for depression in the childbearing woman. In addition, some researchers identified that nurses caring for postpartum women serve as an access point to services (Driscoll, 2006; Sword et al., 2008). A heightened understanding of the role of nurses would provide a better understanding of how care is provided to postpartum women.

Much of the literature that has described the role of the Community Health Nurse in caring for women with PPD comes from the United Kingdom (UK). The role of the Health Visitor is well described (Rothman, 2006). Health visitors are nurses who routinely contact women in the postpartum period, first for a well baby visit and later for a 6 week postpartum check. Health visitors assess the woman's wellbeing, including identifying a history of or current mental health concerns. The health visitor sometimes provides the supportive care a woman needs without referral to other services. If a woman has a serious mental illness, a health visitor would refer the woman to mental health services but continues to provide support to the woman (Rothman, 2006).

Baldwin and Griffith (2009) interviewed eight community health nurses, including health visitors, and reviewed 60 charts, in order to determine if community health nurses assess South Asian mothers for risk factors of depression, self harm, and suicide. The aim of this study was to clarify the role of health visitors when caring for South Asian postpartum women. The focus on the South Asian population was due to the fact that the rates of suicide were higher for these mothers than for other ethnic groups in London.

Baldwin and Griffith (2009) concluded that the community health nurses did assess South Asian mothers for general risk factors for PPD and some culturally specific risk factors. None of the nurses were aware of any policy or guidelines for the assessment of PPD and they did not use a specific assessment tool in assessing for PPD. The nurses assessed the women's psychological wellbeing by asking general questions about mood and emotions and combined this information with observations of the woman and her interactions with her baby. The lack of formal screening is not congruent with the national guidelines for the UK. These guidelines state that all health care professionals

use specific questions in assessing all postpartum women for PPD (Baldwin & Griffith, 2009). Additional findings from the chart reviews included very little documentation of risk of suicide or self harm (3.3%), violence (5%), and isolation (3.3%) (Baldwin & Griffith, 2009). Although this study examined the care of a specific cultural group of new mothers, it raises questions as to the assessment strategies for PPD that health visitors employ when caring for all new mothers.

Yelland, McLachlan, Forster, Raynor, and Lumley (2007) reviewed the hospital-based postpartum care and more specifically examined how the psychosocial health of postpartum women was assessed and promoted. The first phase of the study was a postal survey to all publicly-funded hospitals that provided postpartum care. Sixty six hospitals (96% response rate) responded and they included any documents, such as care paths or policies, related to psychosocial care. The second phase involved interviewing 38 health care providers from 14 hospitals. Although nurse managers were among the interviewees, no direct care nurses were included. The surveys and interviews included questions on a range of factors that influence psychosocial health such as violence, lack of support, or mental illness (Yelland et al., 2007). Findings revealed that physical health was more frequently assessed in a standardized way than psychosocial health. Health care providers reported assessing a woman's mood through observation and conversation. There was no standardized approach to the assessment of psychosocial health and practices varied widely (Yelland et al., 2007). These findings parallel the results of (Baldwin & Griffith, 2009) in relation to health visitors. Yelland et al. also identified that participants had a range of skills in dealing with complex psychosocial issues and hospital care was described by participants as busy and chaotic, leading to a lack of time

spent on these issues (Yelland et al., 2007). One limitation in this study was that hospital nurses did not participate in the interviews making it difficult to determine if the findings accurately represented the care the hospital nurses provided to postpartum women.

Logsdon, Tomasulo, Eckert, Beck, and Dennis (2012) clearly articulated a potential role for hospital perinatal nurses related to PPD. They developed a best practice guideline to inform the work of hospital perinatal nurses because of previous reports that hospital nurses were not comfortable addressing the issue of PPD. The guideline begins with outlining the nurses' responsibility to assess each woman's individual risk factors for PPD and to screen each woman for PPD prior to discharge. The second part of the guideline involves the nurse educating women about the symptoms of PPD to facilitate help seeking behavior in women if they develop PPD symptoms later. The third role that Logsdon et al. described was providing women with a list of community resources (2012). The use of this guideline has the potential to improve the care of women in the postpartum period related to PPD and given that most women encounter hospital nurses they have an opportunity to have an impact on PPD outcomes.

Morell et al. (2009) performed a prospective cluster trial in the UK and studied the benefits of two psychological interventions delivered by specially trained health visitors. Health visitors were trained to assess for PPD using Edinburgh Postnatal Depression Scale (EPDS), in addition to clinical assessment skills, provided care to the intervention group. These health visitors were also trained to provide two psychologically informed interventions, one based on cognitive behavioral principles, the other using a person-centered approach. Health visitors who provided care for women in the control group did

not receive this additional training and provided usual care. In this study, 101 general practices consented to take part and were randomized after they consented to participate. Out of these practices, 7649 women were eligible to take part in the study and 4084 (53%) consented to participate (Morrell et al., 2009). Eighty-five percent of the women completed the questionnaire six weeks postpartum. The researchers used a cut off score of 12 or greater on the Edinburgh Postnatal Depression Scale (EPDS) and 16% of the women in the control group and 18% of the women were eligible for interventions (Morrell et al., 2009).

The primary outcome of the study was an EPDS score of less than 12 at six months postpartum. At six months, when the researchers retested the women who had a score of 12 or higher at the six week questionnaire, the women who were in the intervention group were 40% less likely than women in the control group to still have a score of 12 or greater (OR 0.60, P = .028) (Morrell et al., 2009). The researchers also measured scores at 12 months and 18 months. The researchers reported that the effect of the intervention appeared to be maintained at 18 months, but the researchers could not be confident in the results due to the low number of women responding at that time (Morrell et al., 2009).

The strengths of this study included; it was the largest study to consider the effectiveness of psychological interventions for the treatment of PPD and women were followed for a longer period than in previous studies (Morrell et al., 2009). The findings from this study supported the use of psychological interventions in the treatment of PPD. This was important given that previous research found that individual therapy is the most accepted treatment option for women with PPD (Dennis & Chung-Lee, 2006; Goodman, 2009; Sword et al., 2009). In addition, the researchers reported that with proper

education and support, health visitors effectively screened and provided treatment to women with PPD.

Glavin, Smith, Sorum, and Ellefsen (2010) extended the evidence confirming the ability of nurses to provide screening and treatment of PPD through a large trial where women were offered supportive counseling if they screened positively for PPD. In this trial 2, 247 women agreed to participate. The experimental and usual care groups were determined based on municipality. All women were screened using EPDS at six weeks postpartum. Women in the experimental municipality were offered supportive counseling by the public health nurses, individualized to meet the women's needs, if they had a score of greater than ten on the EPDS. The women in the usual care municipality were offered routine care by public health nurses. The EPDS was used to determine PPD scores at three months and six months postpartum. The researchers found that the women who received the intervention, (supportive counseling), had significantly lower EPDS scores at both three and six months postpartum leading them to conclude that this is an effective treatment for PPD (Glavin et al., 2010). This study and the one by Morrell et al. (2009) generated evidence for a new role for nurses in providing effective and acceptable treatment options for PPD. It is important to note that in both of these studies the nurses were provided with additional training prior to delivering treatment to women with PPD.

Another role that nurses have in relation to PPD is increasing knowledge through research. Nurse researchers have played a significant role in advancing the knowledge related to PPD. In a review of 141 studies on PPD performed by nurse researchers (Beck, 2008a; Beck, 2008b), part one of the review focused on nurse researchers' contribution to

the areas of epidemiology, risk factors, and transcultural perspectives, while part two examined nurse researchers' contribution to instrument development, screening, interventions, and mother-baby interactions.

The nature of PPD across cultures, known risk factors, and the prevalence of PPD among new mothers have been well studied by nurse researchers. Nurse researchers have also completed significant work on screening tools, creating five well developed and validated tools (Beck, 2008b). Beck (2008b) reported a lack of intervention studies found during this review. The contribution of these nurse researchers has led to new knowledge on some aspects of PPD and to the incorporation of evidence into practice (Beck, 2008a). Despite this, there remains a gap between the evidence available and the screening and treatment of women with PPD within the health care system.

In conclusion, nurses, like other health care professionals, most often assessed for PPD informally, with standards and practices varying widely (Baldwin & Griffith, 2009; Yelland et al., 2007). There is increasing support for nurses being able to provide psychologically based treatments for PPD in women's homes (Glavin et al., 2010; Morrell et al., 2009) provided the nurses received additional training. An additional role of nurses in the area of PPD is that of conducting research. Despite the existing knowledge base related to PPD a gap exists in understanding how nurses apply this knowledge in practice. Given the frequent contact of nurses with postpartum women there is a need to further explore the role of nurses in caring for women with PPD in order to improve the experiences of women with PPD.

Health Care Professionals' Knowledge and Attitudes Toward PPD. This section includes a discussion and synthesis of the research related to the knowledge and

attitudes of a variety of health care professionals because at present, there is only one published study that explores the knowledge and attitudes of nurses towards PPD.

Sofronas et al. (2011) used a survey to examine the beliefs, attitudes, and practices of hospital nurses and although the findings add to our knowledge of this topic, gaps continue to exist. Nurses have also been included in studies with both physicians (Lepper, DiMatteo, & Tinsley, 1994) and midwives (Lees, et al., 2009; Skocir & Hundley, 2006). Limited research has been conducted on knowledge and attitudes of health care professionals, including nurses, towards screening for PPD.

In an early study, Lepper et al. (1994) surveyed both obstetricians and obstetrical nurses to assess their knowledge and awareness of PPD. Two hundred obstetricians and 725 obstetrics nurses in the state of California responded to an anonymous postal survey. The response rate to the survey was 20.8% for the obstetricians and 60.6% for obstetrical nurses (Lepper et al., 1994). Both groups of professionals completed surveys that included questions on demographics, job demands, and awareness of PPD. In addition to the survey, the obstetric nurses also completed an empathetic concern scale (Lepper et al., 1994). The researchers did not provide a rationale for the completion of this additional scale.

Male obstetricians had less awareness of PPD than female obstetricians and younger obstetricians appeared more aware of PPD than older obstetricians. The nurses scored significantly higher on the awareness of the impact of PPD than the obstetricians, but had less knowledge than the obstetricians of the antecedents of PPD (Lepper et al., 1994). Lepper et al. (1994) concluded that both the nurses and obstetricians in this study

had gaps in their knowledge of PPD and needed to increase both their knowledge and awareness of PPD (Lepper et al., 1994).

However, given the continuing changes in education of health care providers and evolving knowledge on PPD, it is difficult to know if the conclusions found in this study still apply in today's health care context. Although this study did reveal gaps in the knowledge of nurses related to PPD, it did not address the role of the nurse in screening and treatment of PPD. In another study, Wiley et al. (2004) distributed a nationwide survey to general pediatricians in the U.S.A. to investigate pediatricians' knowledge of PPD and their screening practices. The researchers sent out a self-administered survey to a random sample of pediatricians. The response rate was 32% and they received 311 completed surveys (Wiley et al., 2004). The survey began with a definition of PPD and included questions about the incidence of PPD, the physician's experiences with mothers with PPD, the physician's attitudes and beliefs about screening for PPD, the barriers for screening, and the physician's perceptions of resources (Wiley et al., 2004).

Wiley et al. (2004) found that a little less than half (49%) of the pediatricians reported little or no education about PPD. Approximately half (51%) of pediatricians underestimated the incidence of PPD in the general population and 80% reported the incidence in their own practice to be less than the accepted incidence in the general population (Wiley et al., 2004). Almost all pediatricians (94%) agreed that PPD is a valid diagnosis. The majority (83%) recognized that PPD can have a negative impact on the family. The researchers found that only 25% of pediatricians felt that a mother would discuss symptoms of PPD and only 31% of pediatricians felt confident that they would recognize PPD in the mothers of their patients (Wiley et al., 2004).

In this study, 11% of the pediatricians reported that they would not seek help for depression due to the stigma attached. The researchers questioned the extent to which pediatricians felt comfortable discussing depression with mothers and how this influenced their practice. Health care provider's own personal attitudes toward PPD had not been previously disclosed in the literature. Very few pediatricians (7%) in this study were familiar with any screening tools for PPD (Wiley et al., 2004). The most common approach to screening women was to ask general questions about how they were doing. Twenty-seven percent of respondents did not attempt to screen for PPD. The most common barrier cited was lack of time (Wiley et al., 2004).

Despite the fact that having a mother with PPD can potentially have a long term negative impact on a child, Wiley et al. (2004) reported that there was little information given to pediatricians. In addition, the relationship between a new mother and a pediatrician is unique in that they often have early and frequent contact with the new mother yet the mother is not the patient (Wiley et al., 2004). The results of this confirmed that gaps exist in health care providers' knowledge of PPD and that health care professionals have perceived barriers to identifying PPD. It also provided new information on personal attitudes of physicians related to the stigma of depression.

Keng (2005) developed a questionnaire for Malaysian midwives to determine both their knowledge of PPD and their views on the training they received on PPD. Fifty-seven midwives participated in the study. The survey was piloted and included 10 closed questions. Questions were asked about the duration of and prevalence of PPD, the contributing factors for, and the strategies that could prevent PPD. The midwives were asked to rate the quality of their education regarding PPD (Keng, 2005).

The majority of midwives rated their education on PPD as excellent (10.5%) or good (63.2%) (Keng, 2005). Despite this, Keng (2005) found that the midwives in this study were confused on the definition of PPD and the majority of midwives could not differentiate between postpartum blues and PPD. Midwives felt that PPD was most often a difficulty in adjusting to motherhood. Keng concluded that midwifery education related to PPD was not sufficient given that midwives were unable to correctly identify PPD (2005). Keng (2005) suggested this lack of knowledge on PPD was likely the result of a lack of education, however, she stated that it may also be related to “attitudinal problems” (p. 83). This researcher adds to the concern that health care professionals have gaps in their knowledge regarding PPD. However, due to the limited information gained in the study the researchers were not able to conclude why these gaps exist.

Jones, Creedy, and Gamble (2011) used a national postal survey to gather information about Australian midwives knowledge of both antenatal and postpartum depression. The researchers postulated that midwives were in an ideal position to provide emotional care to childbearing women but may not have the required knowledge. The response rate for the survey was 81.5% and the results showed that on average 70.6% of midwives answered the questions on postpartum depression correctly. Despite this, there were gaps in the midwives knowledge, in particular related to onset, assessment of, and management of depression in childbearing women. The midwives in this study also answered that they felt their education did not prepare them to care for women with PPD and they were interested in more education related to PPD. One limitation to a large survey is a selection bias; midwives with more interest in PPD may have been more likely to complete the survey influencing the results (Jones et al., 2011). The other

limitation that was not identified by the authors was that increased education may not have had an impact on the care that midwives provided, as practice is influenced by a multitude of factors.

In a study that included both midwives and nurses, Skocir and Hundley (2006) also explored knowledge of PPD. They were interested in knowing if the midwives and nurses felt prepared to take on a greater role in caring for women with PPD. A convenience sample consisted of hospital nurses, community nurses, and midwives. All study participants worked with women during the postpartum period. In total, 134 surveys were completed and the response rate was 77.5% for the hospital participants and 75% for the community participants. The questionnaire included 26 questions divided into four themes; employment data, knowledge regarding PPD, experiences and opinions about PPD, and demographic data (Skocir and Hundley, 2006).

Skocir and Hundley (2006) also found large gaps in knowledge of both the nurses and midwives. Most participants could not identify the common time of onset of the illness, and more than half of the participants did not know of any screening test that could assist in detecting PPD (Skocir & Hundley, 2006). Skocir and Hundley concluded that it is likely that this gap in knowledge would interfere with the midwives' and nurses' ability to detect PPD and intervene early (2006). The participants in this study confused symptoms of postpartum blues and postpartum psychosis with symptoms of PPD (Skocir & Hundley, 2006). The majority of participants were not confident in their knowledge related to PPD and all but one participant stated the need for further training in this area (Skocir & Hundley, 2006).

One limitation of this study was that Skocir and Hundley (2006) did not report differences between knowledge of the nurses and midwives. The authors did identify several variations between participants in the hospital and the community groups. The hospital group identified the prevalence of PPD correctly at 10-15%, whereas the community group estimated the prevalence of PPD as much lower at 2%. This difference was statistically significant ($p=.0001$). In the hospital group, 40.5% were aware that there are screening tools to detect PPD and only 8.5% of the community were aware of any screening tools. The nurses and midwives stated a lack of confidence in caring for women with PPD and 99% of participants felt the need for further education on PPD (Skocir & Hundley, 2006).

In addition to the research conducted related to the general knowledge and attitudes of health care professionals towards PPD, there were two published studies exploring health care professionals' knowledge and attitudes towards screening for PPD (Delatte, Cao, Meltzer-Brody, & Menard, 2009; Mason & Poole, 2008). Currently there is no universal screening for PPD in Nova Scotia; however, in some parts of the world, routine screening for PPD exists. Researchers are beginning to evaluate the routine use of the EPDS as a screening tool (Delatte et al., 2009; Mason, Poole & Osborn, 2006), as well as, the attitudes of health care providers using the screening tool (Delatte et al., 2009; Mason & Poole, 2008).

Mason and Poole (2008) used interpretive phenomenology to explore the views of health care professionals who screen women for PPD. Nineteen nurses or health visitors were interviewed and the following themes identified: the staff felt satisfied with the extent of the training and support provided in the use of the EPDS, many of the staff

described workload pressures that impacted the use of the screening tool, and a lack of privacy, limited time, and staff shortages influenced the timing of screening, and the professionals' comfort with screening. Nurses did not want to begin to discuss this issue if they did not have the time or privacy to deal with any concerns that arose (Mason & Poole, 2008).

The participants in Mason and Poole's (2008) study reported discomfort in relying primarily on the EPDS as a screening tool and stated that they preferred to use it as a way to open up conversation about PPD. They felt that their professional judgment, including assessment of a woman's overall situation, was necessary to accurately interpret the information they received from the woman (Mason & Poole, 2008). The heavy reliance on clinical judgment influenced screening practices in two ways. First, variations existed with regard to how and when individual professionals used the screening tool. Second, even with the same provider there were often variations in how they used the tool with different women (Mason & Poole, 2008). The combination of reliance on clinical judgment, variation in screening practices, and the influence of workload pressures led Mason and Poole to recommend that the work context in which the screening occurs must be understood in order to support implementation of best practice (2008).

In March 2006, the University of North Carolina implemented a routine screening program for PPD (Delatte et al., 2009). All women were screened using the EPDS at their 6-week postpartum check up. Delatte et al. (2009) evaluated the use of the EPDS by obstetric providers. Providers' knowledge and attitudes toward detecting and treating PPD were also explored. The first phase of the study was a chart review of 512 postpartum patients. Results revealed that providers recorded the EPDS score in only

39% of visits and counseled patients on their score in 35% of visits. There was a significant difference ($p < .0001$) found between different categories of providers, with nurse practitioners ($n=19$) and certified nurse midwives ($n=65$) documenting the EPDS score significantly more often than their physician colleagues ($n=100$). One limitation to this type of evaluation was that the results were only as accurate as the documentation of the providers and that providers may have been using the screening tool more often than the documentation reflected (Delatte et al., 2009).

In the second phase of this study, Delatte et al. (2009) used an email survey to assess the obstetric providers comfort in detecting and treating PPD. The survey was sent to both attending and resident physicians, certified nurse midwives, and nurse practitioners. There was a 77% response rate. All respondents felt that a diagnosis of PPD was part of their professional responsibility. Ninety-four percent of respondents were confident with diagnosing. In comparing this high rate of confidence with diagnosing to the low rates of charted EPDS scores and notes on counseling Delatte et al. concluded that there appeared to be gaps between what providers know they should do and what was actually being done at postpartum visits (2009). Although in both of these studies the researchers were limited to exploring the attitudes of health care professionals towards using routine screening tools for PPD, the knowledge gained from these studies revealed that even when health care providers have more knowledge about PPD, there were discrepancies in how that knowledge was implemented into practice. Researchers to date have not explored why this gap exists or how the knowledge and attitudes impacts on the care provided.

Sofronas et al. (2011) conducted the sole published study located, involving only nurses. They used a cross sectional survey design to explore both obstetrical and neonatal nurse knowledge, attitudes, and practice related to the management of maternal depression. The researchers used a convenience sample and had a response rate of 83%. The nurses in this study somewhat agreed that it was their responsibility to assess for symptoms of depression and intervene and refer to mental health services if needed. Only about half of the nurses assessed women for symptoms of depression, and they did not use a screening tool. The nurses in this study also provided counseling, referral to mental health services, or consultation with mental health services. The nurse most often referred women to social work or the women's GP (Sofronas et al., 2011).

Sofronas et al. (2011) suggested some of the barriers to assessment included; lack of time, language barriers, stigma, and lack of knowledge or skills. The nurses reported that they did not have adequate education related to symptoms of depression and those that were more confident and more knowledgeable were more likely to assess women for symptoms of depression. This evidence contributed to furthering understanding of the knowledge and practice of hospital nurses related to one aspect of maternal depression. As with some of the other studies, there were limitations to the nature and depth of the data captured by the survey. In addition, this study did not include the perspective of community health nurses that provided significant support to childbearing women.

Researchers have investigated the knowledge and attitudes of health care professionals specific to screening for PPD and collectively concluded that although health care professionals acknowledged the importance of identifying PPD there was a gap between what is known and what is practiced (Delatte et al., 2009; Mason & Poole,

2008). Despite well developed screening tools, health care professionals most often used informal approaches to PPD assessment (Mason & Poole, 2008) or they were varied in how they used a screening tool (Delatte et al., 2009). Evidence to date has largely been gathered by survey design including the study by Sofronas et al. (2011). A survey method is limited in that it captures what the items ask as opposed to the perceptions of the individuals themselves about a phenomenon. Conducting research from the perspectives of the individuals experiencing a phenomenon has the potential to further understanding related to nursing knowledge and attitudes as well as role in the care of women experiencing PPD.

Summary

The aim of this literature review was to provide an understanding of what is currently known related to the knowledge and attitudes of nurses toward PPD, and the role of the nurse in relation to PPD. In the first section of this review, the literature on both 'knowledge' and 'attitude' was presented to situate the reader with how these concepts were used in this study. I explored the concept of 'knowledge' in nursing beginning first with theorists such as Carper and Benner, and continued on to present more contemporary definitions of knowledge using elements such as broad, contextual, and multifaceted. In a practice discipline, such as nursing, knowledge also relies on clinical practice

Attitude is a concept that is not well explored in nursing literature. One theory commonly used when exploring the attitudes of health care professionals is Azjen's 1991 Theory of Planned Behavior (TPB). Azjen defined attitude toward a behavior as the degree to which the person has a favorable or unfavorable evaluation or appraisal of a

given behavior. The TPB provides a theoretical framework and the empirical evidence on how attitudes are one of the factors that form behavioral intentions, the antecedents to behaviors. In a practice discipline such as nursing, how a concept relates to a practice behavior is of great importance.

The second section on PPD was limited to a discussion of two aspects of the literature; the experiences of women with PPD within the health care system and what is known about the role of nurses in caring for women with PPD. Women frequently reported negative experiences within health care and stated their symptoms were often dismissed or delegitimized by health care providers (Dennis & Chung-Lee, 2006; Goodman, 2009; Holopainen, 2002; Letourneau et al., 2007; Sword et al., 2008). In addition, the types of treatment regularly offered to women were not considered acceptable to the women. Women reported preferring to talk with someone and many felt that medication was not acceptable (Dennis & Chung-Lee, 2006; Goodman, 2009; Stewart et al., 2003; Sword et al., 2008). Despite the fact that nurses had frequent and routine contact with postpartum women, the role of nurses caring for women with PPD was not well developed. Most studies to date included nurses along with other health care professionals and their role in PPD management was not made explicit.

The final section of this literature review describes the limited research on the knowledge and attitudes of health care professionals related to PPD. Only one published study was located examining the knowledge and attitudes of nurses towards PPD, and only three studies included nurses along with other professionals (Lees et al., 2009; Lepper et al., 1994; Skocir & Hundley, 2006). In each study, the researchers identified gaps in the knowledge of health care professionals towards PPD (Lees et al., 2009;

Lepper et al., 1994; Keng, 2005; Skocir & Hundley, 2006; Wiley et al., 2004).

Researchers also reported wide variation on how health care professionals screened women for PPD (Delatte et al., 2009; Mason & Poole, 2008).

The literature to date confirmed that there are gaps in the knowledge of all health care professionals towards PPD. There are also discrepancies between the knowledge that is available related to PPD and how that knowledge is applied in practice, for example what is the role of the nurse related to PPD? There is little research that considers the context in which these health care professionals provide care to postpartum women. In this study, I plan to contribute to the knowledge in the areas where gaps have been identified. The knowledge generated from this study may help further nurses' understanding of the care that is currently being provided in relation to PPD and can potentially influence the practice of nurses caring for postpartum women.

Purpose

The overall purpose of this study is to explore the knowledge and attitudes of both hospital postpartum and public health nurses towards PPD, the role of the nurse related to PPD, and the context of care using interpretive descriptive methodology. The following research questions were designed to achieve this purpose.

Research Questions

1. What is the knowledge of hospital postpartum nurses and public health nurses of PPD?
2. What are the attitudes of hospital postpartum nurses and public health nurses towards PPD?
3. How do hospital postpartum nurses and public health nurses care for women at risk for or with PPD?

4. What is the context in which nurses provide postpartum care both in the hospital and in the community?

Chapter Three

Methodology

Interpretive Description

The most common qualitative methodologies used by nurse researchers include phenomenology, grounded theory, or ethnography (Thorne, 2008). Each of these methodologies is rooted in their own distinct disciplinary traditions. These methods arose primarily from philosophy, sociology, and anthropology. Unlike nursing research, these disciplines primarily emphasize the role of research in the development of theory and each method comes with rigid rules of how to conduct research (Thorne, 2008). The practice of nursing differs significantly in that it is a practice or applied discipline. That is, nursing research is most often concerned with going beyond theory development with the intent to inform the practice of nurses (Thorne, 2008).

Interpretive description was first described by Thorne, Reimer Kirkham, and MacDonald-Emes (1997) as a new qualitative method that was uniquely suited to the development of nursing knowledge. Thorne et al. recognized that nurse researchers had been using a variety of qualitative methodologies to answer questions arising from nursing practice (1997). Thorne (2008) asserted that qualitative research is well suited to exploring questions related to nursing practice because qualitative research methodologies are particularly useful in understanding the depth, complexity, or contextual nature of a phenomenon.

During the development of interpretive description, Thorne (2008) identified that nurse researchers needed to adapt the various qualitative methodologies to suit the unique issues arising from being part of an applied or practice discipline. Thorne et al. (1997)

presented interpretive description as a qualitative methodology that allows nurse researchers to identify the need for necessary and appropriate departures from traditional qualitative approaches. Interpretive description methodology and methods were developed expressly to encourage nurses to use systematic reasoning and logic based on nursing science. The aim of this methodology is to “contribute directly to our understanding of how people experience their health and illness and what nursing can do to make a difference” (Thorne et al., 1997, p.173).

Thorne, Reimer Kirkham, and O’Flynn-Magee (2004) described interpretive description as philosophically aligned with other interpretive naturalistic orientations. Like these naturalistic orientations, Thorne et al. explained interpretive description as being philosophically based on the following three assumptions (2004). First, multiple realities exist that are contextual, complex, constructed, and subjective necessitating a holistic approach to research. Second, the inquirer and object of the research are inseparable and influence each other. When using this method the researcher must continuously reflect on both personal and professional bias. There must also be an ongoing reflection on the influence of the researcher on research participants. The third key assumption is that the findings are considered constructed and contextual and therefore must be grounded in the data (Thorne et al., 2004). Thorne et al. goes on to acknowledge that interpretive description is not a prescriptive methodology (2004). Data collection methods and data analysis techniques will vary but all studies must be founded upon the above assumptions.

Interpretive description is a methodology intended for the study of a phenomenon that is of clinical interest. The researcher identifies patterns, and then interprets these

patterns in a way that can inform clinical understanding (Thorne et al., 2004). By systematically analyzing a phenomenon and describing it, the phenomenon is brought to the attention of clinicians and may generate further questions. The researcher is then required to go beyond description and put this understanding of the phenomenon into the context of the practice environment in which it occurs (Thorne, 2008). Thorne et al. (2004) assumed that clinicians are rarely satisfied with description alone and will look for explanations and interpretations that can be applied in practice.

The researcher is also expected to look beyond the self-evident in a clinical issue and analyze the issue using the social, political, and ideological complexities of the nursing discipline. This interpretation process is realized when a researcher uses the description of a phenomenon, and then goes on to analyze patterns and relationships among the patterns (Thorne, 2008). The product of this research process is “a coherent conceptual description that taps thematic patterns and commonalities believed to characterize the phenomenon that is being studied and also accounts for the inevitable individual variations within them” (Thorne et al., 2004, p.7). Thorne (2008) explained that in an interpretive descriptive study the researcher is not focused on reaching a point of saturation in the data but needs to consider commonalities and theorize any outliers. The researcher must consider the possible outliers and what they contribute to the analysis to ensure that those variations are not ignored for the more common patterns.

Using an interpretive descriptive design the aim of this current study is to explore the knowledge and attitudes of nurses toward PPD, the role of the nurse in relation to PPD and the context of PPD. The product of this study first includes a description of the knowledge and attitudes, role, and context as described by the nurses. I then go beyond

this description and identify patterns and relationships that exist within the phenomenon. The interpretation is important in order for the product of this research to be useable to practitioners. I chose interpretive description in order to both describe this phenomenon, as there is currently little in the literature, and then place the information into the current context in which nurses operate. Overall, this research adds to the nursing knowledge on the topic of PPD and more specifically, provides information that could inform nursing practice in the care of postpartum women.

One of the reasons why I chose to use this methodology was it allowed me to explore the research questions in a way that is consistent with my assumptions about the topic. I have presented a definition of nursing knowledge and attitudes that is broad and influenced by the context in which they exist. Interpretive description is a qualitative methodology that assumes that knowledge is contextual and multifaceted (Thorne, 2008). The research questions in this study began from questions that arose in my own nursing practice. Interpretive description is designed to answer questions that have arisen from clinical problems. Thorne (2008) stated that one of the intentions of an interpretive descriptive study should be to generate new knowledge to meet a practice goal. One of the objectives of this study was to produce new knowledge with an aim of influencing the practice of nurses caring for postpartum women. I have gone beyond the description of the nurses' knowledge and attitudes and have addressed what relevance this knowledge has in the context of current nursing practice.

Setting

The nurses in this study were employed in two separate settings; an in-patient postpartum unit and a public health services program that provides care to postpartum

women. Participants in both settings provided care to postpartum women and shared the common experience of providing holistic care for women at risk for, or experiencing PPD. The two settings were unique and I will be describing them separately below.

In-Patient Postpartum Unit. The in-patient postpartum unit in this study was located in a university-affiliated, regional, tertiary care hospital in Atlantic Canada. This hospital provides services to women, children, and families in the local area and across the Atlantic Provinces. The postpartum unit provides care for both postpartum women and their newborns. It also provides services to gynecology patients. There are 42 beds devoted to the mother-baby care and 14 beds devoted to gynecology services. Many of the nurses who work on this unit are trained to provide care for both services; however, they would not be caring for a mix of postpartum women and gynecology patients in a single shift (B. Whynot, personal communication, May 25, 2010).

At the time of the study, there were 78 nurses in this postpartum unit. Sixty-four registered nurses and 14 licensed practical nurses (B. Whynot, personal communication, May 25, 2010). Each of the nurses was responsible for providing care for a range of women, typically in the first two to three days following the birth of their babies. This care included a daily assessment of mood, although how mood was assessed was not defined. In addition, there was a policy that outlines the expectation that each woman be assessed for risk factors for PPD and given information about the emotional changes in the postpartum period (IWK Health Centre, 2004).

Public Health Services. Public health services offer a variety of programs aimed at the level of the individual, family, and community and involved a range of health care professionals, including public health nurses (<http://www.cdha.nshealth.ca>). Although

public health services offered a variety of programs, in this study I have included only the public health nurses that worked in the program that provides care to women during the postpartum period. This program is called Healthy Beginnings and at the time of the study, included approximately 30 public health nurses. All of the public health nurses in this program were Registered Nurses (C. McGinnis, personal communication, June 8, 2010). The public health nurse's worked in a range of geographical areas throughout one region in Atlantic Canada; some offices were located in metropolitan locations while others serviced a more rural population.

The public health nurses in this program provided a range of services in the community such as prenatal education, as well as breastfeeding and parenting groups. They met with women prior to discharge from hospital, following the birth of their babies, in order to help connect the women with resources in the community. Following discharge, and within 72 hours each woman received a telephone call from a public health nurse. It was during this telephone call that the public health nurse assessed if the women needed or wanted a home visit (C. McGinnis, personal communication, June 8, 2010). The public health nurses in this program worked with women who were at risk for PPD or were experiencing PPD and therefore were a valuable source of information for this study.

Participants

Participant Selection. The recruitment of participants for this study was based on purposive sampling techniques. Purposive sampling meant that I selected nurses working with women following delivery who had experience related to PPD, the phenomenon being studied (Coyne, 1997; Thorne, 2008). Through purposive sampling, I

recruited nurse participants who proved to be rich sources of information and who provided insight into experiences of nurses working with women experiencing PPD (Coyne, 1997; Thorne, 2008). In my use of purposive sampling, I carefully considered which groups or individuals to include to ensure that the findings “rang true” to the participants (Thorne, 2008).

The participants in this study were Registered Nurses who worked on either the postpartum in-patient unit in the tertiary care center in Atlantic Canada or in the program within public health services that provided care to postpartum women in the community. Both settings were located in the same geographical area so they provided services to the same group of women.

Data Sources and Recruitment

Thorne (2008) recommended that the data sources for an interpretive description study be chosen by the researcher in a way that makes sense to the purpose of the study. Thorne also reminded researchers that each data source has both strengths and limitations, and therefore it is beneficial to use multiple data sources when possible. The three data sources that I used for this study were focus groups, participant observation, and reflective journaling. In the following section, I describe each data source and the recruitment procedures that I used for each.

Recruitment of participants began following approval from my Thesis Advisory Committee and subsequent approval from the IWK Health Centre Research Ethics Board. I used a variety of recruitment strategies at both settings, which are described below. Recruitment for both the focus groups and participant observation is described separately, however both occurred concurrently. Hospital postpartum nurses and public health

nurses could choose to participate in either focus groups or participant observation, or both.

Focus Groups. Focus groups are one method to gather a group of people, engage them in a topic, and hear perceptions revealed under the pressure of group dynamics (Kruger & Casey, 2000). The main purpose of using focus groups is to uncover shared knowledge, relationships, or power within a group (Patton, 2002; Thorne, 2008). In planning my focus groups I explained to the participants that the purpose of the focus groups was not to come to consensus about their perceptions of PPD but rather to share these with the group (Kruger & Casey, 2000). As a data collection strategy, I also used focus groups to better understand the influence of society (Thorne, 2008) and societal forces on a subset of society, that is, nurses working with postpartum women.

Focus group interviews provided insights into what factors influenced opinions, behaviors, and motivations (Kruger & Casey, 2000) for example lack of collaboration with other health care providers. The purpose of this study was to explore the knowledge and attitudes of hospital and public health nurses' toward PPD, the role of the nurse in PPD management and the context of care using interpretive description. I have presented assumptions about the nature of nursing knowledge as broad and multifaceted. Due to this, I expected that participants would provide a variety of perspectives that were informed by their various professional and personal experiences. Earlier I also presented the assumption that beliefs and attitudes influence behaviors. The goal of any interpretive description study is to provide insights that can be applied to a practice problem (Thorne, 2008; Thorne et al., 2004). These two ideas combined led me to

anticipate that focus group data was an appropriate data source to reveal information useful in understanding the clinical issue of how nurses care for postpartum women.

One of the limitations of focus group research is that it may not reveal individual differences as clearly as the shared perspective due to the influence of the group dynamics. Focus groups may not be the most appropriate tool when attempting to hear individual stories (Thorne, 2008). There is a risk that ideas that are highly personal or difficult to articulate in a group setting may not be revealed and participants who realize they are in the minority may not share their viewpoint (Patton, 2002; Thorne, 2008). The researcher must be aware of these issues and use skills such as emphasizing confidentiality prior to starting the discussion, as well as, encouraging input from all participants. In order to minimize these limitations, the second type of data that I chose to use in this study was participant observation, making time to be spent with individual nurses. This individual time allowed me to gain access to data that participants may not have been able to share in a group setting.

Focus Group Recruitment. Prior to beginning recruitment, I contacted the managers for both the postpartum in-patient unit and the public health services program that provided care to postpartum women and requested a meeting to discuss the study. I sought preliminary support from each manager prior to making my ethics submission and managers provided a letter of support to accompany my ethics application. This meeting allowed me to describe the purpose of the study, answer any questions, and address potential concerns. During this meeting, I shared my plans for recruitment for the focus groups and asked the managers to share any suggestions for recruitment. During this meeting, I also discussed the participant observation shifts.

Posters (Appendix A) were displayed in each respective area and nurses were encouraged to contact the researcher if they were interested in participating in a focus group on this topic. Emails and electronic communication (Appendix B) were used with the information from the poster and the researchers' contact information. A letter of invitation (Appendix C) to participate in the study was placed in the work mailboxes of all hospital nurses. During participant observation shifts I had an opportunity to discuss the study with nurses on each unit in an attempt to increase recruitment of participants. All communication regarding this study included the contact information, both phone and email, of the researcher.

Due to the limited information on this topic, all interested registered nurses were invited to participate. Therefore, the inclusion criteria for this study were any registered nurse that currently worked on either the hospital postpartum unit or the healthy beginnings program within public health.

Once a nurse contacted me, I followed up immediately to thank them for their interest, explained the study, answered any questions, and confirmed their intent to participate in the study. I then took their availability and let them know that I would be in touch as soon as I had the required number of participants to hold a focus group. I also informed nurses that if a two week period went by without a focus group I would contact them to update them on the study and continue to be in touch until the next focus group was arranged. Focus groups were arranged at times that were convenient to the participants, when they were not working, and at a location that was convenient to them. In one area it was possible, with the support of the unit manager, to offer to do focus groups during the nurses working time which was the preference of the nurses.

Sample size. Thorne (2008) asserted that interpretive description studies, typically have small sample sizes, but can be conducted with samples of almost any size. The sample size in qualitative studies can vary between studies based on a number of factors including, the nature of the topic, the quality of the data, and the type of data sources being used (Morse, 2000; Thorne, 2008). I used both Thorne (2008) and Morse (2000) in projecting a sample size, considering the various factors that impact on sample size. Thorne also suggests providing a range and accounting for the fact that you may need to expand data collection (2008). In projecting sample sizes for focus groups, Kruger and Casey (2000) as well as Patton (2002) offer general guidelines. Based on these guidelines I projected six to eight nurses in each focus group. In order to allow for attrition when organizing focus groups I aimed for 8-10 nurses per focus group.

Kruger and Casey (2000) suggest that a focus group should ideally have similar groupings of participants. If there are major differences between participants then there should be separate focus groups, this increases the comfort of participants and increases the sharing of information (Kruger & Casey, 2000). Based on this recommendation, focus groups were arranged according to the two separate work settings. In total, there were four focus groups, two from each area.

Participant Observation. Participant observation is one of the most common data sources used in qualitative research (Thorne, 2008). During participant observation shifts, I was able to spend time with participants in a purposeful way. It was an opportunity to observe the participants in their natural setting, systematically watching, and documenting behaviors. I documented my observations, and later used those observations to reflect on potential patterns and themes within the behaviors. During

analysis my observations added to my understanding of the social structures that influenced the behaviors I observed. Thorne asserted that the identification of patterns in behavior helps the researcher understand the participants thinking (2008).

Nursing knowledge, attitudes, and the nature of qualitative research all require consideration of the context in which the knowledge exists. Exploration of context and the role it plays is important in understanding the reality for these nurses. Although my own nursing practice was in a perinatal setting, I did not work in either of the above practice settings. Participant observation allowed me to add insights gained from observing the practice settings that I would not have been able to obtain through the focus groups alone.

One challenge in doing participant observation is that the researcher may already be socialized in a way that they interpret what is observed through a professional lens. This can cause the researcher's products to be superficial and lose credibility (Thorne, 2008). Despite the fact that I did not work in either nursing setting, this remained a concern because I am a nurse and undoubtedly brought my professional lens. Thorne (2008) suggested that the way to overcome this is to constantly challenge your interpretations and conclusions. I took time throughout the study to reflect on and critique my own observations and assumptions. I discussed these thoughts and reflections with my thesis supervisor and documented this in my reflective journal.

Participant Observation Recruitment. During the planning stages for this study I planned to spend three (two to three hour shifts) in each area to begin with, to get an initial understanding of the context in which the nurses worked. Midway through the collection of data from the focus groups, I would spend a further three (two to three hour)

shifts in each setting to allow testing of my initial hunches and the gathering of new data. Due to some challenges in arranging a convenient time for focus groups with the hospital nurses, I spent more time in participant observation prior to doing focus groups.

In my initial meeting with the managers of each unit, I asked permission to send out an electronic message (Appendix B) asking for interest in participating in the participant observation component of the study. In the meeting with the managers, I also asked permission to come to each respective unit at convenient times to speak to the nurses regarding the purpose of the study, answer questions, and leave my contact information for any nurses that would like to participate in the participant observation component of the study. If a nurse expressed an interest in participating, I worked with that nurse to be present during her working time at her convenience.

Participant observation provided a rich source of data and served as a strategy to assist in aspects of recruitment for the focus groups. Spending time in the individual work settings of participants enabled the building of trust and rapport (Thorne, 2008). This time also allowed me to answer any questions and discuss the study with nurses who were possibly interested in participating in focus groups. As the focus group data collection preceded the participant observation shifts, this allowed me to identify rich sources of information or nurses that had different perspectives. During participant observation shifts nurses talked about their experiences and described their beliefs and perceptions related to PPD. This provided me with valuable insights that I used throughout the analysis and added depth to my description and interpretation of the data.

Reflective Journal. Throughout all aspects of the study it was important for me to rigorously and systematically ensure that I was open and transparent. Thorne (2008)

does not assume that a researcher can suspend all prior beliefs but must (a) bring beliefs to the surface, (b) be willing to consider alternatives, and (c) consider what may be missing. In this study, the use of reflective journaling and discussions with my thesis committee members was used to continually evaluate my own beliefs, assumptions, and interpretations.

The journal included my observations from the focus groups and the participant observation sessions. I also used the reflective journal throughout this study in order to capture my own thoughts and my potential impact on the participants. The reflective journal was also the place where I captured some of my hunches and early interpretations. These observations were combined with the data from the other data sources to add depth to my interpretations. The role of my reflective journaling is also discussed in the section on credibility and was used to ensure a high quality research product.

Data Collection

Three separate data sources were used in this study; focus groups, participant observation, and reflective journaling. For the data collection procedures, these three data sources will be described separately but occurred concurrently.

Focus Groups. At the beginning of each focus group, every participant was given a full explanation of the study's purpose and given time to review the consent form (Appendix D). Any questions were answered and if the participant agreed to participate they were asked to sign the consent form and fill out a demographic form (Appendix G). Participants were informed that participation in the focus group was voluntary and their decision to participate or not in addition to any information they shared would not impact

on their employment. I assured participants that no names would be used in transcripts, or in future publications or presentations. Due to the nature of the focus groups, each participant was aware of the information shared by others. I informed participants that it was an expectation of the group that the comments of other participants be kept confidential; despite this, I could not guarantee that this would be the case. Participants were made aware of this prior to their decision to participate.

Each focus group lasted approximately 60-90 minutes and was recorded. A court recorder was present during the focus groups to create both the digital recording and provide a written transcript. I facilitated the focus group discussion using a general focus group question guide (Appendix E). This guide consisted of general questions about both the participants' understanding of PPD, and their experiences caring for women with PPD, or women at risk for PPD. In addition, I asked about the factors that influenced their clinical practice. The questions were open-ended and designed to encourage sharing both by individuals and among participants. I also used prepared prompts such as "tell me more about ..." or "would anyone like to add more details about...", in order to continue the discussion among participants, without leading the discussion in a presupposed direction. Thorne (2008) suggests that having these types of prompts are particularly crucial for a novice researcher who may struggle with the new role and must attempt to avoid influencing the participants. The focus group questions evolved as data were collected in order to test early hunches.

At the end of each focus group, I thanked participants for their time and valuable insights. I also verbally summarized key themes from the discussion for the group. Summarizing some key themes helps participants to feel heard and to feel that that they

were a valuable resource to the research process (Thorne, 2008). This summary also gave participants the opportunity to confirm or refute what had been stated. The recordings from each focus group were transcribed verbatim to ensure accuracy of the data.

Participant Observation. Once a nurse agreed to participate in a participant observation shift, I worked with the nurse to find a time that was convenient to her. When planning shifts, I attempted to be present in the two work environments during a variety of both times and situations. For example, on the in-patient unit I was present during different shifts and during shift changes. In the public health setting, I was able to attend during phone support, prenatal classes, and a community drop in. Prior to beginning an observational shift, I reviewed the study purpose and my role as an observer with the nurse that I was observing. The nurse was given the opportunity to review the informed consent form (Appendix F) and fill out a demographic form (Appendix G) prior to the beginning of an observational shift.

In the event that other nurses were present during my observational shift, the nurses were informed prior to my entering the areas about the study and my role as an observer. My contact information was given in case there were questions or concerns prior to being present. On the day of the observational shift, I took the time to remind any nurses present about the study's purpose and my role as an observer. At this time, any nurses that were present were asked if they would like to participate and if they agreed they were asked to sign a consent form (Appendix F). If a nurse did not consent to participate, anything that I observed about that specific nurse was not included in the study. I also assured all of the nurses present that if they did not consent to participate in

the study I would not record any observations of them. The nurses that consented to participating in the study were also asked to fill out the demographics sheet (Appendix G).

During the observational shifts, the aim was to observe the nurses and their work environment. In order to protect the comfort of patients, I did not follow hospital nurses into patient rooms or accompany public health nurses on home visits. Despite this, I was privy to both seeing and hearing patient information. In order to protect patients' privacy and confidentiality I did not record any identifying information about patients.

Thorne (2008) emphasized that, in order to obtain high quality data during participant observation, it is essential to systematically document. Throughout the shift, I took frequent opportunities away from the work area to take notes, including direct observations, and my own reflections. At the end of each shift I also spent time documenting my observations, taking field notes, and ensuring my notes were clear for future analysis. These notes were typed and both the written and typed notes were kept in locked files available only to myself.

Reflective Journaling. Thorne (2008) suggests that the researcher record any pre-conceptual biases prior to beginning data collection. I used a reflective journal to record my thoughts and beliefs prior to beginning data collection and throughout the research. I also used the reflective journal as a place to record ongoing observations.

Following each focus group, I wrote my own reflections and observations based on the focus group. I used these recordings to track both my observations and initial interpretations. In addition, it guided further recruitment and questions development. These observations were important because they may not have been captured in the

discussion and therefore would have been lost if not recorded. The primary way of capturing data during participant observations is using field notes. During participant observation shifts, I frequently stepped away from the unit to record observations. These notes were recorded frequently and on a regular basis. These notes included my observations on each unit, as well as early hunches and interpretations about these observations.

Data Analysis

Within an interpretive description research study, data analysis could involve a variety of data analysis techniques. The process of data analysis is more dependent on the intellectual ability of the researcher than on the steps used in organizing and sorting data. Regardless of the steps involved in data analysis, ultimately it is the job of the researcher to take the raw data and provide an interpretation that is meaningful and useful to practitioners (Thorne et al., 2004). The cognitive processes involved in any interpretive description study are described as:

(a) *comprehending* the phenomenon under study (b) *synthesising* a portrait of the phenomenon that accounts for relations and linkages within its aspects (c) *theorising* about how and why these relations appear as they do, and (d) *recontextualising*, or putting the new knowledge about phenomena and relations back into the context of how others have articulated the evolving knowledge.

(Thorne, 2000, p.70)

Thorne (2008) outlines steps that can guide data analysis, and states that they may be particularly useful to the novice researcher. I heavily relied on this guide as I proceeded with data analysis. In the beginning phases of data analysis, a researcher can

be easily overwhelmed by the mass of data. Despite this, Thorne does not recommend proceeding too quickly to coding the data in order to avoid premature closure (2008). In the first stage, I spent time making accurate records, typing written notes, and reading my records in order to develop a sense of the whole of the data prior to coming to any conclusions.

The data in this study included transcripts from the focus groups in addition to my own notes from each focus group. I also had detailed records from the participant observation shifts and my reflective journal notes. The recordings from each focus group were transcribed verbatim. Thorne (2008) suggests listening to transcripts in order to hear the silences, nuances, and words used versus reading a storyline. I began by listening to each focus group recording while reading the transcript to both clean the data (removing personal identifiers) and to get a sense of the whole. During this time, I also documented any new impressions in my reflective journal.

As I spent time immersing myself in the whole of the data, including both the focus group transcripts and the records from the participant observations, I continually asked the questions recommended by Thorne et al. (2004): “Why is this here? Why not something else? and What does this mean?” (p.13). This helps the researcher to remain open to all possibilities, examine alternate patterns, and not limit themselves to early conceptualizations (Thorne et al., 2004).

Thorne (2008) acknowledges that in order to organize the data there is a need for some degree of early coding. After spending time questioning and understanding the whole, I then began to code the data using a creative process including the use of color codes to connect like pieces of data and in turn make early connections. I used broad

code names, such as code A, code B and so on, to label these initial codes. Thorne stated that breadth is more important than precision in early coding as codes may need to be changed (2008). Highly detailed coding is also discouraged as themes and patterns are more important than precise codes in an interpretive description study (Thorne, 2008).

Following the completion of the initial coding, the researcher looks at the linkages or relationships that may exist between the various codes and patterns (Thorne, 2008). In order to do that, Thorne recommended going back to the data as a whole and consider the possible linkages, as well as, any alternative linkages (2008). I considered potential linkages and documented these connections. I worked closely with both my supervisor and co-supervisor during this stage to test the logic of my interpretations. I also had an additional committee member review the coding of one transcript. At all times through the data analysis phase, I kept detailed notes of my logic and decisions on patterns. These notes were used to guide the analysis and inform the findings.

After I had begun to consider initial patterns and relationships, I continued to code and re-code as patterns became clearer. I also returned to my research questions in order to help clarify what patterns were related to the original aim of the study. These initial broad codes informed further refinement of the relationships and linkages between the patterns that I was seeing.

The patterns and relationships were ordered in a way that would make sense to a professional and convey the important ideas that were found during the analysis. Throughout the analysis, I attempted to remain aware of and document the impact of the context. Interpretive description products rely on the researcher's interpretations and are therefore considered constructed truths (Thorne et al., 2004). The context is essential in

understanding how the relationships have come to exist and need to be communicated in the findings in order to have meaning to the reader. The researcher must consider how to communicate the findings in a way that is meaningful and persuasive to the reader (Thorne et al., 2004).

Establishing Credibility

Due to the emergent nature of a qualitative study, all researchers must pay attention to trustworthiness throughout the design, throughout the research process, and in the reporting of any findings (Thorne et al., 1997). Thorne (2008) also developed principles to guide researchers in planning a study and to help ensure that the study findings are of high quality.

The criteria that Thorne (2008) outlined to ensure credibility in an interpretive description research design include: epistemological integrity, representative credibility, analytic logic, and interpretive authority. In order to ensure that these credibility criteria were addressed, I have incorporated features throughout the study design, data collection, and data analysis phases of this study. Firstly, epistemological integrity requires that the researcher consider the fit of the research question to the research design. In order to ensure that each aspect of the design follows logically from the assumptions about the research I have received guidance from experienced researchers and documented my design and analysis decisions in a way that ensures that the logic of those decisions can be defended. My design and analysis decisions are documented throughout the methodology section of this document and in my reflective journal.

Secondly, through representative credibility, Thorne (2008) asserted that two techniques, prolonged engagement and triangulation of sources, can be used to ensure

that the findings are representative of the study sample. Spending time in both settings enabled me to build trust and rapport, as well as, help me understand the context of the work settings. The use of three data sources, focus groups, participant observation, and my reflective journal also added credibility to the findings through triangulation of findings from 3 data sources. The third credibility indicator that Thorne described was analytic logic (2008). In order to meet this criterion I used an audit trail to detail and make accessible the reasoning that guided my interpretations.

The final indicator of trustworthiness is interpretive integrity (Thorne, 2008). This indicator is met when the researcher provides enough information regarding the data to convince the reader of the truth of the findings. Thorne (2008) recommends that although all knowledge is perspectival, the researcher must give enough information to demonstrate that the findings are grounded in the data. In order to make the interpretations clear to the reader, I have shared insightful pieces of data, my understanding of the context, and ensured that the participants had opportunities to confirm or refute early hunches and initial interpretations.

When discussing credibility of research findings Thorne (2008) extends the above criteria and states that a researcher in the applied health sciences has an additional responsibility to the community in which the products of the research could be applied. An applied health researcher must consider the moral defensibility of their research products. The researcher must go beyond the ethical requirements and look to the potential uses of their research products prior to even knowing the results. There is also a pragmatic obligation on the part of the researcher to consider what would be the results if the findings were applied in practice (Thorne, 2008).

Thorne (2008) also reminds us that because an interpretive description is an approach that is designed to answer practice questions a researcher must be able to justify how this research will add to the disciplinary knowledge and advance the profession. Lastly, Thorne recommends that the researcher must always present the findings with an awareness of the context in which the interpretations were constructed (2008). I took time to consider these questions prior to beginning this study and continued to use them as a guide throughout the research process. Through this research, I hope to add to nursing's knowledge of PPD, and inform how care is provided to postpartum women, including an understanding of the context in which postpartum nurses work.

Ethical Considerations

Subsequent to approval from the IWK Health Centre's Ethics Review Board, I began recruitment of participants and data collection. All participants who agreed to participate in either focus groups or participant observation were given an opportunity to review the appropriate consent form (Appendix D and F) and ask any questions prior to signing the consent form. I reminded all participants that their participation was voluntary. Participants who consented to the participant observation shifts could withdraw at any time and I would leave the area. Participants that consented to participate in focus groups were informed that they could chose not to participate at any time but it may be difficult to distinguish individual voices on the digital recording and therefore it was not possible to remove their information after the focus group had begun. I also informed them that their decision to participate and any information that they provided would not be shared with their employer.

At the beginning of each focus group and participant observation shift, I informed all participants that their names would not be used in the transcripts, or in any future publications or presentations. Someone unknown to the participants transcribed the recorded information and that person signed a confidentiality agreement. The participants, recordings, and transcripts were identified by numeric codes to ensure confidentiality. All participant information, observational data, audio recordings, and transcripts were kept in a locked area at Dalhousie University available only to myself and my supervisor. Five years after completion of the study, I will destroy the audio recordings as per IWK research ethics policy.

One of the challenges to confidentiality when doing focus group or participant observation research is that the participants will be aware of what is shared by others. I informed participants that due to this fact, it was not possible for me to guarantee that the information would be kept confidential. Prior to data collection, I reminded participants that the information provided was for the purposes of the study and it was expected that all participants keep any information shared by others as confidential.

The topic of PPD and mental illness in general, is a sensitive one and may provoke a variety of emotional responses. I anticipated that the participants would be female and that there would be the potential that a participant may have experienced PPD personally or may have been personally impacted by PPD. I pointed out the sensitive nature of the topic prior to beginning focus groups and that it was possible that some of the discussion would be upsetting. I let participants know that they were free to leave the group at anytime. I also informed them that they could speak to me following the focus

group if they preferred. I had materials on local mental health resources and employee assistance programs available for any participant that wanted them.

Chapter Four

Findings

In this chapter, I will describe the findings from this study in detail. The purpose of this study was to explore the knowledge and attitudes of both hospital postpartum and public health nurses towards postpartum depression (PPD), the role of the nurse in PPD care, and the context of care. The following research questions were used:

1. What is the knowledge of hospital postpartum nurses and public health nurses of PPD?
2. What are the attitudes of hospital postpartum nurses and public health nurses towards PPD?
3. How do hospital postpartum nurses and public health nurses care for women at risk for or with PPD?
4. What is the context in which nurses provide postpartum care both hospital and in the community?

I grouped the findings into five separate patterns and organized to reflect the above questions. The first two patterns, “Nurses understand PPD in different ways”, and “Nurses know that women need support”, described the nurses’ knowledge about PPD. Pattern three, “Nurses believe teaching about PPD makes a difference”, and pattern four, “Women benefit from a relationship with their health care provider”, described some of the attitudes nurses’ have related to PPD. The fifth pattern, “The role of the nurse is to listen”, is where the nurses described one of their roles related to PPD. The context in which these findings exist is interwoven throughout and will be described further in the

discussion chapter. In order to add depth and highlight a variation within a pattern, I have described a sub-pattern in two of the above patterns.

In each pattern, I have included quotes from the nurses in order to illustrate the pattern. Table one (Appendix H) has a list of each of the patterns and includes several quotes from the nurses that assist in describing the pattern and with the intent of making my interpretations more clear to the reader. Despite the fact that in many qualitative studies the findings and the discussion of those findings are combined, I have chosen to present the findings separately from the discussion. Thorne (2008) advises the novice researcher to consider presenting the findings separately to help create clarity for the reader and assist the researcher in learning the distinct intellectual exercises needed to report findings and reflect on and interpret those findings. In addition, demographic information was collected on all participants and this information will also be summarized in this chapter.

Participant Demographics

The participants in this study were all registered nurses that cared for women during the postpartum period. The nurses worked in one of two settings; an in-patient postpartum unit or the public health services program that provided care to postpartum women. In total, 31 nurses participated in this study. Seventeen of the nurses worked on the in-patient postpartum unit and 14 of the nurses worked at public health in the healthy beginnings program. Demographic information was collected on each of these nurses. The demographic information is described below and displayed in Appendix I.

Sample sizes in interpretive description studies vary but are often relatively small (Thorne, 2008). A sample size of 31 is larger than many qualitative studies however; it is

consistent with the predicted sample size of this study, six to eight nurses per focus group and six participant observation shifts in each of the two settings. Thorne suggests that the size of the sample should not be limited but must be justified to meet the requirements of the study and to answer the question being asked. One of the reasons for a small sample size in qualitative studies is to allow the researcher to ensure the richness and depth of the data. In this study, I ensured richness and depth through time spent with participants in their work setting, allowing nurses to participate in both types of data collection, and repeated observations. Thorne also reminds the researcher to include enough participants to ensure exploration of potential variations recognizing that there will always be additional information that has not been discovered.

The 31 nurses in this study were female and ranged in age from 22 to 59 years of age. Of the 17 hospital nurses, 12 participated in one of two focus groups, nine participated in participant observation shifts, and four participated in both. Thirteen of the 17 hospital nurses had a degree in nursing; the remaining four had a diploma in nursing. Four of the hospital nurses had a university degree other than nursing. They ranged in experience from two of the hospital nurses having less than one year to one nurse with greater than 30 years of nursing experience. Five of the hospital nurses had cared for postpartum women in other settings.

Fourteen of the 31 nurses were public health nurses (PHNs). Thirteen of the PHNs participated in one of the two focus groups, five participated in participant observation shifts, and four participated in both. All of the PHNs had a degree in nursing, three had a university degree other than nursing, and two had a master's degree in nursing. The PHNs years of nursing experience ranged from four years to 31 years.

All but four of the PHNs had experience working with postpartum women in other settings prior to their role in public health. During the collecting of demographic information the participants were asked to identify where they obtained information about PPD. Nineteen of the 31 participants listed learning about PPD from “experiences with patients” and 14 participants listed learning about PPD from their “nursing education”.

Although the participants in this study provided care to the same population of women, the work context varied greatly. In order to help the reader distinguish between the two work settings I used “hospital nurses” or “PHNs” when the findings are specific to one group of nurses. There are times when I refer to “the participants” to represent findings that are common to both groups. In addition, to ensure anonymity when direct quotes are used the quotes are identified only by the data collection time and setting in which it occurred.

Pattern One: Nurses Understand PPD Presents in Different Ways (one size PPD fits none)

This pattern reflects that the participants in this study described PPD in a variety of ways and reported that it can look different for each woman. When the participants were asked what PPD meant to them they had a variety of answers, including that PPD does not always look the same. Some of the participants said they looked at PPD in a variety of ways. Other participants stated that there is variation and a range within PPD. The nurses in the study described those experiencing PPD as women who were having difficulty coping, women who were not as excited as they should be, and women who

were having difficulty caring for themselves or their babies. One PHN summarized her understanding of PPD as follows:

“I think of postpartum depression in a couple of different ways. One is clinical, you know, definition, diagnoses of postpartum depression. But in practice I think of it as that group of women who aren’t coping so well. Those group of women that for whatever reason, whether it maybe a chemical imbalance or hormonal changes or whatever, whatever is happening with them, that they are just not coping as well with becoming a parent” (PHFG #1).

Another PHN agreed, stating “I’m going to concur with that because in my head I was thinking illness and then at the same time I’m thinking adjustment is a huge new role with being a parent” (PHFG #1). For these participants, PPD was best described as impairment in functioning or an inability to cope with the changes associated with becoming a parent and could vary for every woman.

In addition to the variations in what the participants reported PPD meant, the participants also gave examples of the variety of emotions that women with PPD could be experiencing. The participants stated that women may be expressing sadness, guilt, or shame. They also stated that women commonly experience a lot of anxiety, and may be angry or irritable. One PHN described a woman that she cared for with PPD: “She is really irritable. She’s noticing changes in her emotions. She’s going from rage to crying very quickly, which normally is not her typical behavior” (PHFG #2).

In contrast, a few nurses described PPD using a single, narrower definition, describing PPD as a prolonged period of sadness. Others felt that PPD was an episode of depression with the same diagnostic criteria but occurs in the postpartum period. A PHN

stated, "I look at it as an impairment in mood and thinking and behavior in that first year. I always think of it in terms of that first year after birth" (PHFG #2). The remaining participants described PPD as a prolonged period of sadness that impacts on the woman's ability to function and take care of her baby. A PHN summarized her understanding of PPD by providing a direct contrast to one of the above descriptions of PPD. She stated

I think I see it more as a -- I think everybody has an adjustment period, like a parental adjustment -- or postpartum adjustment. And I look at postpartum depression as -- that it's almost the opposite, like the clinical piece in the diagnoses of it (PHFG#1)

The participants in this study explained that sometimes PPD can have very serious consequences. One PHN provided an example of a woman she was caring for and explained that part of her knowledge of PPD was her understanding of the seriousness and danger of PPD. That knowledge of PPD guided her approach to caring for that woman. Several participants also reported that when teaching women about PPD they always tell them that they could experience feelings like wanting to hurt themselves or their babies. Other participants gave examples of caring for women that admitted to having feelings of wanting to harm themselves, suicidal thoughts, or thoughts of wanting to run away. One PHN summed up her understanding of the seriousness of PPD:

We actually had people with postpartum depression that were so sick they were having psychotic episodes. And so it can get that severe that it's not just a difficulty in coping; it's like losing touch with reality, having delusions and hallucinations and you know, and so it can progress from -- and these are people with the diagnoses of postpartum depression (PHFG #1)

Participants in this study provided a range of descriptions of PPD and this is consistent with the belief expressed by the nurses that PPD can look different for different women. The following quote illustrates this belief:

I think that changes for different people. Because there's a different group of symptoms for each person and for one person it maybe debilitating, but with another person they can kind of move through it in a different way, whether that's support that they have in place or whether it's just knowledge, or inner strength that they can pull through, but not everybody can.....it just presents -- everybody presents differently with it. So to have that in the box definition I -- like I don't see that. (PHFG #1)

Another PHN described PPD as a huge continuum and stated that women can fall anywhere on that continuum. The variety of descriptions of PPD is also in congruent with the participants stated understanding that PPD has a range and that it can become a very serious illness for some but not necessarily all women.

Sub-pattern: There is a Normal Period of Adjustment for Everyone. In addition to the range in understandings of how PPD can present, the participants in this study also explained that they often see women experiencing a range of changes in their emotions that are part of the normal adjustment to this major life event. A number of participants reported that they expect to see a range of different emotions. A few participants explained that they were surprised when women do not cry. A hospital nurse described the scenario where a woman becomes weepy during discharge teaching. She stated "I always reassure them and say 'I worry more about the ones who do not cry a little bit'" (FNUFG #2). The nurses found these moments of emotion to be "teachable

moments” (FNUFG #1) but they worried that it can make it hard for women to know what changes are normal.

Some PHNs explained that it can be hard to recognize and define PPD because everyone goes through an adjustment period after their baby is born. In a prenatal class that I observed, the PHN spent time discussing the normal changes in emotions after having a baby. Several hospital nurses stated that one of the roles of a nurse is to teach women to expect some ups and downs emotionally. One hospital nurse gave an example of how she told a woman on the first day after her baby was born that, “[b]y day three you have a lot of changes and you’re going to feel sad and cry for no reason. I can guarantee you” (FNUFG #2). Another hospital nurse stated that when she does her discharge teaching she always tells women “[i]t’s okay if you go home tonight and you burst into tears and you’re overwhelmed and you can’t handle things and it seems like everything is going crazy that’s normal” (FNUFG #1). The participants wanted to ensure that women understood that it is normal to feel teary or overwhelmed.

Participants explained that they may not see PPD in the women they care for because the timing is too soon after the women have given birth. They explained that women were recovering from childbirth, exhausted, and adjusting to big life changes so they expected to see a range of emotions; participants reported that this was normal. Participants gave examples of women feeling let down, angry or experiencing grief after the birth of their baby and these were also normal emotions. Additional examples included women that were not aware that they were getting into trouble because they thought that what they were experiencing was normal.

In summary, when I asked the participants to tell me what PPD meant to them they provided a range of responses. For many PPD was an inability to cope and difficulty adjusting to a major life change. Other felt that PPD had a narrow, medical definition, including that it was a major depressive disorder that occurred during the postpartum period. Participants all described a range of emotions that women expressed including sadness, anger, irritability, and anxiety. There was also acknowledgement that the consequences of PPD can be very serious and understanding this seriousness helped guide their care. The participants also explained that there is a normal and expected period of adjustment for women after having a baby. They spent time teaching women to expect this and reassured them as they experienced these changes.

Pattern Two: Nurses' Knowledge about the Support Women Need Varies

This pattern reflects what participants knew about women's need for support in relation to PPD. Throughout the study the participants repeatedly discussed how women need a lot of support in the postpartum period. Many participants stated that postpartum women did not have enough support and this contributed to PPD. One PHN stated that "there seems to always be a lack of support for moms that get into crisis with the postpartum depressions" (PHFG #1). In addition to the fact that women with PPD often lacked support, the participants in this study explained that when caring for postpartum women the nurses role was to assesses the women's current supports, be knowledgeable of the support in the community, and work to link women up with extra support.

Participants also explained that postpartum women can be very isolated. The PHNs seemed to have a greater awareness of the isolation and lack of support that exists for women once they leave hospital as demonstrated by the fact that the participants that

identified the lack of support for postpartum women were mainly PHNs. The PHNs also gave several examples of the why postpartum women can experience isolation. One PHN pointed out how she worried about women that live in isolated areas. One of the reasons for her concern was due to the lack of health professional services in some rural areas. She also explained that there are often no mental health teams to support women in their own communities and safety mechanisms such as crisis teams that will come to a woman's home. Other PHNs pointed out the lack of support that new immigrant families have after they have their babies. New immigrant women may have left all of their support behind and may not even speak the language. Moreover, participants acknowledged that women living in the middle of the city and with resources can experience isolation if they have PPD.

Because of the participants' knowledge of the need for support in the postpartum period, they reported that one aspect of the care they provide is to assess the supports a woman has when she goes home. One PHN summarized it saying, "one of the other things that we would do is always assess the supports and if they feel like their supports are meeting their needs" (PHFG#2). One specific way that participants reported that they assessed the woman's support was to ask her about her relationship with her family doctor. Do you have a supportive family doctor or do you feel comfortable talking about your emotions with your family doctor were examples of some of the questions that participants asked women. Participants recognized that women often regularly see their family doctor during the first year of their baby's life.

When participants described support, they used examples of both professional and nonprofessional sources. Participants identified mental health professionals, public

health drop in clinics, support workers, and other professionals as sources of professional supports. Several PHNs reported that they would like to spend time collaborating with other community agencies and health care organizations to increase the support to postpartum women. Participants also recognized that support for postpartum women included nonprofessional supports, such as partners, other family members, and other women. Several PHNs gave examples of how they were able to connect women that were isolated, including one with PPD, to other women in their area for extra support. As one PHN pointed out “the whole peer-to-peer thing is so, so important for moms. And we really see ourselves as... We’re really just setting people up with other people to go on their merry way and get their support within their community” (PHFG#2). A PHN summarized the impact of connecting women to support by saying “I think that us fostering those relationships can prevent something like postpartum depression or lighten the severity, right? By increasing those community supports” (PHFG #2).

The hospital nurses in this study explained that discharge teaching is an opportunity to discuss community resources. The hospital nurses reported that they gave women information on community resources but did not know what happens after the woman leaves the hospital. The hospital nurses in this study reported that they had questions regarding the resources that are available in the community to provide support and expressed that they worried that women would not get the support they needed. In contrast, the PHNs reported that they were able to connect women to resources. They gave more examples of community resources that they were able to link women with in order to get that extra support. One PHN summarized her belief about PHNs knowledge

of community resources “We have that -- yeah, we have community knowledge to help finding the right resources at the right times” (PHFG#2).

In summary, this pattern reflects what participants in this study knew about support resources as well as women’s need for support in relation to PPD. Participants explained that women need a lot of support in the postpartum period and one of their roles is to assess the woman’s current supports. Participants reported that this lack of support was often present for women and contributed to the development of PPD. They gave examples of some of the reasons that women were isolated and some of sources of support that were important to women in the postpartum period. Despite these similarities the two groups of nurses differed in their knowledge of community resources and their ability to connect women with additional support during the postpartum period.

Pattern Three: Teaching About PPD Makes a Difference.

In addition to the participants knowledge related to PPD, they also described their beliefs and attitudes related to PPD. One of the beliefs described by participants was that teaching about PPD made a difference to postpartum women. Participants explained that through teaching women about PPD they would have the information that they needed to later self identify if they had symptoms of PPD. In addition, teaching about PPD would help women’s family and support people know what to look for and what to do if the woman was experiencing PPD. Participants also reported that teaching about PPD generally encouraged people to talk about PPD, increasing awareness and decreasing stigma. Although participants in both groups commonly believed that teaching was important and the role of the nurse, PHNs and hospital nurses used different approaches to teaching and had different concerns related to teaching.

All of the participants in this study described the importance of teaching about PPD. They stated that teaching about PPD impacted on the woman's ability to later self identify if she has any symptoms of PPD. One hospital nurse gave this example to illustrate the potential impact that teaching can have, "I've had women come to me in the supermarket, places like that and said, "I'm so glad you told me about that because I was one of those women right that actually had postpartum depression. And I would not have known what was happening to me if you had not said that"" (FNUFG #2). Similarly, a PHN stated "in Public Health say our role isn't so much as identifying, but in educating so that they can self-identify" (PHFG #1). Another PHN explained, "we often talk to them before they have symptoms, and so making sure that they have the information to identify it themselves" (PHFG #1). Other participants added that because their contact with women is so early in the postpartum period, and they may not see them again, it is even more important that women have the information about PPD so they can recognize it and seek help.

Participants used teaching, not only as a way to get the information to postpartum women but also, as a way of educating the woman's support people about PPD. Participants described how they often tried to include family members in their teaching. Most commonly, they talked about including partners in teaching. Participants reported that often partners or others close to a woman will be more likely to notice symptoms than the woman herself will. The following example given by a PHN described a partner who recognized something was wrong and then advocated for better care.

I had a dad who called me and was very concerned about his wife and he had taken her to the family doctor and the family doctor just said, "No, everything is

fine. Just," you know, "Go home," and you know, "Do what you can for your wife and support her." But he knew that there was something bigger going on ...this father was very knowledgeable and very worried and, you know, he was right on key. (PHFG #2)

One PHN who included partners when talking about PPD stated "I find that partners are very interested and they appreciate being asked" (PHFG #1). Another reason participant's included partners in teaching was because they recognized that partners were also at risk for depression and saw this as an opportunity to talk about the impact of depression on the whole family. The participants expressed concerns that including partners in teaching may not be the practice of all nurses.

One of the changes that some of the participants stated they have noticed in their careers is how much more comfortable people are talking about PPD. Participants reported that people are more willing to talk about PPD and that society in general is more aware of the issue of PPD. At the same time, participants explained that they are talking to women and families about PPD more often, asking women questions about emotions that they would not have done earlier in their career, and that this all adds to the overall comfort with the topic and decreases stigma around PPD.

Despite the similarities with the two groups of nurses in their stated value of teaching, the practice and concerns related to PPD teaching varied between the two groups. The hospital nurses had many concerns about how teaching occurs and how women are getting the information they need related to PPD. Hospital nurses explained that teaching about PPD happens during discharge teaching. The hospital nurses explained that discharge teaching most often happens in the few hours preceding the

woman leaving hospital. They recognized that if a woman is emotional that can be a teachable moment otherwise discussion of this topic waits and is included with discharge teaching. The hospital nurses expressed concerns related to the changes in the expectations for discharge teaching. They described that due to time and financial constraints the expectation of how discharge teaching occurs has changed from a nurse doing the teaching one-on-one, to group teaching, to finally a discharge teaching video. One hospital nurse explained “the way we’re set up now we’re not supposed to spend a lot of time on discharge teaching. That’s what the discharge video is for” (FNUFG#2). The discharge teaching video that is now available gives families an option of accessing it at their own convenience, but the hospital nurses worry that many families are not accessing that information at all. One hospital nurse stated “I would say that most patients don’t watch the discharge video” (FNUFG#1). Another hospital nurse agreed “They’re told to go home and watch this video on their computer and they go home and they’re exhausted and they’re busy” (FNUFG#1).

The hospital nurses reported that there are variations in discharge teaching. They gave examples of factors that contributed to variations in practice, such PPD being a sensitive topic, lack of comfort with the topic or with the patient, lack of confidence or lack of knowledge. The hospital nurses in this study expressed concerns that not all hospital nurses are doing discharge teaching. Several hospital nurses stated that their practice is to still spend the time interacting with families one on one prior to discharge in order to make sure women have the information they need. One hospital nurse described her approach to discharge teaching “I try and sit down on a chair. I try and make it -- this

is a meaningful conversation that we need to have before you go home and here's the things that we all need to go over" (FNUFG#1).

An additional concern that was expressed by the hospital nurses was that women are overwhelmed with the amount of information provided to them in a short time. They reported that postpartum women have the pressure of fatigue, physical changes, and excessive visitors that make it very challenging for them to take in information. One hospital nurse stated "I wonder all of the teaching we do in the hospital because we have such a short amount of time -- a lot of teaching -- a lot I wonder if it's just kind of going over their head anyways. There's so much stuff we throw at them" (FNUFG #1).

Another hospital nurse added

And I don't know that things go over their head, but what I do find is that people don't remember things that they are told. You know whether it's just the exhaustion or whether it's hormones or whatever it is, but you can tell someone one shift and have them again the very next day, and they don't recall what you told them the day before. (FNUFG #1)

The hospital nurses also wondered about PPD that is happening prenatally both through antenatal appointment and through prenatal classes, and if they were the first people to teach about PPD.

In contrast, PHNs expressed confidence in their ability to provide information regarding PPD both prenatally and during their postpartum care. One of the things that the PHNs identified as facilitating their ability to teach about PPD was the use of written materials with information on PPD. The PHNs referred specifically to the Loving Care books that they provide for postpartum women and the postnatal guarantee (PNG). One

PHN gave the example of how The Loving Care books are used in teaching, “we refer people back to the Loving Care Books, the difference between depression and postpartum blues have information on both normal changes in emotion and PPD” (PHNFG#2). The PNG is a list of key messages that all PHNs go over with a woman during their postpartum contact. The PNG, which has two separate prompts about emotional health, and the PHN’s in this study reported that it ensures PPD will be discussed with every woman. The PHNs explained that having that tool guides their practice and protects nurses from making assumptions about which women need to know about PPD. One PHN summarized it in this way

if I’m doing the PNG, I don’t care who it is I’m doing the PNG...But that’s because I have a professional tool to support and guide me through the process, right. If I didn’t have that professional tool and it was spontaneous conversation, that might not come up. (PHFG #2)

The PHNs in this study all stated that they felt comfortable teaching about PPD.

The PHNs did share concerns similar to those of hospital nurses related to the fact that they are in contact with women so early in the postpartum period. Participants therefore, agreed that the emphasis needs to be on giving women information so that they could later identify if they are having symptoms of PPD. One PHN explained “Because we often talk to them before they have symptoms, so making sure that they have the information to identify it themselves” (PHFG#1). Some PHN’s also reported their concerns that women would not be able to recognize if they experienced symptoms of PPD. One PHN explained “it isn’t the mom herself that will identify that, but you know...or if she’s really depressed she’s not going to be the one to call” (PHFG#1).

In summary, teaching was considered very important by participants. They explained that teaching about PPD was the role of the nurse and each group saw opportunities where that teaching could occur. Participants believed that teaching about PPD was meaningful because it gave the women the information that was needed to later self-identify if they were having symptoms of PPD. Participants reported it was important to include the woman's family in the teaching, in order to give partners and families information so that they could recognize the signs of when a woman may need help. Participants also believed that teaching about PPD also helped open up the conversation and increase awareness about PPD in society.

Public health nurses used the prenatal class and the PNG to ensure that they talked to women about PPD and expressed confidence in their ability to provide that information. Teaching about PPD was part of discharge teaching for hospital nurses however they described changes in the methods used for teaching, variations in practice, and an inability of women to take in so much information in such a small amount of time in hospital. These factors led hospital nurses to be concerned that women were not getting the information that they need related to PPD.

Pattern Four: Women Benefit From a Relationship With Their Health Care Provider.

Participants in this study verbalized several beliefs related to relationships between health care providers and postpartum women. They reported that women benefit in the postpartum period if there is a relationship between the woman and her health care provider. Participants explained that one benefit was that if there is a consistent health care provider they would be able to more easily notice changes in the woman's mood. In

addition, the nurses themselves also found it was easier to provide postpartum care if they were able to form a relationship with the woman. Participants explained that one of the challenges is that in order to form a relationship they needed to spend time with the woman. Participants explained their belief that the health care provider that sees the woman consistently throughout the postpartum period is responsible for assessing the woman for PPD.

The nurses felt that one of the benefits that can be achieved by a woman having a relationship with a consistent care provider is that person would know them and be able to more easily identify any changes in mood. The hospital nurses all identified that women benefit when their primary care provider knows them well, which is not always the case. The hospital nurses pointed out that often women see someone new for their pregnancy and may not go back to see that care provider postpartum. In addition, women may see a number of different care providers and therefore lack the continuity of care. One hospital nurse explained how this lack of continuity impacts on the woman's care.

Now you're getting a multitude of caregivers and it's never the same one. You're lucky if it is right through the whole pregnancy and postpartum period, you're very lucky. If you had the same person that's caring for you, so that they can recognize very easily. But with all of the different ones there's no way that you'll ever know if this person is -- is this abnormal for her, is this normal for her. It's hard to figure that out. (FNUFG #2)

These two factors, multiple care providers and meeting a new care provider in pregnancy, are summed up by another hospital nurse who stated, "so no one gets to know them" (FNUFG #2).

Hospital nurses reported that there can also be a lack of continuity of nursing care in the postpartum period. Hospital nurses described the lack in continuity of care that occurs because they often do not have the same patients. Hospital nurses explained that it is easier to teach about PPD if you have spent time building a relationship with the woman prior to discharge. They also speculated that if you do not have time to build a relationship, it can make it more difficult to talk about sensitive topics, such as PPD. One hospital nurse explained “If you come back the next day and you don’t have them and it is unfortunate for the patient. You know because it really would have been a much better experience to have that” (FNUFG#1). Another hospital nurse added that “if you had that specific patient first shift or two or three in a row your conversation with them is going to be more meaningful than the nurse that comes in -- for only one more day”(FNUFG #1).

The PHNs also identified continuity of care as beneficial to the women they cared for. They explained that continuity of care makes it easier for the nurse to delve deeper and determine what is really going on with the woman because they have had the time to form a relationship. In contrast to the hospital nurses’ experience where they often do not have the same patients, the PHNs generally follow a woman for as long as she needs the service, however, they acknowledged that women might lose track of who their original PHN was. One PHN gave an example of how a lack of continuity of care occurred and her belief that this was not benefitting this woman.

And so for instance this morning, I have a mom that has called the line ten times since July. So -- and it’s all around feeding questions. So I, on the end of the conversation said, ‘You know what if you would really like to have a consistent person calling you and answering your questions, just call me back.’ Because I

don't think we're meeting her needs and she hasn't talked to anybody more than once...And so...because she keeps presenting with questions about the baby's feeding, but is it really? And that's my question. Is it really the feeding or is there something else going on? And I think it's important for us to have that continuity of, "Let's dig a little bit deeper". (PHFG #2)

Hospital nurses in this study explained that one of the ways that they build that relationship is by spending time with the woman and one of them captured this saying "You can't establish that relationship and that trusting relationship if you don't spend time with them" (FNUFG #2). Some of the hospital nurses explained that they could request to have the same patient if they felt that the woman was benefitting from the continuity. These hospital nurses explained that this can be especially important if the woman has mental health issues or social concerns.

Participants reported that health care providers have a responsibility to talk about PPD with the women they care for. This includes teaching the woman what is normal or not and assessing for signs of PPD. Participants described a belief that the person that is in the best position to do this is the health care provider that sees that woman throughout the postpartum period. Participants explained that they only have regular contact with women during the early days and weeks postpartum and that they do not expect to see symptoms of PPD in those early days but believed that someone should continue to follow up with that woman throughout the first postpartum year. Participants added that women regularly see their family doctors throughout the first year of the baby's life for routine immunizations. Several participants explained that family doctors are in an ideal

position and have a responsibility to assess for PPD at those visits. One PHN summarized the importance of this continued follow up by stating

Whether it's us that does it or a family doctor or -- but it's someone that is seeing that mom on a regular basis. As she moves through her postpartum period there's a responsibility there. If you're looking at the mom's health, that's part of her health that's part -- her mental health is part of it. (PHFG #1)

In summary, participants in this study verbalized several beliefs related to relationships between postpartum women and health care providers with regards to PPD. They explained that in order to provide the best care of postpartum women the health care provider needs to form a relationship with that woman. This will help the health care provider determine if there are any possible signs of PPD. Participants themselves found it easier if they were able to spend time forming a relationship with the women and explained that it would be easier to talk about PPD with women if they had time to form a relationship. Lastly, they reported they see women so early in the postpartum period, it is important for women to continue to have follow up for PPD and that this is best done by someone who sees that woman over time. Participants explained that the health care provider that is administering baby immunizations and therefore seeing the family over that first year has the responsibility and is in an ideal position to make sure that this gets addressed.

Pattern Five: The Role of the Nurse is to Listen.

Although the role of the nurses came out in the other patterns, this fifth and final pattern is focused on what participants explained as one of their primary roles in caring for postpartum women. When asked to describe their role, most of the participants stated

that their role was to listen. Some participants used examples to illustrate how listening was an important part of their care and others stated directly that they felt that listening was their role. One PHN described her understanding of what is helpful to women: “Women want a lot of reassurance. They want to be heard and listened to. Most people just want to be heard. They want you to validate them whether you agree with them or not” (PHPO #1).

Participants described how important it is to listen to women. They gave examples of taking the time to listen to women, “I think we do a lot of listening and letting the patients debrief. I’d agree completely” (FNUFG #1). When participants talked about the value and importance of listening they explained that women needed to have their feelings validated, respected, and honored. As described in the previous pattern, participants explained that the women they cared for often experienced a range of emotions, including sadness, anger, disappointment, and grief. One hospital nurse talked about taking the time to listen to women’s feelings, particularly negative ones, can help them through those difficult emotions.

I think like debriefing the birth experience in those taking in phases. Address stages whenever they first come up. Making sure like they let go like if it was -- something happened that they didn’t want to have one, but they end up with a C-section when they had the big long birth plan from the chart. Making sure they debrief that like let go of it and then they can move on to enjoy you know what they have now. So that they are not stuck on that piece and they can’t continue to go through the stages. (FNUFG #1)

Both groups of participants talked about how the setting had an impact on their ability to listen. Several hospital nurses talked about how the number of visitors and lack of privacy made it challenging for both the women and the nurses to initiate conversations related to emotions. In contrast, the PHNs described how they were able to initiate a conversation about emotions with women in their own homes because women were more comfortable in their own environment. One PHN described how the ability to visit women at home was crucial to her care.

Well, I think that I'd have to say that for us being able to go into the home is really, really crucial, for us to be able to reach them at their comfort zone, because they're more comfortable. So I don't know about you guys, but how many times have you crawled up on a bed and sat with the woman and she's talking about something and you're there, right in her personal space. And she's being able to share that because she's comfortable in that environment, you know, and you're having a great discussion about how's she's feeling. (PHFG #2)

One PHN gave an example that illustrated how important it was to listen not only to the woman's verbalized emotions but to also listen to a woman's understanding of what she needed. This nurse was caring for a woman that was experiencing depression and the woman reached out for help. This example demonstrates how that woman was able to express what she believed would be most helpful her to in her care.

The woman that I visited with that, you know, acute episode connected to the Edinburgh score of 24 told me what she needed. She had history of depression in the past. And she told me, "I don't need to go to the hospital. I don't want to go to an emergency department. I want to talk to..." Well she was saying she

wanted to talk to a woman because she had better success with them feeling heard and understood by woman. And she wanted to try to work it out in the community not in the hospital. She wanted to talk about how bad she was feeling, but she thought if she talked to somebody without having to go to the emergency department that would be a lot more effective and relevant for her. (PHFG #1)

The PHN was able to understand what was needed to care for this woman by listening to the woman and respecting the woman's knowledge of herself. The PHN was then able to help get the right supports in place and ultimately support the woman to determine her own care. This example illustrates the nurse's use of listening as a therapeutic skill. However, it is an example of how this woman was able to be very direct and clear about what her needs were. More often, the nurses in this study found that they had to dig deeper and ask questions to understand what the woman was experiencing.

Sub-pattern: You Need to Ask Questions. In this sub-pattern participants described listening to women, particularly listening to their feelings. In addition to using listening as a way of helping women, the nurses used their listening skills to identify when something did not seem right or when something needed to be explored further. Participants in both settings stated that as health professionals you need to be able to ask the questions and talk about PPD with the women you care for, however as I will describe below the opportunities to ask those questions came about in different ways.

Hospital nurses gave examples of when there was a need to explore how women were feeling, they often described observing women that seemed to be having difficulties attaching to their baby or women that were not reacting as they would expect emotionally. The hospital nurses described caring for women who had a flat affect or

seemed disconnected from their babies. One hospital nurse gave the example of a woman she was caring for who had a flat affect. That nurse talked about how she was the one who initiated a conversation by simply saying “you seem upset or you seem disconnected” (FNUPO #1). She explained that she felt comfortable to ask that question.

The PHNs gave examples of when they knew something was not right and they needed to explore what the woman was saying in more detail. They often described examples of women contacting them with other concerns unrelated to PPD, such as feedings or baby concerns. Some PHNs reported that women were often vague or very subtle. Women may just state that they are not feeling right or that something is different. The following quote illustrates how one PHN took an opportunity to ask more questions:

She just said, “You know, I don’t think I’m feeling all that well about how things are going” and jumped on it because at that point she had enough gumption after months and months to disclose. But she didn’t -- if she would’ve had to say I think I’m having postpartum depression she never would have said that. So it was picking up on those subtle cues ... but you have to be prepared to ask the question and do something about it. And it may not be, "I’m having depression," or "I’m thinking of harming myself," or you know, or the baby. It’s not that obvious a lot of the times. (PHFG #1)

The PHNs explained that it is up to the nurse to dig deeper and ask specific questions. Knowing when to ask those questions required listening to the woman and then identifying that something was not right. Both groups worried that if health professionals

did not ask specific questions then it could get missed that the woman was experiencing symptoms of PPD.

In summary, in this pattern I described participants understanding of one of the roles they have in caring for women. They gave examples of taking the time to listen to women as they shared a range of emotions. Participants explained that women wanted to be listened to and to have their feelings acknowledged and validated. They also described listening as necessary for women to get through difficult emotions, and one PHN gave an example of how one woman clearly articulated what was needed for her to direct her own care. More often, participants gave examples of how listening to women helped them to determine when it was necessary to explore further or ask more questions so that women who are experiencing symptoms of PPD are not missed.

Summary

In this chapter, I have presented the five patterns identified in the data examining nurses' attitudes and beliefs related to PPD, and used direct quotes from the nurses in order to help illustrate the patterns. I organized these patterns using the study questions. In the first two patterns, I emphasized the participants' knowledge about PPD. In the first pattern "Nurses understand PPD presents in different ways" I highlighted the variations in how participants in this study described their understanding of PPD. Some participants provided a narrow, medical definition, but more often they described PPD in relation to women's inability to cope, not being able to enjoy their babies, or being unable to function. Participants also described a range of emotions that women experienced with PPD. In the first pattern, there was also a sub-pattern. In this sub pattern, I highlighted participants' descriptions of the normal range of emotions that women experienced as

they adjust in the postpartum period. In the second pattern, “Nurses knowledge varies on the support women need”, participants revealed their understanding that women needed considerable support in the postpartum period, as well as the variation in their knowledge about available supports, and that a lack of support is common in women that develop PPD.

In pattern three, “Nurses believe teaching about PPD makes a difference”, and pattern four, “Women benefit from a relationship with their health care provider”, I described some of the attitudes nurses have related to PPD. Participants all valued the impact that teaching about PPD has on women and society. They explained that teaching helps women to later identify if they are experiencing symptoms of PPD, can help women’s family members recognize if a woman is experiencing PPD, and increases society’s awareness of PPD.

In pattern four, I described how participants explained that women benefit from having a relationship with a health care provider that knows them. This is challenging as women often go to a new health care provider in pregnancy and can also see multiple care providers. Participants also explained that there can be a lack of continuity in the nursing care that women receive. This makes it harder to recognize when a woman is experiencing changes in her mood and can make it more challenging to talk about PPD with women.

In the fifth pattern, “The role of the nurse is to listen”, I described one of nurses roles related to PPD. Participants explained that they felt their role was to listen and that women wanted to be heard. Within this pattern, the participants also described how important it was for nurses to be prepared to ask the right questions and dig deeper as

women may find it difficult to disclose how they are feeling. The participants in this study identified other roles that are described throughout the other patterns, including teaching about PPD, and assessing and connecting women with supports. The fourth study question “exploring the context in which the nurses provide care” is integrated to within the above five patterns. The context is an integral part of understanding the findings of an interpretive description study and will be further described, in combination with relevant literature, in the discussion chapter.

Chapter Five

Discussion

In this chapter, I will focus on what the findings from chapter four mean. In keeping with the spirit of an interpretive description study, I reflect on the findings and reconsider them in light of the current state of knowledge (Thorne, 2008). Thorne also suggests that the writing of the discussion chapter can be where the researcher can look differently at the findings; considering how they might relate to each other and to the literature.

In this chapter, I discuss the findings based on my thinking about how these findings fit in the current context of both hospital and community postpartum care in one geographical area in Nova Scotia. I also discuss how the patterns relate to each other. I begin with a discussion on nurses' knowledge of what PPD means. Next the nurses' attitudes about teaching, and the context with which they provide this teaching is discussed together with what is the current knowledge about PPD teaching by nurses. I then describe the role of nurses, to listen, to explore the women's feelings further, and to link women with support and how those roles appear connected. Finally, I discuss the nurses' attitudes about the role of relationships and what is known about relationships influence on the care of postpartum women.

Understanding Postpartum Depression

The nurses in this study understood that PPD presented in postpartum women in a number of different ways. A small number of participants described PPD rather narrowly, including that PPD is like any other depression or that it is a prolonged period of sadness. These participants described PPD as a set of symptoms. Most participants

however, described PPD broadly stating that PPD can look different for each woman. These nurses did not see PPD just as an illness; they described women that were having difficulty either coping or adjusting and that PPD could present in a variety of ways.

Previous studies on nurses' and other health professionals' knowledge of PPD, collected information on the health care professionals' knowledge of PPD including their knowledge of timing of onset, duration, incidence, prevalence, risk factors, symptoms, and options for treatment (Lepper et al., 1994; Keng, 2005; Skocir & Hundley, 2006; Sofronas et al., 2011; Wiley et al., 2004). Collectively, these researchers found gaps in health care providers' knowledge of PPD, for example when they compared the health care providers' knowledge to other literature they found an incorrect awareness of the timing of onset and lack of knowledge about screening tools (Lepper et al., 1994; Keng, 2005; Skocir & Hundley, 2006; Sofronas et al., 2011; Wiley et al., 2004). Those researchers provided information related to health professionals' knowledge related to PPD but did not allow health professionals to describe their understanding of PPD and their ability to identify it in the women they cared for.

The limitations of the above studies include that in all but one study, including a recent Canadian study examining nurses' attitudes, beliefs, and practices related to maternal depression (Sofronas et al., 2011) the researchers chose to use a survey to collect data (Lepper et al., 1994; Keng, 2005; Skocir & Hundley, 2006; Sofronas et al., 2011; Wiley et al., 2004). A survey method can be problematic when attempting to explore a complex concept such as knowledge and attitudes related to PPD and limits participants to providing answers to questions in a predetermined way. In the one qualitative study, Mason and Poole (2008) used interviews to explore health

professionals' attitudes but was limited to understanding health professionals' feelings about screening women for PPD. The exploratory nature of this current study and the chosen methodology is unique as it allowed the participants to give information on what they know about PPD without providing a definition of PPD, either before or after the participants shared their views. This style sharing of knowledge without judgment resulted in the nurses providing rich, detailed descriptions of how they understood PPD. In contrast to the previous studies, where researchers identified the gaps in both nurses' and other health professionals' knowledge of PPD, the findings from this study include nurses' descriptions of PPD and how it presents illustrating a fuller understanding of PPD by nurses than previously reported.

The predominant model associated with PPD in the nursing literature at this time appears to be the medical model. This is demonstrated by the fact that much of the nursing literature on PPD, begins with a single definition of PPD that comes from a well recognized medical source, the DSM (Beck, 2002b). During the planning stages of this study, as a nurse who was well read in the PPD literature, I also chose to include the DSM-IV-TR definition of PPD in the introduction of this study. Many of the participants in this study described PPD more broadly and some even disagreed with this definition.

There are a variety of authors and researchers that step outside of the medical model of PPD and use a number of different models and theories to understand PPD. Some examples include, the model assessing maternal adjustment (Boland-Prom & MacMullen, 2011), social exchange theory (Posmontier & Waite, 2011) and critical realism (Sword, Clark, Hegadoren, Brooks, & Kingston, 2011). Nursing researchers have also described how various theories, such as feminist theory and attachment theory,

are used by nurses in understanding PPD (Beck, 2002b; McConnell, Baker, & Marks, 2005). These varied explanations of PPD are more consistent with the descriptions of PPD provided by participants than the previous medical model, but do not answer the question of what impact different definitions of PPD have on women with PPD.

McConnell et al. (2005) used a qualitative approach to explore how health visitors understand PPD. Health visitors are described in greater detail in the literature review chapter but have a similar role to public health nurses. McConnell et al. suggests that there are two predominant models for PPD (2005). First, there is a medical one that views PPD as an illness that affects individual women and second, a social one which presupposes that the development of PPD is impacted by environmental factors.

Participants in this study described PPD consistently using two different models as described by McConnell et al (2005). Very few participants described PPD as a medical illness. Most of the participants described it in terms more congruent with PPD as a response to environmental factors. For most participants PPD was related to difficulties coping and the role of stress and isolation was part of their understanding of PPD.

In trying to understand how nurses view health or an illness such as PPD it is important to consider the documents that may be guiding nursing practice in Canada. The Canadian Nursing Association (CNA) (2007) and the Community Health Nurses of Canada (CHNC) (2011) provide a framework and standards that guide nursing practice in Canada. In addition, the Canadian Public Health Association (CPHA) (2010) provides an overview of the expected roles and functions of community health nurses in Canada. Each of these organizations describe health as broad, with a variety of facets and being different than the absence of disease (CAN, 2007; CHNC, 2011; CPHA, 2010). The fact

that for most participants their understanding of PPD is broader and different than an illness based definition appears consistent with the descriptions of health provided above, that health includes many facets and is not just the absence of disease.

The broad and varied description of PPD provided by participants in this study is also similar to descriptions of PPD provided by women that have experienced PPD. Despite the common use of the DSM-IV definition of PPD in the literature, women's understanding of PPD also differs from the medical definition (Ugarriza, 2002). Women that have had PPD described having a wide range of emotions (Beck, 1992; Beck, 2002a; Edhborg et al., 2005; Hall, 2006). For example, women described feeling angry, anxious, insecure, guilty, and fearful (Beck, 1992). Women described a mismatch between their expectations and society's construction of motherhood, as well as their own experiences of motherhood (Beck, 2002a; Knudson-Martin & Silverstein, 2009). They also shared feelings of being isolated and struggling to take care of themselves and their babies (Edhborg et al., 2005; Hall, 2006). When the participants in this study were asked about their understanding of PPD they provided descriptions that were similar to those provided by women who experienced PPD. This similarity may be connected to the fact that nursing knowledge is holistic and is informed by a variety of sources (Carper, 1978; Manzoukas & Jasper, 2008). More specifically, one of the sources of nurses' knowledge is interactions with patients (Bonis, 2009; Carper, 1978).

The nurses in this study most often relied on their experiences caring for women when describing their understanding of PPD. This provides a potential explanation for why the nurses' descriptions of PPD were similar to the descriptions of PPD provided by postpartum women. A benefit of clinical practice informing knowledge is that the

evidence nurses used to guide practice reflects both their clinical experiences and patient descriptions. A well-recognized definition of evidence includes not only research evidence but also clinical expertise and patient preferences (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). Conversely, a limitation of relying solely on evidence provided through clinical experiences may mean that there are other sources of evidence (research) that nurses are not incorporating into practice. It also provides challenges to nurses who have limited clinical experience. How to facilitate nurses' incorporation of research findings into their understanding of PPD has implications for nursing practice and is an area for future research.

When the participants described their understanding of PPD, including the range of how it presented, they also explained that there was a normal adjustment period after the birth of a baby and that a range of emotional responses is normal. This normal adjustment period can be one of the reasons that it is difficult for both women and health care providers to identify a woman with PPD. The combination of PPD including a range of responses coupled with normal postpartum adjustment can make identifying women with PPD challenging. The understanding of a normal adjustment presents a concern that some women or health care providers may overlook women that are experiencing PPD due to the expectation of a range of emotional changes after the birth of a baby. This makes it very important to continue to clarify not only nurses understanding of PPD but also what aspects of that understanding make it easier to identify if a women has PPD.

Overall, these findings add to our understanding of how participants viewed PPD. Participants in this study provided a broad and varied explanation of PPD. This broad understanding is in contrast to literature that uses a narrow medical definition; however, it

is supported by the literature that advocates viewing PPD from a holistic perspective, using a variety of models and theories. It is important to continue to further clarify how nurses understand PPD and how it influences their practice. Many important facets of care are influenced by the nurses' understanding of PPD, including how a nurse chooses to assess for PPD, the role they assume when caring for postpartum women, and the treatment options that the nurses feel are appropriate (Beck, 2002b; McConnell et al, 2005). In addition to a more broad understanding of PPD, the nurses provided descriptions of PPD that were similar to those provided by women that have experienced PPD. This may be due to the nurses relying heavily on patient experience to base their knowledge and assumptions about health. This leads to the need for further research to determine if this understanding of PPD by nurses is beneficial to women in recognizing PPD.

Teaching about Postpartum Depression

Participants in this study emphasized the importance of teaching women and their families about PPD. They believed that teaching about PPD would help women to recognize the signs and symptoms of PPD early. The participants also believed that helping women to recognize the signs and symptoms of PPD resulted in women seeking help. One of the reasons they felt that self-recognition is important was because nurses often have contact with women before they expected PPD to develop. Despite the fact that all participants provided teaching to women and families related to PPD, the way it was provided varied greatly by setting. In order to integrate the literature and provide an understanding of the influence of the context on teaching I will discuss the two groups of participants separately.

Teaching by Public Health Nurses. The PHNs in this study provided information to women and families about PPD during both the antenatal and the postpartum period. The CPHA (2010) outlines health education as one of the activities of community health nurses. The PHNs in this study all taught prenatal classes, including a class on adaptation to parenthood where both normal emotional changes and PPD are discussed. They also routinely provided information about PPD during the postpartum period. The literature on the effectiveness of education and its impact on PPD outcomes is mixed.

In one systematic review, the authors concluded that despite the fact that antenatal education is common, there continues to be a lack of evidence as to its effectiveness (Gagnon & Sandall, 2007). When looking at the effect of antenatal education specifically on PPD outcomes, several researchers have attempted to use antenatal interventions to decrease rates of PPD (Haynes, Muller, & Bradley, 2001; Lara, Navarro, & Navarrete, 2010; Matthey, Kavanagh, Howie, Barnett, & Charles, 2004). None of the studies reported a decrease in rates of PPD in the intervention groups, leading the researchers to conclude that antenatal education is not effective in preventing PPD (Haynes et al., 2001; Lara, Navarro, & Navarrete, 2010; Matthey, Kavanagh et al., 2004). This is consistent with the results of a systematic review where the authors concluded that there are no clear interventions at this time that have been shown to effectively prevent PPD (Dennis & Creedy, 2004).

The conclusions from the above studies can lead to antenatal education on PPD to be undervalued. However, participants in this study did not state that they felt education would prevent women from developing PPD but believed that the information that they

gave regarding PPD would help women identify earlier if they were developing symptoms of depression. Participants explained that early identification, along with an awareness of where to go to get help for PPD, would benefit women if they experienced PPD. Women lack knowledge related to what PPD is, and that there are effective treatments. This results in women not recognizing that they are experiencing symptoms of depression and is one of the reasons they do not seek help (Dennis & Chung-Lee, 2006). In another study of women with PPD, women reported that they would have been able to cope better if they had been more knowledgeable about PPD (Ugarrizza, 2002). Findings from this study as well as the literature that indicates women would cope better if they knew how to recognize PPD contribute to making the case for continuing to provide education on PPD to ensure women are aware of the signs and symptoms and where to seek support.

Teaching by Hospital Nurses. The hospital nurses in this study only had contact with women during the immediate postpartum period. They referred to PPD teaching as an important part of discharge teaching. This teaching included providing a description of PPD and identifying what resources are available in the community. In a best practice model by Logsdon et al. (2012), the authors agreed that hospital nurses need to both provide teaching about PPD and about the community resources. Dennis and Chung-Lee (2006) found benefits to providing women with information about PPD. In addition, Ho et al. (2009) reported that women had lower rates of PPD at 3 months postpartum when discharge teaching by hospital nurses included information on PPD. Logsdon, Pinto Foltz, Scheetz, & Myers (2010) also concluded that teaching by hospital nurses can help women by decreasing stigma and decreasing women's reluctance to get treatment. These

findings support the hospital nurses belief they should continue to ensure that women receive information related to PPD prior to discharge.

The hospital nurses in this study expressed many concerns related to PPD teaching. There were concerns about whether all nurses were doing this teaching and a lack of confidence in their own knowledge about the community resources. Logsdon et al. (2010) also reported the variation in the provision of PPD teaching described by hospital nurses. These researchers identified some of the barriers that hospital nurses have to providing PPD teaching, including their own comfort and knowledge, expectations by supervisors, and their own self-esteem. The hospital nurses' identified wide variation in nurses' teaching practice and they related these variations to the changes that have been made to discharge teaching, including an organizational change to a standardized discharge video. This is practice is counter to the current literature that PPD teaching is most effective if individualized and based on the individual woman's risk factors (Ho et al., 2009; Logsdon et al., 2012).

The findings from this study that nurses value PPD teaching, combined with the above literature support the need for PPD teaching. These findings are also a call to develop innovative ways to deliver this teaching. If videos are no longer effective perhaps the development of interactive "apps" may find a place in supporting and informing women regarding PPD. This sort of innovation could guide decision makers on ways to use teaching to have the most positive impact possible on PPD outcomes. Despite the fact that antenatal education has not been proven to prevent PPD (Dennis & Creedy, 2004; Haynes et al. 2001; Lara et al., 2010; Matthey et al., 2004) education in the prenatal period may be beneficial in helping women to later self identify if they

experience PPD (Dennis & Chung-Lee, 2006). The hospital nurses in this study were concerned that there were changes and variation in discharge teaching and that not all women were getting the information on PPD. It may be beneficial to explore the reasons why teaching may not be occurring in the hospital and to examine what could ensure that women are getting information about PPD, including considering new uses of technology. The research by Logsdon et al. (2010) may help guide further research in this area and the best practice guideline by Logsdon et al. (2012) provides assistance in guiding the practice of hospital nurses related to PPD.

Nurses Role in Caring for Postpartum Women

Participants in this study were asked to share their experiences of caring for women with PPD. In doing so, they described the role they played when providing care to postpartum women. The role varied according to the setting in which they worked, but generally was comprised of three aspects: Listening, asking direct questions, and linking women with resources.

Listening. Participants unilaterally reported that the role of nurses is to listen. They explained that what women wanted was to be heard and validated. Hospital nurses described how important it was to spend time listening to the woman's birth experience, and help her to go beyond any negative emotions she may be experiencing. The PHNs found that being able to visit the woman's home made it easier to listen as the women seemed more comfortable in their own homes.

The literature related to the importance of listening is considerable. Shipley (2010) asserts that listening is not only essential to any meaningful interaction with a patient, but it may be the thing that patients desire most from their health care providers.

This assertion is consistent with the beliefs of the nurses in this study. Listening has been described as an essential nursing skill (Browning & Waite, 2010; Savett, 2011) and is considered to be more than hearing what the person is saying. Listening is a deliberate and conscious action that requires being silent, being present, and being aware of all of the nuances of communication (Savett, 2011). This may explain why participants explained that they often just knew that something was not right with a patient, leading the nurses to conclude that health professionals need to dig deeper and ask more questions. In a recent PPD best practice guideline for hospital-based perinatal nurses, Logsdon et al., (2012) stated, “the value of a nurse’s intuition that ‘something is just not right’ cannot be overemphasized” (p. 219).

Listening can be a way to gather information, establish trust, and build relationships (Browning & Waite, 2010; Jagosh, Boudreau, Steinert, Macdonald, & Ingram, 2011; Savett, 2011). Savett (2011) and Browning and Waite (2010) stated that listening is a healing intervention. This is consistent with the belief stated by participants in this study that listening can help women move beyond difficult emotions. Despite the acknowledgement of the importance of listening as a nursing skill there remain gaps in our understanding of listening in nursing practice (Shiple, 2010). Listening is often not measured and can be an invisible therapeutic action (Shiple, 2010). Shiple (2010) asserted that there is a need to further understand the impact of listening on patients and to determine what is necessary for a patient to feel they have been heard.

Despite the importance placed on listening by the nurses in this study and by the above authors, listening as an intervention to prevent or treat PPD has not been found to be clearly effective. In two separate studies the researchers concluded that listening visits

were not sufficient to treat women with PPD (Shakespeare, Blake, & Garcia, 2006; Turner, Chew-Graham, Folkes, & Sharp, 2010). Knowledge to date indicates that by simply giving extra home support similar to the service being evaluated by Shakespeare et al. (2006) and Turner et al. (2010) may not be enough to effectively treat women with PPD. In contrast, in studies where nurses were given additional training with the expectation of providing psychological care related to PPD there have been positive results (Gavin et al., 2010; Morrell et al., 2009). Due to these recent positive results and given the barriers that still exist in accessing help for PPD and the evidence that intensive home based support may be effective this is something that should be considered as an option for women with PPD (Dennis & Creedy, 2006).

One of the roles that participants in this study did not identify as their role was that of providing counseling. One PHN reported explicitly that counseling was not her role and several others explained that their role was to listen. There has been limited research on PHNs performing counseling however there is some research that identifies that counseling may be an effective and acceptable treatment for women with PPD (Gavin et al., 2010; Morell et al., 2009). Further research is needed to determine whether this is an acceptable and effective intervention, in addition to what skills PHNs would need to provide counseling to women with PPD.

The hospital nurses in this study expressed concerns about the lack of time spent with patients and the lack of teaching. Schmied, Cooke, Gutwein, Steinlein, and Homer (2008) had similar findings when looking at the care provided by midwives in hospital and made suggestions for changes on hospital units to encourage more one-on-one time between midwives and postpartum women in an effort to improve women's satisfaction

with the care they received. The hospital nurses in this study identified debriefing the birth as an important part of postpartum care. There are conflicting results related to the impact of debriefing. Selkirk, McLaren, Ollerenshaw, McLachlan, and Moten (2006), as well as, Gamble, Creedy, Webster, and Moyle (2002) did not find debriefing to be an effective intervention and may even be harmful. Given this research, it may be more important for hospital nurses to focus on spending time with women to build trust and relationships in order to improve satisfaction and enhance teaching.

The conflicting research related to the impact of listening and debriefing on PPD outcomes could make it difficult for nurses and organizations to ensure that the time for listening is a priority. However, it does appear clear in the literature that even when listening has not been an effective treatment, patients want to be heard; postpartum women identify that they are more satisfied with their care if a health care provider takes the time to listen to them (Gamble et al., 2002; Savett, 2011; Schmied et al., 2008; Turner et al., 2010). In addition, listening helps build trust and establishes a relationship that can aid women in absorbing information and seeking help related to PPD (Schmied et al., 2008; Selkirk et al., 2006). The participants in this study identified the importance of teaching about PPD and the benefit of having a relationship with a health care provider in the postpartum period. All of these factors combined leads to questions about if listening is the skill that enhances teaching and builds relationships and therefore is a critical component of the care of postpartum women.

The Importance of Asking Questions about PPD. Participants explained that it is important for health professionals to notice when something is not right and to ask more questions. They reported that women will not always state outright how they are

feeling and often present with vague or seemingly unrelated concerns. The participants gave many examples of how they were able to help a woman identify that she may be experiencing PPD. Examples included exploring how a woman is feeling or using a screening tool. Study participants all stated that they were comfortable asking questions about emotions but worried that not all nurses are comfortable doing so.

Participants explained that women are often reluctant to disclose due to fear and worries about how they will be viewed if they say how they are feeling and research confirms this finding (Goodman, 2009; Sword et al., 2008). Letourneau et al. (2007) found similar barriers related to getting help and the women in this study explained that they expected to be asked directly about symptoms of depression.

At present, postpartum women in Nova Scotia are not routinely screened. Similarly, Dennis and Chung-Lee (2006) found that women who are experiencing PPD are frequent users of health care services and yet are not screened for PPD. There is a wealth of literature on attitudes of health care providers towards screening women for PPD. This research, however, often occurs in areas where health care providers are employing universal PPD screening. In the absence of a universal screening program the practice of nurses asking questions about PPD could use further exploration to determine practice and factors that influence their ability to ask those questions.

Connecting Women to Resources in the Community. As the participants in this study described their experiences, they illustrated their knowledge of women's need for support during the postpartum period and how they had a role in connecting women with resources. They identified that women in the postpartum period often lacked support and explained that this could contribute to PPD. Dennis and Hodnett (2007)

reported the same finding. They also suggested that lack of social support increases a woman's risk of postpartum depression. Participants in this study identified that part of the care they provide is to assess a woman's supports. When explaining the importance of support, participants clarified that women relied on both professional and personal supports. Scrandis (2005) in a grounded theory study attempted to understand how women with PPD mobilized support. Scrandis found that women with PPD sought out social support to normalize symptoms and relied on both personal and professional relationships to provide social support (2005).

The PHNs in this study described an understanding of the supports available in the community for women. One of the ways that some PHNs were able to increase a woman's support was to link her to other mothers in the community. The PHNs also explained that they would like to increase their ability to connect mothers, thereby enhancing peer support. Several researchers have found that peer support is both an effective treatment for PPD and that women were also happy with their experiences of peer support (Dennis, 2010; Letourneau et al., 2011; Montgomery, Mossey, Adams, & Bailey, 2012). The PHNs may be able to use this information to advocate for, or facilitate the availability of, peer based support as an option for women with PPD.

Participants explained that their role included linking women with resources. They suggested a reproductive mental health programs and the woman's family doctor as resources for diagnosis and treatment for PPD. This is similar to the results by Chew-Graham et al.'s (2009) where health visitors felt it was the GP's role to diagnose PPD. Other authors have agreed that obstetricians and pediatricians are in an optimal position to screen women and identify PPD (Sit & Wisner, 2009; Wiley, 2004). However, in

research exploring physicians' knowledge, attitudes, and behaviors related to PPD the researchers reported gaps in knowledge and inconsistent screening of women for PPD (Lepper et al., 1994; Wiley, 2004).

Participants in this study were also concerned that GP's may not ask women about PPD or may not explore women's emotions. They believed that the long-term relationship that women have with their GP and the fact that women will be seeing their GP for well-baby visits throughout the child's early life gives rise to a responsibility on the part of the GP to assess for PPD. There is minimal research on the practice of GP's related to PPD. In one study, GP's stated that they did not feel they had the skills to diagnose or manage PPD (Chew-Graham et al., 2009). Further research is needed to provide information on the practice of GP's related to PPD. Collectively, the available literature and the current health care practices point to exploring both the types and appropriateness of care family doctors provide to women during the postpartum period

The PHNs in this study spoke confidently about their knowledge of the community resources. Their ability to connect women with resources was learned through working with women that are experiencing symptoms of PPD, and the fact that their work context involves engagement with a range of community supports. In contrast, the hospital nurses reported less confidence and were uncertain of what resources were available and what those resources provided. Perhaps the differences in knowledge related to community resources can be explained by the timing of care. That is, hospital nurses cared for women in the immediate postpartum period and were unlikely to be with women when symptoms of PPD began. Since participants in this study reported relying heavily on their clinical practice to increase their knowledge, and

hospital nurses had less exposure to women with PPD unlike PHNs who have a more consistent exposure to PPD in practice.

The hospital nurses saw their role related to community resources as teaching women about what resources are available to them. Discharge teaching is the time that many hospital nurses in this study stated that they would review community resources. Recent changes to teaching, such as the move to a discharge teaching video, have resulted in reports of a more generalized and less individualized approach to teaching. Logsdon, et al. (2012) in a best practice model for hospital-based perinatal nurses stated that nurses need to provide women with information on community resources prior to discharge. If hospital nurses are not confident in their awareness of community resources then there is a need to increase their knowledge in this area. It may also be possible to consider how to best use technology to enhance women's learning and connection to support, while at the same time using tools and programs that are able to provide individualized information.

In summary, as the participants in this study described their experiences caring for postpartum women, the various roles they enacted have a relationship to each other. Participants began by articulating that their role was to listen to women. Listening is an activity that postpartum women appreciate. It has been defined as an essential skill that is valued by patients, helps gather information, has a healing effect, and provides comfort. Further research into the merits of listening is needed. Along with listening, participants explained that they had a responsibility to ask questions. Asking direct questions related to mood and symptoms of depression are necessary as women are reluctant to disclose symptoms of depression.

Next, the participants described their understanding of women's need for support and their role in helping women get that support. Despite the fact that both groups of nurses acknowledged the importance of support and the need to assess the women's current support systems, the nurses in each setting had a different knowledge of and ability to connect women with sources of support. The PHNs felt confident in their knowledge of community resources but hospital nurses were less confident in their knowledge of these resources. Study findings revealed that nurses rely heavily on their experiences with women to increase their knowledge. Given that hospital nurses are not always using community resources in their work they may need to find other ways to increase their knowledge in this area. Logsdon et al. (2012), in a best practice guideline for perinatal hospital nurses, suggested that nurses provide information on community resources prior to discharge and that information should be individualized.

Relationships in Postpartum Care

Participants reported that women benefited from having a relationship with a health care provider during the postpartum period. Having a health care provider see the woman over time provided an opportunity to continue to assess for PPD. This led the participants to conclude that the health care provider that sees the woman for well-baby visits is in an ideal position to continue to assess for PPD. There are a number of researchers who have concluded that physicians that care for women throughout the postpartum period are in an ideal position to continue to assess for PPD, owing to the timing of the care these physicians provide (Chew et al., 2009; Sriraman, 2012; Wiley, 2004).

This may be particularly important given that nurses in Nova Scotia routinely have very early contact with women, prior to women developing symptoms of PPD. An emphasis on primary care providers continuing to assess for PPD will increase the opportunities to identify women with symptoms of PPD. In the literature, however, with regards to women's experiences disclosing in primary care settings, women were often reported to have felt that their concerns were minimized and dismissed (Goodman, 2009; Holopainen, 2002; Letourneau et al., 2007; Sword et al., 2008). This leads to questions about whether it is more important to have a long term relationship or to ensure that as a health care provider you listen to the woman's concerns and take her concerns seriously.

Participants in this study identified two requirements for building a relationship: continuity of care and time. Schmied et al. (2008) found similar relationship qualities. In their study, hospital midwives did not spend much time with women and these researchers asserted that time is required to build relationships. This study included the evaluation of several changes to the practices of midwives on the unit including a midwife available free of other responsibilities for several hours each day to talk with women. By increasing the amount of time midwives had to spend one-on-one with women the researchers found an increase in women's satisfaction with their care. In addition, Turner et al. (2010) found that the women may be reluctant to disclose concerns related to depression if they believed that the care provider did not have time to talk.

In keeping with the findings of this study, Beck (1995) in a qualitative study to determine women's perceptions of caring behaviors by nurses described these behaviors to include time and continuity of care. Similarly, in a study by Rossiter, Fowler, McMahon, & Kowalenko (2012) women that had intensive home visiting by nurses as

part of a treatment regime for PPD were interviewed. These women described the importance of a strong bond with the nurse and of the nurses knowing them.

To my knowledge, there are no published studies that directly address the issue of the impact of relationships between women and care providers related to PPD. Given the conclusions from the studies above, it may be beneficial to continue to focus on creating an environment where women feel that they are taken seriously and where there is time for care providers to listen to their concerns. A woman having a relationship with her care provider appears closely linked to the practice of listening. Moreover, various researchers reported listening by a health care provider increases the likelihood that women would feel comfortable disclosing feelings (Goodman, 2009; Holopainen, 2002; Letourneau et al., 2007; Sword et al., 2008) and should continue to be the focus of nurses' care. Beliefs regarding continuity of care and time for relationship building were also supported.

The nurses' belief regarding the merits of a relationship with the woman was not located in the literature on PPD and may warrant further study. It may be that there are other factors that have yet to be identified, such as nurses' comfort in teaching or discussing PPD when the nurse feels she has formed a relationship with the woman.

Summary

Findings in this study provide new information on nursing knowledge of PPD. Participants in this study demonstrated a broad and varied knowledge of PPD. They used a variety of ways of knowing, but relied heavily on their experiences with women. Many of the participants' provided an understanding of PPD that was in contrast with the medical model but had similarities to the descriptions reported by women that have

experienced PPD. Participants understood that women experienced a range of emotions and were not always able to disclose how they were feeling. It is not clear if this broad view of PPD helps nurses to identify women that are experiencing PPD. What nurses were able to do if they identified someone with PPD was also unclear. This remains a challenge, as do the facts that there are varying understandings of resources for referral, uncertainty as to the expectations (teaching and follow up), and heavy reliance on GP's to either detect or conduct continued care.

Currently, participants described their roles as listening, asking questions, and making referrals to available community resources. Teaching approaches to PPD and identifying resources are changing in hospital and call for new and innovative ways to individualize care such as using interactive technology designed to give information about PPD. For PHNs, there may be an opportunity to provide additional services in the form of counseling in women's homes. This counseling, however, would require training. Additional research is needed to determine if it is an effective and acceptable form of treatment.

This research adds to the knowledge base of the role of hospital and public health nurses that was not previously articulated. I identified listening as a pattern that included asking questions, and identified the role of nurses in connecting women to social support. The literature supports enhancing the role of hospital nurses in providing individualized education and improving their knowledge of community resources. Listening may not be effective in preventing PPD; however, it is highly valued, may help build trust, is potentially healing, and can improve taking in of information. There is a need to continue to increase nurses' therapeutic skills in order to ensure that listening is used

effectively. In addition, it is important to consider what aspects of the context facilitates or impedes nurses ability to effectively listen and continue to work towards an environment that promotes the use of this skill.

The discussion of the findings from this study highlighted the new knowledge generated in this study, integrated the current literature and descriptions of the context in which the findings were created with the intent to further understanding of the topic. In the next chapter, I will provide a concise overview of the conclusions from this study, along with study limitations and implications for both research and practice.

Chapter Six

Conclusion

Postpartum depression is a serious disease that affects many women. In a meta-analysis of 59 studies, the overall prevalence of PPD was found to be about 13% (O'Hara & Swain, 1996). In a more recent systematic review Gavin et al. (2005) found the prevalence rate of depression in the first three months postpartum to be 19.2% and is considered the number one complication following childbirth. At this time, there has been significant research on this topic, with much known about women's experiences, risk factors, screening tools, identification, and treatment (Beck, 2008a; 2008b).

My own clinical practice, as well as the research, supports the proposition that women in the postpartum period are not getting the help they need related to PPD, despite having frequent contact with health professionals during this time (Hall, 2006; Beck, 2002). This problem has not been explained in the literature, as there is very little published literature on health care professionals' knowledge of and attitudes towards PPD. In addition, nurses commonly care for postpartum women yet their exact role in caring for this population has not been clearly articulated (Holopainen, 2002). This information led to the identification of the need to conduct this study in order to make a contribution to improving the care that postpartum women get related to PPD, by better understanding nurses' knowledge, attitudes, and role related to PPD.

Participants in this study were involved in either focus groups, or participant observation or both. Key findings are as follows: participants knowledge of PPD included viewing PPD in a variety of different ways; participants were knowledgeable of the need for support in the postpartum period; participants explained that teaching about

PPD made a difference in women being able to identify PPD; participants explained that first and foremost they were there to listen to women, and that it was their responsibility to ask specific questions and dig deeper, and connect women with supports if they sensed that something is not right; and finally having a relationship with a health care provider was beneficial to postpartum women. Of these findings, the rich and varied understanding of PPD and the participants' detailed descriptions of their role in caring for women in the postpartum period was unique to this study.

Participants' knowledge about PPD in this study contrasts with findings in previous studies. Other researchers have all identified gaps in health professionals' knowledge (Lepper et al., 1994; Keng, 2005; Skocir & Hundley, 2006; Wiley et al., 2004) whereas in this study the nurses were able to share their knowledge of PPD. This may be related to the fact that in previous studies the questions were asked in a way that did not fit with nurses' definition of PPD. The majority of the nurses in this study did not define PPD using a medical definition but rather in keeping with the definition articulated in the research on women's experiences with PPD. This finding is possibly due to the fact that the nurses relied heavily on their clinical experiences to understand PPD.

Participants in this study valued teaching about PPD; however, the research to date does not support teaching as a way to prevent PPD (Gagnon & Sandall, 2007). Put more broadly, there have been no identified antenatal interventions, including antenatal education, that have been effective in decreasing the rates of PPD (Dennis & Creedy, 2004; Haynes et al. 2001; Lara et al., 2010; Matthey et al., 2004). Participants in this study believed that the role of teaching was to help women self-identify PPD and get help sooner. It has been found that knowledge of PPD may help women seek help sooner

(Dennis & Chung-Lee, 2006) but that the education about PPD should be individualized based on each woman's risk factors (Logsdon et al., 2012).

The role of nurses as described by participants in this study included, listening, asking questions, and connecting women with supports. The importance of listening to women in the postpartum period has not been adequately explored, and there are authors that suggest that listening is not well understood, however listening has been identified in the general health care literature as a way to gather information, establish trust, and build relationships (Browning & Waite, 2010; Jagaosh et al., 2011; Savett, 2011). In the research looking at the care of women with PPD, listening has been deemed inadequate as a treatment (Shakespeare et al., 2006; Turner et al., 2010). Participants in this study felt it was the responsibility of the health care provider to ask direct questions about PPD as they felt women would not disclose symptoms of PPD directly or voluntarily. Finally, the participants saw their role as one where they would connect women with resources in the community. Many of the participants reported connecting women to their GP's and peer support was also a type of support that was seen as highly valuable. The knowledge of community resources and the participants' perceived ability to connect women to the various community resources varied by work setting.

The participants emphasized the positive impact of having a relationship with the woman. They identified that they are often in contact with women prior to the time you would expect to see symptoms of PPD. This led participants to recommend that the health care provider that sees that woman throughout the first year postpartum, most often a GP, has a responsibility to continue to assess for symptoms of depression. Women have a perception that there is insufficient time to discuss symptoms of PPD with

their primary care provider (Goodman, 2009) but have reported that they feel more comfortable disclosing if they have a good relationship (Chew-Graham et al., 2009). Another significant concern related to women's ability to get help for PPD was that women at times described feeling worse after talking with a health care provider (Dennis, & Chung-Lee, 2006; Letourneau et al., 2007). This description highlights the importance of identifying who is in the best position to identify women with PPD and to ensure that that this health care provider is able to provide high quality care.

Strengths and Limitations of This Study

The exploratory nature of this study provided participants an opportunity to share more in-depth information related to PPD than previously described in the literature. This study began with a clinical question that arose in a practice setting. The use of interpretive description was specifically intended to enable the researcher to go beyond the theoretical and interpret the findings in the current context of care, with the aim of providing insight into a clinical problem. Some of the specific strengths of this study design were the multiple data sources, focus groups, participant observation, and reflective journaling, each was specifically chosen to compliment the other, and the long period of time spent in the field by the researcher.

In any interpretive description study, it must be noted that the findings from this study are not intended to represent an objective truth, but rather provide a view that may not have been previously considered. One limitation of this study was the decision made by the researcher to delay coding of the data until the majority of data were collected. Early formal coding would have allowed me to explore hunches in more depth with each subsequent focus group, potentially strengthening the study. This decision was made to

offset the risk, particularly to the novice researcher, of premature closure by coding too early. I did use my reflective journal and field notes to record hunches and further refine the questions after each data collection point. In order to further the trustworthiness of these findings I was able to observe the same participants on multiple occasions in order to build trust and clarify my reflections and developing patterns. During analysis I was also able to go back to participants to seek more information if I found something I needed to explore further. The study involved one institution and catchment area, and all participants were women.

Implications for Nursing Practice

Participants in this study relied heavily on their clinical experiences with women to inform their nursing practice in the care of women with the potential to develop PPD. Through their clinical experiences, more specifically through listening to women, the participants in this study were able to share a rich and deep understanding of PPD. Nurses can continue to spend time listening to women's experience in order to both enhance their own understanding of PPD but also to be able to continue to articulate how PPD can present. Given that participants in this study reported that PPD presents in a variety of different ways, nurses' need to also be aware of how their view may differ from other views and models of PPD and how each perspective influences assessment and treatment options.

Participants in this study placed high value on teaching and there is literature supporting teaching as a way to help women identify and seek help for PPD sooner (Dennis & Chung-Lee, 2006); however, teaching was done in large groups or by providing generic information. Teaching about PPD is most effective if individualized,

this creates challenges in a health care system that also needs to consider the efficiency of its resources. Logsdon et al. (2012) provides a best practice guideline related to PPD for hospital postpartum nurses that include the use of individualized teaching based on risk factors. Hospital nurses may find the use of this guide can help improve the quality of the teaching women receive in hospital. In addition, nurses may want to partner with others to create technology that combines both their expertise of the postpartum period with an ability to provide individualized information to postpartum women in an innovative and efficient way.

The participants in this study all recognized that women need additional support in the postpartum period. They described their role as making women more aware of the supports available and helping connect women with these supports. However, they varied in their knowledge of the supports available to women. Given that the PHNs reported being more aware of community supports and the hospital nurses reported feeling less confident about the community resources but wanted to be able to provide that information to women prior to discharge there is an opportunity to improve practice through the sharing of this information on between the two groups of nurses. The end result would not only include an increase in accurate information being provided to women and increased consistency of care but may lead to collaboration in other areas of postpartum care.

Participants in this study also recognized the different types of support that benefit women in the postpartum period. One of the types of support that has been particularly effective for women with PPD is peer support (Dennis, 2010; Letourneau et al., 2011; Montgomery et al., 2012). The nurses in this study recognized the value of peer support

and can continue to direct women toward those resources, as well as advocate for more peer support options to be made available to postpartum women.

Participants identified that having a relationship with a woman makes it easier to identify changes in her mood and to teach the woman about PPD. The literature suggests that women reported being more comfortable disclosing symptoms of PPD based on their comfort with the person, and the ability of that person to listen to the woman and to take their concerns seriously (Schmied et al., 2008). The nurses in this study explained that they often do not have a long term relationship however described their role as listening to women and can continue to use this skill to help women feel comfortable disclosing any symptoms of PPD.

When describing the benefits of having a relationship with a health care provider during the postpartum period the participants also identified their lack of understanding of the practices and role of others related to PPD. This lack of understanding and lack of collaboration can negatively impact on the care of postpartum women and contribute to them not getting the help they need. In order to continue to improve the care of postpartum women related to PPD there is a need to recognize this gap and bring together all care providers that provide care to postpartum women with a goal of working towards a more consistent and seamless approach to postpartum care.

Implications Future Research

One of the key findings from this study was the value that participants placed on listening to women. Listening as a therapeutic skill is not well understood in the literature, and has conflicting results in relation to PPD. Some researchers concluded that it is not effective as a treatment for PPD (Shakespeare et al., 2006; Turner et al., 2010)

and others found that with additional training nurses were able to provide counseling to women as treatment for PPD (Glavin et al., 2010). Listening may offer benefits that have not yet been identified and given that it is highly valued by both postpartum women and nurses there is a need to explore it further. This may include clarifying what “listening” means and the impact it has on both women and the nurses. Nurses see listening as their primary role and therefore are in an ideal position to lead research in this area of postpartum care.

Participants in this study also reported concerns about women’s reluctance to disclose PPD symptoms and the importance of asking direct questions related to PPD. Given the fact that Nova Scotia does not use universal screening of women for PPD there is a need to better understand the practice of nurses in relation to asking questions about PPD, the factors that influence their ability to ask those questions, and the impact on nurses ability to detect PPD.

There is some evidence that counseling of women with PPD decreases the rates of PPD. Further research could be directed to determining whether this is an acceptable and effective intervention and what skills PHNs would need to provide counseling to women with PPD.

An additional key finding in this study is that participants reported a variety of ways of understandings PPD including an explanation that that PPD can look different for each woman. An important next step in improving the care of postpartum women related to PPD would be to determine if the use of a broad definition of PPD is beneficial to women in terms of early identification or in getting treatment for PPD. More specifically, the nurses in this study provided descriptions of PPD that were similar to the

descriptions in the literature provided by women with PPD and it is presently unclear if women benefit from nurses having a similar understanding of PPD as the women themselves.

Findings from this study suggest that nurses gain much of their understanding of PPD through their clinical experiences working with postpartum women. This can potentially create challenges for nurses that have limited clinical experience providing care to postpartum women. Further research could include exploring how nurses with limited clinical experience gain knowledge related to PPD or identifying the barriers and facilitators to the inclusion of other forms of evidence that could inform nurses' care of postpartum women related to PPD.

The hospital nurses in this study expressed concerns that not all nurses provided teaching related to PPD and that changes to discharge teaching have led to fewer women getting the information that they need prior to discharge. There is some research that may explain some of the factors that influence teaching about PPD by hospital nurses (Logsdon et al., 2010). In addition, there is a best practice model for hospital based nurses in caring for women related to PPD (Logsdon et al., 2012). The findings from this study combined with the above research could lead to a knowledge translation or an intervention based study to demonstrate improvements in care of women with PPD related to the teaching provided by hospital nurses. An additional area of research that could result from this finding is the exploration and evaluation of the effectiveness of different types of technology in providing information related to PPD to postpartum women and their families.

The current published literature offers little on the influence of a long-term relationship with a woman in relation to PPD outcomes. The participants in this study explained that although nurses have frequent contact with women in the postpartum period they are often in contact with women prior to the period when one would expect to see symptoms of PPD and may not have continued contact with women beyond the immediate postpartum period. In Nova Scotia, GP's tend to provide the continuity of care throughout the first year postpartum, through well-baby visits. The participants in this study had questions about the practice of GP's given that they are the care provider that provides that continuity of care throughout the first year postpartum. There is a need to extend this research to better understand the care that GP's provide related to PPD. There is also a need to fill the gap in our knowledge on the role of relationships and their influence on the care of postpartum women related to PPD.

Dissemination Strategies

It is important when using interpretive description to remember that the ultimate aim is to provide a product that can be useful to a clinician, therefore it is necessary to reflect on how the findings can make their way back to the sources that can influence practice (Thorne, 2008). I plan to disseminate the findings of this research through the standard academic methods, including journal articles, and both oral and poster presentations. This generally helps information to reach the academic community.

In addition, I plan to present the findings back to the community from which it came, the nurses. Some of the nurses that participated have requested a summary and this summary will be made available widely throughout the hospital postpartum unit and the public health unit in which the research occurred. I also plan to present the findings

in both the hospital and public health setting where the research occurred for example as a “lunch and learn” or presentations at the various work settings.

The summaries will also be provided to the managers of each area with an offer to meet and review the potential of this study to influence the care nurses’ provide to postpartum women. I also plan to explore opportunities to partner with organizations to present these findings, for example the College of Registered Nurses of Nova Scotia and the Reproductive Care Program of Nova Scotia. Both organizations are provincial and have the ability to access nurses and other health care providers that provide care to postpartum women. The other groups that may discover the findings relevant to their practice are students and other health professionals, particularly GP’s. There are publication and presentation opportunities that would allow me to share the findings of this study to these groups. This would increase the awareness of nurses’ knowledge and role in relation to PPD, as well as, challenge others to consider their own role practice in the care of postpartum women.

Appendix A
Recruitment Poster

Are you a Registered Nurse
who is willing to share your
thoughts and experiences
related to postpartum
depression?

This is a research study that involves focus groups and observations of
Registered Nurses work in the postpartum period.

If you are interested in learning more about this study please contact
Cynthia Mann, RN, BScN at 433-3143 or at greening@dal.ca.



Principal Researcher
Cynthia Mann, RN, BScN
Masters of Nursing student
Dalhousie School of Nursing

Research Supervisor
Dr. Erna Snelgrove-Clarke
Dalhousie School of Nursing

Appendix B

Email and Electronic Notice to Nurses

1. Email and electronic notice to nurses on in-hospital postpartum unit regarding focus groups

Dear nurses,

My name is Cynthia Mann and I am currently in the master's of nursing (MN) program at Dalhousie University. As part of this program I am doing a qualitative research study that is titled "Knowledge and Attitudes Regarding Postpartum Depression of Hospital Postpartum and Public Health Nurses". The purpose of my study is to explore the knowledge and attitudes that hospital postpartum nurses and public health nurses have towards postpartum depression (PPD).

Currently little is known about nurses' knowledge and attitudes regarding PPD. The knowledge gained from this study has the potential to positively impact on the care provided to postpartum women, as well as, influence the work context in which nurses provide this care.

As part of this study I will be holding focus groups with Registered Nurses on your unit to discuss your experiences caring for postpartum women. These focus groups will be held at a time that is convenient for you and you will be compensated for your time.

If you are interested in participating or have any questions I would be happy to discuss the study with you further. You can contact me at greening@dal.ca or by phone at 433-3143.

2. Email and electronic notice to nurses on in-hospital postpartum unit regarding participant observation

Dear nurses,

My name is Cynthia Mann and I am currently in the master's of nursing (MN) program at Dalhousie University. As part of this program I am doing a qualitative research study that is titled "Knowledge and Attitudes Regarding Postpartum Depression of Hospital Postpartum and Public Health Nurses". The purpose of my study is to explore the knowledge and attitudes that hospital postpartum nurses and public health nurses have towards postpartum depression (PPD).

Currently little is known about nurses' knowledge and attitudes regarding PPD. The knowledge gained from this study has the potential to positively impact on the care provided to postpartum women as well as influence the work context in which nurses provide this care. As part of this study I will be present in your unit as an observer. Participant observation shifts are particularly important to this study in order to help be better understand the broader context in which you work.

In order to facilitate these observations I will be paired with a Registered Nurse who works in the area. Participant observation shifts will be held during your regular work time, at a time that is convenient for you. My role will be as an observer only and will not impact on the care you provide to women and their families.

If you are interested in participating or have any questions I would be happy to discuss the study with you further. You can contact me at greening@dal.ca or by phone at 433-3143.

3. Email and electronic notice to nurses in public health regarding focus groups

Dear nurses,

My name is Cynthia Mann and I am currently in the master's of nursing (MN) program at Dalhousie University. As part of this program I am doing a qualitative research study that is titled "Knowledge and Attitudes Regarding Postpartum Depression of Hospital Postpartum and Public Health Nurses". The purpose of my study is to explore the knowledge and attitudes that hospital postpartum nurses and public health nurses have towards postpartum depression (PPD).

Currently little is known about nurses' knowledge and attitudes regarding PPD. The knowledge gained from this study has the potential to positively impact on the care provided to postpartum women, as well as, influence the work context in which nurses provide this care.

As part of this study I will be holding focus groups with Registered Nurses in your clinical area to discuss your experiences caring for postpartum women. Focus groups will be held at a time that is convenient for you and you will be reimbursed for your time.

If you are interested in participating or have any questions I would be happy to discuss the study with you further. You can contact me at greening@dal.ca or by phone at 433-3143.

4. Email to nurses in public health regarding participant observation

Dear nurses,

My name is Cynthia Mann and I am currently in the master's of nursing (MN) program at Dalhousie University. As part of this program I am doing a qualitative research study that is titled "Knowledge and Attitudes Regarding Postpartum Depression of Hospital Postpartum and Public Health Nurses". The purpose of my study is to explore the knowledge and attitudes that hospital postpartum nurses and public health nurses have towards postpartum depression (PPD).

Currently little is known about nurses' knowledge and attitudes regarding PPD. The knowledge gained from this study has the potential to positively impact on the care provided to postpartum women, as well as, influence the work context in which nurses provide this care. As part of this study I will be present in your clinical area as an observer. Participant observation shifts are particularly important to this study in order to help be better understand the broader context in which you work.

In order to facilitate these observations I will be paired with a Registered Nurse who works in your area. Participant observation shifts will be held during your regular work time at a time that is convenient for you. My role will be as an observer only and will not impact on the care you provide to women and their families.

If you are interested in participating or have any questions I would be happy to discuss the study with you further. You can contact me at greening@dal.ca or by phone at 433-3143.

Appendix C

Letter of Invitation

Dear nurses,

My name is Cynthia Mann and I am currently in the master's of nursing (MN) program at Dalhousie University. As part of this program I am doing a qualitative research study that is titled "Knowledge and Attitudes Regarding Postpartum Depression of Hospital Postpartum and Public Health Nurses". The purpose of my study is to explore the knowledge and attitudes that hospital postpartum nurses and public health nurses have towards postpartum depression (PPD).

Currently little is known about nurses' knowledge and attitudes regarding PPD. The knowledge gained from this study has the potential to positively impact on the care provided to postpartum women, as well as, influence the work context in which nurses provide this care.

I am hoping that you will be able to help me better understand both the care nurses provide to postpartum women related to PPD and the context in which you provide this care. In order to do this I am asking Registered Nurses in your area to participate in focus groups and or participant observation shifts.

The focus groups will consist of a 60-90 minute conversation with myself and a group of your colleagues that will be recorded. The focus group will be held at a time that is convenient to you. During participant observation shifts I will be paired with a Registered Nurse and spend time for approximately two hours of her shift. I will be present as an observer only and will not impact on your work. By being present at your work place I hope to better understand the factors that influence your work.

The information that you share will be kept confidential and will not be shared with your employer. The purpose both the focus groups and participant observation shifts is to collect information for the purpose of this study only and will not be used to judge your work.

You can choose to participate in either the focus groups, participant observation shifts or both. If you would like to participate or would like to discuss this study further please contact me at greening@dal.ca or 433-3143.

Thank you for taking the time to consider participating in this study,

Yours sincerely

Cynthia Mann RN

Appendix D

Focus Group Consent Form



Focus group consent form

Study title: Knowledge and Attitudes Regarding Postpartum Depression of Hospital Postpartum and Public Health Nurses: An Exploratory Study.

Principle Investigator: Cynthia Mann, RN, BScN, PNC(c)
Masters of Nursing Student, Dalhousie University

Co-Investigators: Erna Snelgrove-Clarke (Research supervisor), PhD, RN, School of Nursing, Dalhousie University
Megan Aston, PhD, RN, School of Nursing, Dalhousie University
Marilyn MacDonald, PhD, RN, School of Nursing, Dalhousie University
Janet Rush, PhD, RN, School of Nursing, Trent University

Funding Sources:

Nova Scotia Health Research Foundation
Canadian Nurses Foundation
Dalhousie Nursing Research Fund

Introduction and Purpose:

You are invited to take part in a voluntary research study that is part of a Master of Nursing program at Dalhousie University. This form provides information about the study. Before you decide if you want to take part, it is important that you understand the purpose of the study, the risks and benefits and what you will be asked to do. You do not have to take part in this study. Taking part is entirely voluntary. Informed consent starts with the initial contact about the study and continues until the end of the study. A member of the research team will be available to answer any questions you have. You may decide not to take part or you may withdraw from the study at any time. This will not affect your employment in any way.

The overall purpose of this study is to explore the knowledge and attitudes of both in-hospital postpartum and public health nurses towards postpartum depression. Nurses commonly care for postpartum women in both hospital and community settings. Currently very little is known about nurses' knowledge and attitudes towards postpartum depression. The information gained during this study will provide insights into nurses' knowledge and attitudes towards postpartum depression, as well as, help me to better

understand the care that nurses provide related to postpartum depression and the context in which this care is provided.

How will the researchers do the study?

This study is a qualitative study that includes nurses who care for women in the postpartum period. Nurses are eligible to participate if they work in the Family Newborn Adult Surgery Unit at the IWK Health Centre or if they work in the Healthy Beginnings program, Public Health services, Capital Health. There will be approximately 60 nurses participating in this study with approximately 30 from the IWK Health Centre and 30 from Public Health services.

I will be holding a total of four to six focus groups of nurses from these areas. During the focus groups, I will facilitate the discussion by asking a variety of open ended questions. Nurses will be asked to share their knowledge and experiences related to postpartum depression and the context in which they provide nursing care to postpartum women. There will be a professional transcriptionist present during the focus group to record and make a written record of the focus group.

What will I be asked to do?

If you choose to participate in this study you will be asked to participate in one focus group with six to eight other nurses that work in your area. The focus group will last approximately 60-90 minutes. It will be arranged at a time and place that is acceptable for you. You may choose not to answer any question.

Potential Harms and Burdens.

There are no expected harms from participating in this study. There is the possibility of harms that have not been foreseen by the research team. The topic of postpartum depression is a sensitive one and some of the conversation that occurs may be upsetting to you. If this happens to you please talk to one of the researchers and we will provide you with information on local mental health and employee assistance resources.

Potential Benefits.

Taking part may not benefit you directly. It is hoped that what is learned will be of future benefit to others. The knowledge gained may provide important information that can benefit nurses that provide care to postpartum women and ultimately may benefit postpartum women and their families.

Can I withdraw from the study?

You may withdraw prior to the beginning of the focus group. After the focus group has been taped it is often too difficult to distinguish different participant voices on the tape and I cannot guarantee that I will be able to identify your voice and remove it from the data. Withdrawal from the study will not impact on your employment in any way.

Costs and reimbursements.

There will be no costs to you for participating. If you take part in a focus group when you are not working you will be provided with an honorarium of \$25 to compensate you for any expenses that you may incur. If the focus group occurs during your paid work day you will not be given the above honorarium. As a token of appreciation for participating in a focus group during your work time you will be provided with a five dollar Tim Horton's gift certificate.

How will my privacy be protected?

Any information that is learned about you will be kept private. The professional transcriptionist that will be present during the focus groups to transcribe the discussion will be required to sign a confidentiality agreement. The transcripts and demographics sheets will be labeled with codes and will not contain your identity. The coding key will be kept separate from the data. Any electronic files will be kept on a laptop that is password protected. The study records will be kept in a locked area at Dalhousie University for 5 years following publication of the results. Only study staff will have access to these records. After that time all records, including audiotapes, will be destroyed. The study results may be published or presented but any identifying information about you will be removed.

Your decision to participate or not and any information that you share with the researcher will not be shared with your employer or colleagues. The information that you share will be used for the purpose of the study to better understand nurses' knowledge and attitudes related to postpartum depression. It will not be used to judge your practice in any way.

During each focus group all participants will be reminded that information shared in the focus group is for the purposes of the study and is confidential. Participants will be asked not to share the information that they have heard during focus groups outside of the focus group. I cannot guarantee that the information you share will be kept confidential by other participants.

There is the potential that research files will be requested as part of a research ethics board routine audit. If this were to occur information requested by the IWK Research Audit Committee will be provided.

What if I have study questions or problems?

For questions about the study please contact:

Researcher conducting the study

Cynthia Mann, RN, BScN, PNC(c)

Graduate Student

Masters of Health Administration/Masters of Nursing Program

Dalhousie University

Halifax, Nova Scotia

Phone: (902) 433-3143.

Email: greening@dal.ca

Research supervisor

Erna Snelgrove-Clarke, PhD, RN
Assistant Professor
Dalhousie School of Nursing
Halifax, Nova Scotia
Phone: (902) 494-2490
Email: erna.snelgrove-clarke@dal.ca

What are my Research Rights?

Your signature on this form shows that you have understood the above information and have had all of your questions answered prior to deciding to participate. Participation in the focus group indicates that you have agreed to take part in this research and that the information that you share can be used for that purpose. In no way does this waive your legal rights nor release the investigator(s), sponsors, or involved institution(s) from their legal and professional responsibilities. If you have any questions at any time during or after the study about research in general you may contact the Research Office of the IWK Health Centre at (902) 470-8520, Monday to Friday between 8:00a.m and 4:00p.m”.

How will I be informed of study results?

The results of this study will be available to you one year after the completion of the study. If you would like to receive either a full copy or a summary of the study results please check the appropriate box and provide your name and address on page six of this document.

Signature Page

Study title: Knowledge and Attitudes Regarding Postpartum Depression of Hospital Postpartum and Public Health Nurses: An Exploratory Study.

Participant ID: _____
Participant INITIALS: _____

Participant Consent

I have read or had read to me this information and consent form and have had the chance to ask questions which have been answered to my satisfaction before signing my name. I understand the nature of the study and I understand the potential risks. I understand that I have the right to withdraw from the study at any time without affecting my employment in any way. I have received a copy of the Information and Consent Form for future reference. I freely agree to participate in this research study.

Name of Participant: (Print) _____
Participant Signature: _____
Date: _____ Time: _____

CONSENT FOR USE OF DIRECT QUOTES

I give permission for the use of direct quotes from the focus groups to be used for the purpose of data analysis, discussion, and publication as long I will not be identified in any way. Yes _____ No _____

STATEMENT BY PERSON PROVIDING INFORMATION ON STUDY

I have explained the nature and demands of the research study and judge that the participant named above understands the nature and demands of the study.

Full name: (Print) _____
Signature: _____ Position: _____
Date: _____ Time: _____

STATEMENT BY PERSON OBTAINING CONSENT

I have explained the nature of the consent process to the participant and judge that they understand that participation is voluntary and that they may withdraw at any time from participating

Full name: (Print) _____
Signature: _____ Position: _____
Date: _____ Time: _____

Request for Study Results

The following information will be used to provide you results of this study at your request.

Please indicate if you would prefer a hard copy of the results or a copy via your email address.

I would like to receive a copy of full copy of the results of the study?

Yes___ No___

I would like to receive a summary of the study results?

Yes___ No___

Full Name (print): _____

Mailing address: _____

Email address: _____

Appendix E

Focus Group Question Guide

Focus group question guide

1. What does PPD mean to you?
2. Tell me about your experience in working with women that have experienced or are currently experiencing PPD?
3. How do you identify women who you feel are at risk for developing PPD?
4. How would you recognize a woman that has symptoms of PPD?
5. What do you feel your role is in working with women that are experiencing or are at risk for PPD?
6. Where have you received information/education on PPD in the past? Could you describe the education /skills you feel are needed to perform the role you described above?
7. Please identify some of the facilitators when providing care to women at risk for or are currently experiencing PPD.
8. Please identify some of the barriers when providing care to women at risk for or is currently experiencing PPD.

At times during the focus groups I will use prompts to facilitate the discussion. Some examples of prompts that I will be used during the focus groups to facilitate discussion include; (a) can you tell me more about ... (b) would anyone like to add more details or add to

Appendix F

Participant Observation Consent Form



Participant observation consent form

Study title: Knowledge and Attitudes Regarding Postpartum Depression of Hospital Postpartum and Public Health Nurses: An Exploratory Study.

Principal Investigator: Cynthia Mann, RN, BScN, PNC(c)
Masters Student
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Co-Investigators: Erna Snelgrove-Clarke (Research supervisor), PhD, RN,
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Dalhousie University
Janet Rush, PhD, RN, School of Nursing, Trent University

Funding Sources:
Nova Scotia Health Research Foundation
Canadian Nurses Foundation
Dalhousie Nursing Research Fund

Introduction and Purpose:

You are invited to take part in a voluntary research study that is part of a Master of Nursing program at Dalhousie University. This form provides information about the study. Before you decide if you want to take part, it is important that you understand the purpose of the study, the risks and benefits and what you will be asked to do. You do not have to take part in this study. Taking part is entirely voluntary. Informed consent starts with the initial contact about the study and continues until the end of the study. A member of the research team will be available to answer any questions you have. You may decide not to take part or you may withdraw from the study at any time. This will not affect your employment in any way.

The overall purpose of this study is to explore the knowledge and attitudes of both in-hospital postpartum and public health nurses towards postpartum depression. Nurses commonly care for postpartum women in both hospital and community settings. Currently very little is known about nurses' knowledge and attitudes towards postpartum

depression. The information gained during this study will provide insights into nurses' knowledge and attitudes towards postpartum depression, as well as, help me to better understand the care that nurses provide related to postpartum depression and the context in which this care is provided.

How will the researchers do the study?

This study is a qualitative study that includes nurses who care for women in the postpartum period. Nurses are eligible to participate if they work in the Family Newborn Adult Surgery Unit at the IWK Health Centre or if they work in the Healthy Beginnings program, Public Health services, Capital Health. There will be approximately 60 nurses participating in this study with approximately 30 the IWK Health Centre and 30 from Public Health services.

As part of this study I will be spending six shifts in each work area as an observer. These shifts are called participant observation shifts and will last two to three hours. I will be spending time as an observer in each work setting in order to learn about the care that nurses provide to postpartum women. I will also be observing the work environment in order to better understand the context in which your work occurs. You can expect to continue your work as usual and share your thoughts and experiences related to postpartum depression. During the shift I will take frequent breaks to take notes describing my observations.

What will I be asked to do?

If you chose to participate in a participant observation shift I will be present as an observer during your regular work time. The participant observation shifts will be arranged at a time that is most convenient for you and will last two to three hours. You do not have to be with me continuously during this time and will be able to continue your work as usual. During this time I may ask questions and discuss issues with you related to postpartum depression to better understand your work. Any information that you share with me may be included as data in the study. I will not be accompanying you in any patient rooms or on home visits. The purpose of this study is to better understand the knowledge and attitudes of nurses and not to observe direct patient care.

Potential Harms and Burdens.

There are no expected harms from participating in this study. There may be potential harms that have not been foreseen by the research team. The topic of postpartum depression is a sensitive one and it is possible that participation in this study may cause you to feel uncomfortable or upset. If this happens to you please talk to one of the researchers and we will provide you with information on local mental health and employee assistance resources.

Potential Benefits

Taking part may not benefit you directly. It is hoped that what is learned will be of future benefit to others. The knowledge gained may provide important information that can benefit nurses that provide care to postpartum women and ultimately may benefit postpartum women and their families.

Can I withdraw from the study?

You may withdraw from the study up to two months after the participant observation shift by notifying the principal investigator. If you decide to withdraw from the study in the middle of a participant observation shift where I am paired with you I will leave the area at that time. Withdrawal from the study will not impact on your employment in any way.

Costs and reimbursements.

There will be no costs to you for participating. The participant observation shifts will occur during your regular work time and you will be provided with a five dollar Tim Horton's gift certificate, as a token of appreciation.

How will my privacy be protected?

Any information that is learned about you will be kept private. Any notes that I take during or after a participant observation shift will not contain your identity. The notes and demographics sheets will be labeled with codes and will not contain your identity. The coding key will be kept separate from the data. Any electronic files will be kept on a laptop that is password protected. The study records will be kept in a locked area at Dalhousie University for 5 years following publication of the results. Only study staff will have access to these records. After that time all records will be destroyed. The study results may be published or presented but any identifying information about you will be removed.

Your decision to participate or not and any information that you share with the researcher will not be shared with your employer or colleagues. The information that you share will be used for the purpose of the study to better understand nurses' knowledge and attitudes related to postpartum depression. It will not be used to judge your practice in any way.

Each participant observation shift will occur in your normal work setting and therefore it is possible that other people including other nurses will be present. When I am present I will discuss the research with all nurses who are present. No information will be recorded unless that nurse has given their consent to participate and signed this informed consent form. I will explain to all nurses present that the information shared is for the purposes of the study and is confidential. Participants will be asked not to share the information that they have heard during participant observation shifts. I cannot guarantee that the information you share will be kept confidential by others that may be present at the time.

There is the potential that research files will be requested as part of a research ethics board routine audit. If this were to occur information requested by the IWK Research Audit Committee will be provided.

What if I have study questions or problems?

For questions about the study please contact:

Principal Investigator

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What are my Research Rights?

Your signature on this form shows that you have understood the above information and have had all of your questions answered prior to deciding to participate. Your signature on this form indicates that you have agreed to take part in this research and that the information that you share can be used for that purpose. In no way does this waive your legal rights nor release the investigator(s), sponsors, or involved institution(s) from their legal and professional responsibilities. If you have any questions at any time during or after the study about research in general you may contact the Research Office of the IWK Health Centre at (902) 470-8520, Monday to Friday between 8:00a.m and 4:00p.m”.

How will I be informed of study results?

The results of this study will be available to you one year after the completion of the study. If you would like to receive either a full copy or a summary of the study results please check the appropriate box and provide your name and address on page six of this document.

Signature Page

Study title: Knowledge and Attitudes Regarding Postpartum Depression of Hospital Postpartum and Public Health Nurses: An Exploratory Study.

Participant ID: _____
Participant INITIALS: _____

Participant Consent

I have read or had read to me this information and consent form and have had the chance to ask questions which have been answered to my satisfaction before signing my name. I understand the nature of the study and I understand the potential risks. I understand that I have the right to withdraw from the study at any time without affecting my employment in any way. I have received a copy of the Information and Consent Form for future reference. I freely agree to participate in this research study.

Name of Participant: (Print) _____
Participant Signature: _____
Date: _____ Time: _____

CONSENT FOR USE OF DIRECT QUOTES

I give permission for the use of direct quotes from the focus groups to be used for the purpose of data analysis, discussion, and publication as long I will not be identified in any way. Yes _____ No _____

STATEMENT BY PERSON PROVIDING INFORMATION ON STUDY

I have explained the nature and demands of the research study and judge that the participant named above understands the nature and demands of the study.

Full name: (Print) _____
Signature: _____ Position: _____
Date: _____ Time: _____

STATEMENT BY PERSON OBTAINING CONSENT

I have explained the nature of the consent process to the participant and judge that they understand that participation is voluntary and that they may withdraw at any time from participating

Full name: (Print) _____
Signature: _____ Position: _____
Date: _____ Time: _____

Request for Study Results

The following information will be used to provide you results of this study at your request.

Please indicate if you would prefer a hard copy of the results or a copy via your email address.

I would like to receive a copy of full copy of the results of the study?

Yes ___ No ___

I would like to receive a summary of the study results?

Yes ___ No ___

Full Name (print): _____

Mailing address: _____

Email address _____

Appendix G

Demographic Form

Code: _____

Demographic Form

Age _____

Gender Female _____ Male _____

Highest Level of Education

Diploma in Nursing _____

Degree in Nursing _____

Masters in Nursing _____

Doctorate in Nursing _____

University degree other than nursing (please specify)

Years of experience in nursing _____

Number of years in current position _____

Have you provided care to postpartum women in a position other than the one you currently hold?

Yes _____

No _____

If yes, please state type and length of prior experience

Where does the majority of your understanding of postpartum depression come from?

Nursing education _____

Ongoing professional education _____

Experiences with patients? _____

Personal experiences _____

Other (please specify) _____

Appendix H

Pattern Findings and Nurses Quotes

Patterns	Nurses quotes
<p>Pattern one</p> <p>“Nurses understand PPD in different ways” (Knowledge)</p>	<p>“I think of postpartum depression in a couple of different ways. One is clinical, you know, definition, diagnoses of postpartum depression. But in practice I think of it as that group of women who aren’t coping so well. Those group of women that for whatever reason, whether it maybe a chemical imbalance or hormonal changes or whatever, whatever is happening with them, that they are just not coping as well with becoming a parent” (PHFG #1 pg 3)</p> <p>“I look at it as an impairment in mood and thinking and behavior in that first year. I always think of it in terms of that first year after birth” (PHFG #2 pg 7)</p> <p>“I agree with that and I think there’s a really fine line. I don’t -- and I think that changes for different people. Because there’s a different group of symptoms for each person and for one person it maybe debilitating, but with another person they can kind of move through it in a different way, whether that’s support that they have in place or whether it’s just knowledge, or inner strength that they can pull through, but not everybody can.....it just presents -- everybody presents differently with it. So to have that in the box definition I -- like I don’t see that” (PHFG #1 pg 7)</p>
<p>Sub pattern</p> <p>There is a normal period of adjustment for everyone</p>	<p>“I think I see it more as a -- I think everybody has an adjustment period, like a parental adjustment -- or postpartum adjustment. And I look at postpartum depression as -- that it’s almost the opposite, like the clinical piece in the diagnoses of it” (PHFG #1 pg 3)</p> <p>“we actually had people with postpartum depression that were so sick they were having psychotic episodes. And so it can get that severe that it’s not just a difficulty in coping; it’s like loosing touch with reality, having delusions and</p>

	<p>hallucinations and you know, and so it can progress from -- and these are people with the diagnoses of postpartum depression” (FGPH #1 pg 10)</p> <p>“I always reassure them and say ‘I worry more about the ones who do not cry a little bit’” (FNUFG #2 pg 5).</p> <p>“By day three you have a lot of changes and you’re going to feel sad and cry for no reason. I can guarantee you” (FNUF #2 pg 5).</p> <p>“[i]t’s okay if you go home tonight and you burst into tears and you’re overwhelmed and you can’t handle things and it seems like everything is going crazy. That’s normal” (FNUFG #1, pg. 8).</p>
<p>Pattern two</p> <p>“Nurses know that women need support” (knowledge)</p>	<p>“there seems to always be a lack of support component to moms that get into crisis with the postpartum depressions” (PHFG #1 pg 46)</p> <p>“I find that women that are struggling, even though they are right in the urban centre, they’re so isolated” (PHFG#1 pg 32).</p> <p>“that’s one of the other things that we would do is always assess the supports and if they feel like their supports are meeting their needs” (PHFG#2 pg 47).</p> <p>“And I think that us fostering those relationships can prevent something like postpartum depression or lighten the severity, right? By increasing those community supports (PHFG #2 pg 47).</p> <p>“We have that -- yeah, we have community knowledge to help finding the right resources at the right times” (PHFG#2 pg 55).</p>
<p>Pattern three</p> <p>“Nurses believe teaching about PPD makes a difference” (attitude)</p>	<p>“And I’ve had women come to me in the supermarket, places like that and said, “I’m so glad you told me about that because I was one of those women right that actually had postpartum depression. And I would not have known what was happening to me if you had not said that””</p>

	<p>(FNUFG #2 pg 4).</p> <p>“Well in Public Health say our role isn’t so much as identifying, but in educating so that they can self-identify” (PHFG #1 pg 26).</p> <p>Because we often talk to them before they have symptoms, and so making sure that they have the information to identify it themselves” (PHFG #1 pg 26)</p>
<p>Pattern four</p> <p>“Women benefit from a relationship with their health care provider” (attitude)</p>	<p>“Now you’re getting a multitude of caregivers and it’s never the same one. You’re lucky if it is right through the whole pregnancy and postpartum period, you’re very lucky. If you had the same person that’s caring for you, so that they can recognize very easily. But with all of the different ones there’s no way that you’ll ever know if this person is -- is this abnormal for her, is this normal for her. It’s hard to figure that out” (FNUFG #2 pg 11)</p> <p>“if you had that specific patient first shift or two or three in a row your conversation with them is going to be more meaningful than the nurse that comes in -- for only one more day”(FNUFG #1 pg 23).</p> <p>“And so for instance this morning, I have a mom that has called the line ten times since July. So -- and it’s all around feeding questions. So I, on the end of the conversation said, ‘You know what if you would really like to have a consistent person calling you and answering your questions, just call me back.’ Because I don’t think we’re meeting her needs and she hasn’t talked to anybody more than once...And so...because she keeps presenting with questions about the baby’s feeding, but is it really? And that’s my question. Is it really the feeding or is there something else going on? And I think it’s important for us to have that continuity of, "Let’s dig a little bit deeper" (PHFG #2 pg 25).</p> <p>“how can you build patient trust if you’re not in their room. Or you’re going in to address your own agenda and walking back out. You can’t build the trust. You can’t establish that relationship and that trusting relationship if you don’t spend time with them” (FNUFG #2 pg 26)</p>

<p>Pattern five</p> <p>“The role of the nurse is to listen” (role)</p>	<p>“Women want a lot of reassurance. They want to be heard and listened to.... most people just want to be heard. They want you to validate them whether you agree with them or not” (PHPO #1 pg 2-3).</p> <p>“Well, I think that I’d have to say that for us being able to go into the home is really, really crucial, for us to be able to reach them at their comfort zone, because they’re more comfortable. So I don’t know about you guys, but how many times have you crawled up on a bed and sat with the woman and she’s talking about something and you’re there, right in her personal space. And she’s being able to share that because she’s comfortable in that environment, you know, and you’re having a great discussion about how’s she’s feeling” (PHFG #2 pg 21)</p> <p>“I think like debriefing the birth experience in those taking in phases. Address stages whenever they first come up. Making sure like they let go like if it was -- something happened that they didn’t want to have one, but they end up with a C-section when they had the big long birth plan from the chart. Making sure they debrief that like let go of it and then they can move on to enjoy you know what they have now. So that they are not stuck on that piece and they can’t continue to go through the stages” (FNUFG #1 pg 10)</p> <p>“I think we do a lot of listening and letting the patients debrief. I’d agree completely” (FNUFG #1 pg 11)</p> <p>“The woman that I visited with that, you know, acute episode connected to the Edinburgh score of 24 told me what she needed. She had history of depression in the past. And she told me, “I don’t need to go to the hospital. I don’t want to go to an emergency department. I want to talk to...” Well she was saying she wanted to talk to a woman because she had better success with them feeling heard and understood by woman. And she wanted to try to work it out in the community not in the hospital. She wanted to talk about how bad she was feeling, but she thought if she talked to somebody without having to go to the emergency department that would be a lot more effective and relevant for her.” (PHFG #1 pg 12)</p>

<p>Sub pattern</p> <p>You need to ask the questions</p>	<p>“I had one experience in the last year where I was supporting a mom who was in the process of losing her own mom, and I think my role with her was just to listen to her. And I -- you know, I touched base with her a little more frequently than I would have with any other mom. And then when the time came where she really was needing support beyond what I could offer -- because my limits are really just to listen -- my role then switched to linking her with help... and then to continue being there just to listen to her where we had developed a relationship” (PHFG#2 pg 25)</p> <p>She just said, “You know, I don’t think I’m feeling all that well about how things are going” and jumped on it because at that point she had enough gumption after months and months to disclose. But she didn’t -- if she would’ve had to say I think I’m having postpartum depression she never would have said that. So it was picking up on those subtle cues that they were -- she was given to her physician, a different mom again, but you have to be prepared to ask the question and do something about it. And it may not be, "I’m having depression," or "I’m thinking of harming myself," or you know, or the baby. It’s not that obvious a lot of the times (PHFG #1 pg 18)</p> <p>I just recently had a client who is kind of having a few symptoms. But her -- she said, “You’re the only person I actually...” Like part of our postnatal guarantee we talk about postpartum adjustment and your emotions that you’re feeling. And she said, “When I -- every time I go into my doctor, my doctor said, 'So you’re feeling okay?'" That’s it. She doesn’t explore it at all. So she said it doesn’t enable her to say, “Actually you know what, no I’m not.” She always just says, “Yeah, fine," you know?” (PHFG #1 pg 8)</p>
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Appendix I

Demographics Information

Table 2: Demographics Table

Question	Response Range	Hospital (Total = 17)	Public Health (Total =14)
Data Type	Participant Observation	9	5
	Focus Group	12	13
	Both	4	4
	Total	17	14
1. Age	21-30	8	0
	31-40	1	5
	41-50	5	3
	51-60	3	4
	Not Reported	0	2
2. Gender	M	0	0
	F	17	14
3. Highest Level of Education (multiple Responses permitted)	Diploma in Nursing	4	0
	Degree in Nursing	12	12
	Masters in Nursing	0	2
	Doctorate in Nursing	0	0
	Other Degree	4	4
4. Years of Experience in Nursing	5 or less	10	1
	6-15	2	4
	16-25	2	3
	>25	3	8
	Not Reported	0	1
5. Number of years in current position	5 or less	13	4
	6-15	3	8
	16-25	1	2
6. Have you provided care to postpartum women in a position other than the one you currently hold?	Yes	5	10
	No	12	4

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