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**EXPERIENCES OF POSTPARTUM PSYCHOSIS
FROM THE PERSPECTIVES OF WOMEN WITH
THE DIAGNOSIS AND PSYCHIATRIC NURSES**

BY

INGER ENGQVIST

**A DISSERTATION SUBMITTED IN PARTIAL
FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY**

IN

NURSING

UNIVERSITY OF RHODE ISLAND

2011

DOCTOR OF PHILOSOPHY DISSERTATION

OF

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2011

ABSTRACT

Postpartum psychosis occurs in approximately two out of every 1000 women after childbirth. Although rare, it is a very serious illness with a potential for suicide and infanticide. The suffering associated with this illness and the effects on the entire family system are severe. Nurses need a comprehensive understanding of this disorder, how women present and experience the illness and the nursing care required to keep women and their newborns safe. They also need to promote early detection to facilitate prompt treatment. To date, there is little research examining the women's experiences and the nursing care provided to this population.

Two descriptive qualitative studies were completed. One study analyzed internet narratives of ten women with the diagnosis of postpartum psychosis and the other study analyzed ten interviews with psychiatric nurses working on inpatient psychiatric units in Sweden. These two studies and subsequent secondary analyses addressed four research questions.

How do women diagnosed with postpartum psychosis describe their experience?

What are psychiatric nurses' descriptions of women with postpartum psychosis and what are their responses to these women when caring for them on an inpatient psychiatric unit?

What nursing care strategies are used by nurses in caring for women with postpartum psychosis?

How do psychiatric nurses describe the use of presence when caring for women with PPP?

The women described overwhelming fear, a detachment and inability to care for their babies, delusions and hallucinations, shame and guilt, sleep deprivation, a sense of being controlled, disorganized, confused and paranoia during hospitalization. A number also felt abandoned and discontented with the nursing staff and the nursing care they received. The nurses described a kaleidoscope of symptoms and a range of positive and negative emotional responses they had towards the women. Nursing strategies included satisfying basic needs, keeping the women and babies safe and secure, connecting the women with reality, creating a partnership, teaching the women and their family members, giving hope and facilitating recovery. The nurses described their use of physical presence in great detail and the learning that took place in the context of caring for this population.

Future research studies need to examine the on-going interaction of patients and nurses on inpatient psychiatric units. Nurses and nursing students need education about disease manifestations, women's experiences, nursing care strategies and ways to address nurses' own emotional reactions.

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Professor Björn Sjöström initiated this joint PhD program in 2004. He was my main professor until he became seriously ill in 2006. We were all affected by his death in August 2008. Without his encouragement I would not have started this dissertation at all.

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JOINT PhD PROGRAM IN NURSING

– University of Skövde and University of Rhode Island

This joint PhD program in nursing was developed by Professor Björn Sjöström at the School of Life Sciences, University of Skövde and Professor Emerita Suzie Hesook Kim at the College of Nursing, University of Rhode Island.

Its purpose was to prepare nurse scholars and researchers capable of advancing nursing knowledge through the development and testing of nursing theory and the conduct of research in clinical practice. The program cultivated a sense of inquiry and stimulated international collaborative relationships with professional colleagues, both in nursing and other disciplines.

INGER ENGQVIST

was a student in this

JOINT PhD PROGRAM

between 2004 and 2011

Preface

The Manuscript Format has been used for this dissertation.

List of Original Papers

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Strategies in caring for women with postpartum psychosis--an interview study with psychiatric nurses. *Journal of Clinical Nursing*, 16(7), 1333-1342.

IV Engqvist, I., Ferszt, G. & Nilsson, K. (2010). Swedish registered

psychiatric nurses' descriptions of presence when caring for women with postpartum psychosis – an interview study. *International Journal of Mental Health Nursing*, 19(5), 313-321.

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Chapter One

Introduction

The experience of childbirth is an important event in the lives of women. In addition to the excitement that usually accompanies pregnancy, women may also experience a number of fears concerning pregnancy and childbirth, such as pain, their well being and that of their baby, losing control, caesarean section, and even survival during pregnancy (Bondas & Erikson, 2001; Stern, Bruscheiler-Stern & Freeland, 1999).

According to Areskog, Kjessler and Uddenberg (1981), it is estimated that 6% of all pregnant women have a strong fear of childbirth. This finding has been confirmed by Sjögren (1997), Melender, (2002) and Saisto & Halmesmälis (2003). Previous experience in earlier pregnancies, negative stories told by other people about pregnancy and childbirth, and life circumstances can also influence a woman's expectations (Melender, 2002; Nylander, 2005). The transition to motherhood immediately following childbirth requires adapting to a number of physiological and psychological changes. Even for women who have a normal transition to their new role with additional responsibilities, this time is typically characterized by both positive and negative feelings (Harwood, McLean & Durkin, 2007; Nylander, 2005; Saisto & Halmesmälis, 2003). While many new mothers experience contentment and satisfaction, for a minority, the picture is complicated by a postpartum psychiatric disorder; the most severe being

postpartum psychosis (PPP) (Ayers & Pickering, 2005; Lagan, Knights, Barton & Boyce, 2009; Morrissey, 2007; Nylander, 2005).

Between 1970 and 1998 I worked as a nurse midwife and cared for many women during their deliveries. When working in forensic nursing, I met people with mental health problems, of which I understood very little. I wanted to know more about these problems, so I embarked on a one-year program to study mental health in 2000.

In my first psychiatric nursing clinical placement, I met a woman on a general psychiatric unit who had delivered only a few days earlier. Given my midwifery background, I was very interested in her condition. This woman was transferred to the psychiatric unit two days after her delivery in an acute psychotic state, manifested by auditory hallucinations and delusions. She was very confused and thought she was still pregnant. When her husband brought the baby to her, she refused to see and touch the baby, saying that it belonged to someone else. It was apparent to me that this woman was very depressed and absorbed in her own world. She had an absent stare, did not answer when she was spoken to, and talked only to herself. She was very restless, had unrelenting insomnia and wandered around the ward carrying a small teddy bear. Since this patient was at risk for suicide, repeatedly stating that she wanted to die, she was placed under constant observation. Her clinical presentation was consistent with descriptions found in the literature of women with PPP (Beck & Driscoll, 2006; Brockington, 1996, 2004a; Chandra, Bhargavaraman, Raghunandan & Shaligram, 2006; Spinelli, 2009).

During the five weeks I was providing care for this woman, I did not see any positive changes in her condition. I was deeply touched by how much this woman was suffering. After this initial experience, I met and provided psychiatric nursing care for a few other women diagnosed with this illness. As I tried to develop therapeutic relationships with them, at times I was greatly affected by their deep level of distress. When I decided to pursue my doctoral studies, I knew that my focus would be related to learning more about women's experiences of PPP and how nurses provide nursing care for this population. Although it had been three years since I first cared for a woman with PPP, my memories were still fresh and many questions still remained.

How do women with PPP experience their illness? What are psychiatric nurses' descriptions of and responses to women with PPP? What nursing care strategies are used by nurses when caring for women with PPP?

Initial Research Effort

In the beginning, I was interested in conducting in-depth interviews with women who had experienced PPP. I sought and received approval from the Ethics Board of the University of Gothenburg and was given permission to access the diagnostic register of the Skaraborg Hospital in order to search for women who had been diagnosed with PPP within the last ten years.

According to prevalence statistics found in the literature (Kendell, Chalmers & Platz, 1987; Terp & Mortensen, 1998; Valdimarsdottir, Hultman, Harlow,

Cnattingius & Spare, 2009), approximately 30-40 women should have been diagnosed with this disorder in the region of Skaraborg, Sweden.

Surprisingly, only nine women were listed in the register. After searching through the case records with one of the psychiatrists at the hospital, five of these women were identified as potential participants for interviews. The other four women were considered to be too ill to participate and were therefore not contacted.

A letter was sent to the five women requesting an interview, but none of them replied. Subsequently, I placed an advertisement in four daily newspapers, which reached about 1 million people. Although a few women diagnosed with postpartum depression replied, there were no responses from women who had experienced PPP.

The following semester I went to the United States, where I was enrolled in doctoral studies at the University of Rhode Island, College of Nursing. My advisor, a certified psychiatric clinical nurse specialist, contacted several psychiatric clinical nurse specialists with the hope of finding women with PPP who might be willing to be interviewed. These clinicians reported that this was not a population they served, nor did they think these women would give consent because it would be much too difficult for them to share their experiences.

Subsequently, my advisor contacted the only psychiatric hospital in the state of Rhode Island in an effort to locate potential participants. She was informed that it would be very difficult to identify women who had been diagnosed with PPP given the changes in the Diagnostic and Statistical

Manual of Mental Disorders (DSM, 1994) nomenclature. The diagnosis of PPP was considered an entity of its own in earlier versions of International Classification of Disorders, ICD 9 (ICD, 1974) and the DSM IV (APA, 1994). However, since the early 1990s with the new edition of ICD 10 (ICD, 1992) and the DSM III (APA, 1980) and IV postpartum onset has been used as a specifier, which can be applied to a current or most recent Major Depressive, Manic or Mixed Episode of Major Depression Disorder, Bipolar I or Bipolar II Disorder, or a Brief Psychotic Disorder. The onset for the diagnosis of PPP must be within 4 weeks after their baby is delivered.

This could be the reason why it had been so difficult to access this population in Sweden. I also questioned if psychiatrists were hesitant to use this diagnosis because of the stigma associated with PPP. Many people do not want to be known as an individual with a psychiatric disorder (Edwards & Timmons, 2005; Littlewood, Jadhav & Ryder, 2007; Nylander, 2005). Being labeled as 'mentally ill' can carry a number of consequences (Doucet, Dennis, Letourneau & Robertson Blackmore, 2009). If the diagnosis becomes public, individuals can also lose their social status and are at great risk of encountering prejudice and discrimination (Edwards & Timmons, 2005). Furthermore, the shame and guilt those women with PPP experience may be another impetus for keeping silent and protecting themselves from the judgments of others by not revealing their diagnosis (Doucet et.al, 2009).

When interviews with this population did not seem feasible, I decided to search for women's narratives on the Internet. The Internet has been identified as a rich source of data that can be used to gain insight and

understanding of individual's experiences (Cotton, 2003; Liu & Tien, 2009; Miles, 2009; Stone, 2007; Sullivan, 2008). A number of search engines were used to locate potential websites and one in particular was found to have rich narratives written by women who had experienced PPP (npr.com, app-network.org).

Given the acute nature of this illness, its fluctuating course and the danger of suicide and infanticide, nurses need to be able to carefully assess their patients, recognize changes in the patients' status, and be alert for subtle cues that may lead to suicide and/or infanticide (Currid, 2004a; Doucet et al., 2009). Since women with PPP often experience shame and guilt, nursing care that is compassionate can foster an environment where these patients feel safe, supported, and understood. In order to accomplish this, nurses need a detailed and comprehensive understanding of the depth and breadth of this experience (Doucet et al., 2009; Lagan et al., 2009; Salzmann-Erikson, Lützn, Ivarsson & Eriksson, 2008).

There are only a few studies in nursing concerning women with PPP, and this dissertation contributes to this knowledge base. Since nurses play a key role in caring for women with PPP it is essential that they have a good understanding of what these women experience. This knowledge will improve the individualized and holistic (which means seeing the whole person as body, mind, and spirit) care that nurses provide for these women, their babies and their families.

Given the gaps in the literature, the following research questions were raised:

- How do women diagnosed with postpartum psychosis describe their experience?
- What are psychiatric nurses' descriptions of women with postpartum psychosis and what are their responses to these women when caring for them on an inpatient psychiatric unit?
- What nursing care strategies are used by nurses in caring for women with postpartum psychosis?
- How do psychiatric nurses describe the use of presence when caring for women with PPP?

The following ten chapters begin with background information related to the diagnosis of PPP and conclude with framing the problem. Chapter three discusses Kim's theoretical framework, which provided the frame for the dissertation. Three of Kim's domains; client, client-nurse, and practice are discussed. Chapter four briefly lists the specific aims and chapter five discusses the methodology. Chapters six through nine include four papers (manuscripts). Each of these chapters begins with a brief overview of one of the four papers followed by the entire paper that has already been published. Chapter ten provides an in-depth summary and discussion of the findings of the four papers including their relationship to Kim's theoretical framework. A comparison of PPP described in the medical and nursing literature, interviews with psychiatric nurses, Internet narratives and general information on the Internet begins chapter eleven. This chapter concludes

with the limitations, strengths, and implications for research, knowledge development, clinical practice, and education.

Chapter Two

Background

In the following sections the epidemiology, prevalence, etiology, diagnosis, medical treatment, prognosis, and consequences of the illness are reviewed. The background chapter ends with a discussion of nursing care for women with Postpartum Psychosis (PPP).

Epidemiology and Prevalence

After childbirth women have an increased risk of being stricken with a psychiatric illness, and PPP is the most serious. This disorder is one among several psychiatric disorders women can experience during the transition to parenthood (Heron, Haque, Oyebode, Craddock & Jones, 2009). For newly delivered women, the risk of developing PPP is 1–2 cases in every 1000 (Allwood, Berk & Bodemer, 2000; Anis-ur-Rehman, St Clair & Platz, 1990; Kendell et al., 1987; Paffenbarger, Steinmetz, Pooler & Hyde, 1961; Terp & Mortensen, 1998; Valdimarsdottir et al., 2009) and is consistent across cultures (Brockington, Margison, Schofield & Knight, 1988; Kumar, 1994). The illness is usually severe enough to require inpatient psychiatric care (Brockington, 2004a; Lanczik, Bergant & Klier, 2006; Murray, Cooper & Hipwell, 2003; Valdimarsdottir et al., 2009). A family history of psychopathology has been found to be related to a higher incidence of PPP, as high as 57% (Harlow et al., 2007; Jones & Cantwell, 2010; Jones & Craddock, 2001; Jones & Venis, 2001; Nager, Sundqvist, Ramirez-León & Johansson, 2008). Once afflicted with this illness, the risk of a repeated

incidence following childbirth may be as high as 50% (Cantwell & Cox, 2006; Valdimarsdottir et al., 2009).

There is a considerable peak in the incidence of a psychotic illness immediately after childbirth, and 50% of cases are women without any previous psychiatric hospitalization (Heron, McGuinness, Blackmore, Craddock & Jones, 2008; Valdimarsdottir et al., 2009). The illness occurs frequently after the first delivery, increasing maternal age, after a long and difficult delivery, cesarean section and a pregnancy that is short for date or involves a low birth weight baby (Jones & Craddock, 2005; England, Richardson, & Brockington, 1998; Nager, Johansson & Sundqvist, 2005; Nager et al., 2008; Valdimarsdottir et al., 2009).

Etiology

Although the specific cause of PPP has not yet been clearly determined, evidence does suggest that the sudden drop in estrogen levels occurring immediately after the birth of a baby combined with the sleep disturbances that usually occurs during pregnancy and postpartum play a significantly role (Sharma, 2003; Sharma & Mazmanian, 2003; Sharma, Smith & Khan, , 2004; Sit, Rothschild & Wisner, 2006). Additional factors such as primiparity, a difficult labor, sleep loss and genetic predisposition have also been identified as possible contributory factors (Sharma & Mazmanian, 2003).

Diagnosis

A rapid change from normality to a fully developed psychosis is characteristic of this illness (Ebeid, Nassif & Sinha, 2010; Schopf & Rust, 1994; Sit et al., 2006). PPP occurs very abruptly (Halbreich, 2005; Heron et al., 2008), often with no other warning signs than one or two sleepless nights (Brockington, Macdonald & Wainscott, 2006; Chandra, Venkatasubraminian & Thomas, 2002; Seyfried & Marcus, 2003; Sharma, 2003; Sharma et al., 2004; Sit et al., 2006). Already stated on page 1, according to Valdimarsdottir et al. (2009) one third of the cases occur within the first seven days postpartum. In order to be diagnosed with PPP the onset of the illness should occur within four weeks after delivery (APA, 2000). However, 22% of women diagnosed with PPP present with symptoms during the first postpartum days (Heron, Robertson Blackmore, McGuinness, Craddock, & Jones, 2007; Okano et al., 1998).

Typically PPP starts with insomnia for a couple of nights followed by the usual symptoms of psychosis, such as delusions, grandiosity or worthlessness, hallucinations, confusion, and over-activity or motor retardation. Other common symptoms include megalomania concerning the identity of the child (God, Jesus or the Devil), delusions about the child being a changeling, paranoia, verbal and/or visual hallucinations, thought insertion, thought broadcasting, mania and even catatonia (Brockington, 2004b; Brockington, 2006; Chandra et al., 2002; Currid, 2004a; Seyfried & Marcus, 2003; Sharma et al., 2004; Sit et al., 2006; Spinelli, 2009).

Suicidal and infanticidal ideation are common (Austin, Kildea, & Sullivan, 2007; Babu, Subbakrishna & Chandra, 2008; Cantwell & Cox, 2006; Drife, 2001; Friedman, Horwitz & Resnick, 2005; Putkonen, Weizman-Henelius, Collander, Santtila & Eronen, 2007; Spinelli, 2009). The risk of suicide is 4% and of infanticide 5% for those women stricken with PPP (Comtois, Schiff & Grossman, 2008; Knops, 1993; Koenen & Thomsen, 2008; Oates, 2003; Pfuhlmann, Stöber & Beckmann, 2002; Spinelli, 2001, 2004). The suicide risk for women with postpartum psychiatric disorders is 70 times higher than the age-specific mortality rate (Appleby, Mortensen and Faragher, 1998). In comparison with all postpartum deaths, regardless of the cause, suicides of women with PPP account for as high as 20% of the mortality rate (Lindahl, Pearson & Colpe, 2005). In developed countries, the risk of postpartum death is estimated to be one in 2800 and in developing countries it is 175 times higher (Filippi et.al, 2006).

Medical Treatment

Early detection and, prompt treatment, of this illness are crucial (Sit et al., 2006). In light of the increased risk for infanticide and suicide, inpatient hospitalization during the acute phase of the illness is usually required (Friedman, Resnick & Rosenthal, 2009; Spinelli, 2001, 2004, 2009). One of the primary care objectives is to have as little disturbance as possible in the initial mother–child bonding period (Jones & Venis, 2001; Menon, 2008). This can be quite challenging when the mother is severely psychotic.

When a woman with PPP refuses hospitalization, involuntary treatment is often necessary because of the acuity of the illness. Involuntary commitment of psychiatric patients is accepted worldwide as a needed measure to treat severely ill psychotic patients who are opposed to treatment. The Law of Compulsory Psychiatric Care Act in Sweden (1991:1128 / 2008:415) provides for compulsory treatment. A patient who is detained under this Act may be restrained for a short time with a belt or similar device, and/or isolated from other patients (1991:1128 / 2008:415).

Initial treatment consists of antipsychotics, anxiolytics, and/or electroconvulsive therapy (ECT), depending on the clinical presentation (Boritz Wintz, 1999; Doucet, Jones, Letourneau, Dennis & Robertson Blackmore, 2010; Ebeid et al., 2010; Forray & Ostroff, 2007; Menon, 2008; Reed, Sermin, Appleby & Faragher, 1999; Sharma, 2008), and the severity of the psychosis (Jones & Craddock, 2001; Jones & Venis, 2001; Spinelli, 2009; Yonkers et al., 2004). Once the woman is stable, an outpatient treatment plan is developed and outpatient treatment can last for a number of months or years (Hagberg, Marsal & Westgren, 2008). Involvement of the patient and family in the discharge plan is essential (The Health and Medical Services Act, 1982:363).

Until a few years ago a Swedish woman presenting with PPP would still have been admitted to the postnatal unit and only transferred to a psychiatric unit after being assessed by the psychiatrist (Darj & Stålnacke, 2000; Hagberg et al., 2008; Nielsen Dana & Wambach, 2003). However in recent

years, the length of newly delivered woman's stay in the postnatal units has decreased (The National Board of Welfare, 2009).

Prognosis

Even though it is a disabling illness, the prognosis for PPP in most cases is favorable; most patients recover within a few weeks, and certainly within a year, and regain good social functioning (Cantwell & Cox, 2006). However, approximately 10% will never fully recover (Pfuhlmann, Franzek, Beckmann & Stöber, 1999; Pfuhlmann et al., 2002). The risk of relapse in a subsequent birth is about 50%, especially if the woman has a history of a psychiatric illness (Munk-Olsen et al., 2009; Pfuhlmann et al., 1999; Videbech & Gouliaev, 1995).

Nager (2009) conducted a register study where all Swedish women with the diagnosis of PPP from 1975-2004 were included, and found that the risk of a non-puerperal psychiatric readmission for the afflicted women remained high for several years for all the included women in the study.

In a study conducted by Engqvist, Åhlin, Ferszt & Nilsson (2010), a multidisciplinary specialist team (including psychiatrists, psychologists, nurses, and social workers) working in collaboration when treating women with PPP was important in helping these patients regain and preserve their health and well being. This is especially important in outpatient care; follow up treatment of the woman and her family and the creation of a supportive network is essential in preventing a relapse (Brockington, 2004a; 2004b; Chaudron, 2006; Currid, 2004b; Ebeid et al., 2010). The importance of

adequate social support for childrearing women cannot be overstated. Patients and their significant others must often be encouraged to elicit assistance from other family members and close friends following the patient's discharge to reduce family burden (Sit et al., 2006).

Consequences of Postpartum Psychosis

To prevent serious far-reaching consequences for the mother and child, careful clinical risk assessments of women with a history of a psychiatric disorder is crucial (Green et al., 2008; Nager et al., 2008). A postpartum psychiatric illness must be looked at as a potentially severe disease with possible long-term effects on the woman's health and her social functioning, as well as possible adverse long-term effects on the infant and the whole family (Bågedahl-Stridlund & Ruppert, 1998; Brockington, 2004b; Currid, 2004a; Hornstein et al., 2006; Moehler, Brunner, Wiebel, Reck & Resch, 2006; Philipp, Fivaz-Depeursinge, Corboz-Warnery & Favez, 2009). Accordingly, there is considerable evidence that postpartum illness can adversely affect the psychological and intellectual development of the newborn as well as other children in the family. Bågedahl-Stridlund (1987) conducted a study of children with mothers admitted due to postpartum psychiatric disorders, and discovered a higher occurrence of behavioral and developmental disturbances in these children at six years of age. Interestingly, in this longitudinal study, a follow-up study (Ruppert & Bågedahl-Stridlund, 2001) around ten years later than the former one, no differences in mental or physical health or in school achievement in the same

children of these mentally ill mothers, was found in comparison with controls.

Furthermore, Wilson and colleagues (Wilson et al., 1996) found that the whole family is affected. The relationship with the partner as well as with the older children often becomes strained (Grube, 2005; Lovestone & Kumar, 1993; Whitmore, Heron & Wainscott, 2010; Wilson et al., 1996). The severity of the illness and the onset close to the child's birth may have severe consequences for the child because of the high risk of injuring the child or of infanticide. This might happen due to the woman's practical incompetency or as a result of her delusions with command hallucinations (Putkonen et al., 2007; Spinelli, 2009).

Nursing Care

Nursing practice encompasses the nurse's ability to address the patient's health problems and to assist patients as they struggle to live with their illness within the context of their specific situation (Kim, 2000a; Lagan et al., 2009). In caring for women during the acute phase of their illness when they are hospitalized on an inpatient psychiatric unit, the priority is to keep the mother and baby safe.

In a study conducted by Semprevivo (1996), women described intense feelings of anxiety, panic and uncontrollable fear for their own safety due to suicidal ideation. Also Robertson and Lyons, (2003) describe how the women who suffered from PPP experienced a lack of normal feelings during their illness, which persisted long after recovery. These authors as well

described the illness as a life-changing experience and they used words such as “old sense of self” as a marker for recovery. Edwards and Timmons (2005) assert that the stigma of this illness could lead to isolation and withdrawal and a feeling of being labeled.

According to Kim (2000a) a careful assessment is the basis for the strategies used by nurses when providing care to their patients. When caring for women with PPP this assessment includes an awareness of the woman’s health status, her level of functioning and what she is capable of doing during the day.

When caring for patients, consideration of the environment is also considered the nurses’ responsibility (Kim, 2000a). In facilitating the patient’s recovery from PPP, it is important for the nurses to be calm and supportive and to assure that the surrounding environment is not over stimulating (Godkin, 2001; Posmontier, 2010; Ugarriza, 1992). Marmion (2000) states, that the nurse can give the woman and her partner information about the illness to reduce blame, guilt, and isolation that typically accompany the knowledge of having this illness. This preventive nursing activity may not be possible in the acute phase of the illness, but can begin when the woman is in the recovery phase. However the nurse can provide information to the partner from the beginning.

Although it is optimum to support mother-infant bonding by caring for the child and mother together, the degree of the woman’s psychosis may be a barrier (Currid, 2004b; Moehler et al., 2006; Whitmore et al., 2010). According to Whitmore et al. (2010), co-joined care encourages the

development of the maternal bond, facilitates mothering skills and promotes confidence in adjusting to the role of a mother. This view is also supported by Currid (2004b). Gaskell (1999) claims that patients who are cared for together with their child recover faster than if they are cared for alone. Noorlander, Bergink & van den Berg (2008) compared the mother-infant-bonding of mothers with PPP and mothers with postpartum depression. It was found that it was more important to keep the mother and her baby together for women with postpartum depression than for the ones with psychosis, because mothers with postpartum depression had more and stronger negative thoughts about their babies than had women with PPP. Friedman et al. (2009) state it is more important to consider the safety of the child in a mother with PPP, especially if the mother has psychotic thoughts about her child. Here Gaskell points to the necessity for the nurse to consider the security risk for the newborn, which requires continuous assessment to identify subtle cues of thoughts of hurting the child (Gaskell, 1999). Given these different viewpoints, at least one assumption can be made concerning nurses caring competence. If the nurse provides care for the mother and child together, she must have advanced knowledge and experience caring for women with PPP.

When the mother and baby are able to be cared for together, the nurse can be a role model for the woman and teach her how to care for her baby (Gaskell, 1999). Supporting the woman's partner and including her/him in the care of the child is also important (Engqvist, Åhlin, Ferszt & Nilsson, 2011; Kendall-Tackett 1993; Marmion, 2000).

Since women with PPP frequently have experienced significant sleep deprivation (Sharma & Mazmanian, 2003) the nursing staff must ensure that these women have a good night's sleep which may require that they take care of the child at night. The problems with sleeping disturbances are raised by several researchers (Sharma, 2003; Sharma & Mazmanian, 2003; Sharma et.al, 2004; Sit, et.al, 2006). Sit et al. (2006) discuss that sleep loss is a major cause of mania in women with PPP. Therefore, to be able to care for these women it is essential that the nursing staff is aware of the importance of sleep loss related to this illness (Currid, 2004a; Posmontier, 2010). Sharma, Smith and Mazmanian (2006) recommend other measures to promote post-delivery sleep, including stimulus reduction by restricting the number of visitors in the hospital.

Developing a therapeutic relationship with psychiatric patients is essential (Peplau, 1952; 1988; 1997) and must also be deemed to be necessary for the woman with PPP. A therapeutic relationship can contribute to the women feeling safe (Langley & Klooper, 2005), supported (Coastworth-Puspoky, Forchuk & Ward-Griffin, 2006) and understood by their caregivers (Johansson & Eklund, 2003). When providing care to this population, the nurses need to be understanding, patient, caring, and have a holistic view of the patient, which means seeing the whole person with body, mind, and spirit (Comitz , Comitz & Semprevivo, 1990; Kim & Kollak, 1999; Posmontier, 2010). The nurse can demonstrate her interest and supportive attitude for the woman by giving her the space to speak freely and openly about her concerns and anxiety (Comitz et al., 1990; Lagan et al.,

2009; Ugarriza, 1992). Since it can be very difficult for these women to speak about their illness and the feelings that surface about their hospitalization, nurses can maintain a calm, friendly and supportive attitude when interacting with their patients (Comitz et al., 1990; Holma & Aaltonen, 1998; Lagan et al., 2009; Ugarriza, 1992). The nurses' attitudes may reduce the negative psychological impact of some birth experiences (Gaskell, 1999; Nystedt, Högberg & Lundman, 2005). The nurse needs to realize that childbirth is not just a momentary occurrence but a major life event for the woman (Comitz et al., 1990). Therefore in providing holistic care, the nurse needs to acquire as much knowledge about the illness as possible in order to understand what the woman tells her and thereby increase her ability to provide good care (Dyson, 1999; Kim & Kollak, 1999). At the same time, nurses need to maintain good boundaries and recognize the difference between a therapeutic relationship and a friendship (Forchuk, Westwell, Martin, Azzopardi, Kosterewa & Hux, 1998a).

Nursing presence is vital to nursing and is intimately tied to receptivity of the other person's experience. In this dissertation, nursing presence is understood as an interpersonal process characterized by sensitivity, holism, intimacy, vulnerability and uniqueness (Fingeld-Connett, 2008a). Presence is important in psychiatric care when the nurse sits beside the woman with PPP, listening wholeheartedly to her life story. By her presence, the nurse reduces the patient's anxiety and provides comfort; this is defined as "being there" (Osterman & Schwarz-Barcott, 1996). Here the nurse integrates presence as a physical, mental, emotional, and spiritual act that can create

order out of chaos. Helping the woman to become balanced through the practice of presence is an example of fostering a safe and secure haven, and helping patients to distance themselves from destructive wishes to harm themselves, their children or others (Semprevivo, 1996).

The main goal of nursing, from the individual perspective, is health (Kim, 2000a). The nurse has a unique and central role in facilitating the patients' recovery, as well as in health promotion (Arvidsson & Skärsäter, 2006). These authors also argue that the emphasis in clinical psychiatric nursing is still on alleviating and reducing mental illness, not on actively enhancing the patient's mental health. Furthermore, psychiatric nurses need to acquire a different perspective – turning from a pathological point of view to an increased focus on health (Arvidsson & Skärsäter, 2006; Berg, Hedelin & Sarvimäki, 2005).

Framing the Problem

Women who experience PPP have been described as fragile and vulnerable women, who are suffering deeply (Handsley & Stocks, 2009; Semprevivo, 1996). Given the risk of suicide, infanticide and the stigmatization associated with being stricken with PPP, studies examining the experiences of women diagnosed with this illness and nursing care of these women are highly warranted. The women's illness affects not only their own lives but also the lives of their children and their partners. Since the illness is rather rare, nurses in different positions in the healthcare organization might be less aware of it. Furthermore, the fact that the

diagnosis of PPP is now used as a specifier and applied to a number of different psychiatric disorders, may contribute to making this serious illness invisible. Given the severity of the illness, there is a need to raise awareness about these women, their children and families, so that the illness can be detected and treated as early as possible and facilitate a prompt recovery.

Several studies have been conducted about the illness from the perspective of biomedicine, describing signs, symptoms, prevalence, and treatment of this disorder. However, there is a gap in the literature that speaks to the women's experiences. Only a few studies have been found where women describe their experiences of being stricken with PPP (Edwards & Timmons, 2005; Robertson & Lyon, 2003; Semprevivo, 1996). This is also true for studies related to nurses specifically caring for this group of women.

In the few studies found on women's experiences associated with the illness, the women have consistently indicated that they feel neglected and they believe that health professionals generally have little knowledge about the disease (Robertson & Lyon, 2003). Since hospital stay during childbirth has been shortened, it is essential that nurses working in different healthcare sectors have knowledge of this disorder. In the context of mental health nursing, nurses must be compassionate and foster an environment where these patients feel safe, supported, and understood. In order to accomplish this, nurses require an understanding of the depth and breadth of this experience, a detailed and comprehensive knowledge of PPP, and the ability

to provide nursing care indicated for these women based on their individual presentation and individualized needs.

Chapter Three

The Conceptual Framework

The focus of this dissertation is women with postpartum psychosis (PPP) and the nurses caring for these women on inpatient psychiatric units. Kim's (2000a) theoretical framework was used to categorize and develop a better understanding of the phenomena related to the experiences of women diagnosed with PPP and phenomena related to nursing practice with this population. Kim's (2000a) framework includes a typology of four conceptual domains which organizes phenomena and concepts that are important in nursing, *client, client-nurse, practice and environment*. Although the word patient is used in the Swedish context where most of the data for this dissertation is collected, the client will be used in this chapter as this is the term Kim uses.

The client domain is concerned with phenomena that are only related to the individual and can help nurses better understand the client's experiences, which can lead to effective and client centered nursing care. The client-nurse-domain includes phenomena that are related to the direct contact that the nurse has with the client which can impact the care provided to the client. Phenomena in the practice domain are related to what nurses do or what is considered nursing work. In order to improve the way nurses practice, nurses are required to understand how they arrive at the nursing strategies they select with individual clients. Finally, the domain of the environment includes phenomena related to the external world that surrounds the client

and the context in which the nurse interacts with the client and provides nursing care. Knowledge of the environment imparts a better understanding of the client's problems, as it explains the client's physical existence (Kim, 2000a).

Since the focus of this dissertation is women who experience being stricken with PPP and nurses who care for these women, the *client domain*, *client-nurse domain*, and the *practice domain*, will be described in more detail.

The Client Domain

In order to provide comprehensive, holistic, and client centered care for women with PPP, the nurse needs to have a good understanding of the client's experiences with this serious disorder (Comitz et al., 1990; Doucet et al., 2009; Kim, 2000a; Kim & Kollak, 1999). In this dissertation, phenomena in the client domain include the woman's experiences of PPP and the nurse's descriptions of women with PPP whom they cared for on inpatient psychiatric units.

Kim (2000a) divides the key concepts in the client domain into three categories. *Essentialistic concepts* refer to phenomena that are essential characteristics of human nature and are important in increasing the nurses' understanding of the human person. Concepts such as self image, hope, and maturation could apply to women with PPP and would be included in this category (Mowbray, Oyserman, Zemencuk, Ross, 1995).

The second category, *problematic concepts*, includes phenomena that are a deviation from health and need some kind of nursing intervention.

Problematic concepts related to women with PPP include anxiety, stress, sleep loss, suffering, delusions, and self-destructive behavior (Brockington et al., 2006; Chandra et al., 2002; Seyfried & Marcus, 2003).

The third category in Kim's (2000a) description of the client domain is healthcare *experiential concepts*. This category includes phenomena that arise from clients' previous experiences of care, such as hospitalization, and their capacity for compliance as well as recidivism and isolation. Related to women with PPP, this category could include the women's previous experiences with healthcare and healthcare staff, as well as relapse of the illness. The women might have had earlier experiences of mental health inpatient or outpatient treatment (Jones & Venis, 2001; Nager et al., 2008).

In this dissertation, it is the problematic concepts that are of most interest as it can be expected to be the women's focus when they express their experiences of being stricken by PPP. However, they might also talk about experiences related to other concepts.

According to Kim (2000b), clients and nurses incorporate the ontological realities of the features and lives of human beings, and of human care which include human living. Human living consists of three dimensions: *living with oneself*, *living with others* and *living in situations*. Human *living with oneself* refers to the human body and to the person. A woman with PPP often has a major change in her personality due to her psychosis (Harlow et al., 2007; Jones & Cantwell, 2010; Jones & Craddock,

2001). Furthermore, she may have an alteration in how she perceives her body, which might lead to self-destructive behaviours (Brockington, 2006; Chandra et al., 2002; Currid, 2004a; Seyfried & Marcus, 2003; Sit et al., 2006; Spinelli, 2009). Living and socializing with other people, communicating, and interacting with family, friends and other clients are described as *human living with others* (Kim, 2000b). When women are hospitalized with the illness of PPP, their ability to socialize, communicate and interact with others is disturbed (Bågedahl-Stridlund & Ruppert, 1998; Moehler et al., 2006; Philipp et al., 2009). This can be very difficult for the woman's family and friends as well as for the woman when she begins to recognize the severity of her illness (Bågedahl-Stridlund & Ruppert, 1998; Moehler et al., 2006; Philipp et al., 2009; Robertson & Lyons, 2003). *Living in situations* refers to living that takes place where the client lives; it may vary from ordinary life situations such as family, work, and community settings to more specialized situations such as hospitals or prisons (Kim, 2000b). For the woman with PPP, this can mean that she is in the inpatient setting, or even in coercive care due to her psychosis and self-destructive behavior. Women with PPP are typically treated in an inpatient hospital for a short period of 3–4 days (Brockington, 2004a; Hagberg et al., 2008; Lanczik et al., 2006; Murray et al., 2003; Valdimarsdottir et al, 2009).

Phenomena in the client domain include the woman's suffering from PPP, her perception of her situation, her behavior, and her responses to the illness (Kim, 2000a; Mowbray et al., 1995). The woman is dependent on the care given by the nurse and is affected by how the nurse is engaged in the

care that she/he provides (Comitz et al., 1990; Holma & Aaltonen, 1998). In the context of caring for women with PPP, this could be interpreted as the woman is dependent on the nurse's care. If the nurse has difficulty understanding the woman's experience and is focused on her own internal uncomfortable feelings rather than the client's illness, a disturbance in the therapeutic relationship might occur. In order to provide optimum nursing care, an understanding of the client's suffering is therefore imperative (Comitz et al., 1990; Ugarriza, 1992). In order to provide holistic care, nurses who are engaged in "body work", i.e. involved in caring for and treating parts of the body or the body as a whole, must also be concerned with responding to the client's emotional, existential, and spiritual needs (Kim, 2000b; Kim & Kollak, 1999).

One way to see the client holistically is to individualize the care provided (Kim & Kollak, 1999; Koslander, Barbosa da Silva & Roxberg, 2009; Suhonen, Gustafsson, Katajisto, Välimäki & Leino-Kilpi, 2010). In this study, this means that nurses need to understand the different ways in which women with PPP present (Doucet et al., 2009). Nurses need to also strive to see each woman as an individual, unique human being (Kim, 2000a), and treat her with compassion and understanding (Doucet et al., 2009). Each woman has a different life story as do all individuals (Kim, 2000a). The meaning of the experience of PPP may vary and influence how each woman responds to the illness (Semprevivo, 1996). It is essential that the nurse recognizes that she/he is encountering the woman at a vulnerable time in her life. Remembering this, the nurse will be able to develop a good

understanding of this specific client, in order to identify her needs and provide the most effective care (Glavin, Smith, Sörum & Ellefsen, 2010; Koslander et al., 2009; Suhonen et al., 2010).

The Client – Nurse Domain

This domain is related to specific types of encounters between the client and the nurse (Kim, 2000a). In this dissertation the psychiatric nurse, who encounters the woman with PPP in the context where providing nursing care, is the focus. Kim (2000a) suggests these encounters consist of various types of processes such as physical contact, communication, emotional connection and the exchange of information which are associated with the philosophy of therapy.

In various situations, the nurse and client talk with each other, assume different roles, share feelings and get to know each other. The nurse has the opportunity to provide support to the client and the client has the opportunity to receive attention and care from the nurse (Lagan et al., 2009). Through client nurse contacts, nursing actions are implemented including providing information, expressing emotions, and exchanging energy. In this dissertation, the client nurse domain includes encounters between the nurse and the woman with PPP. These encounters include physical and emotional contact. As the nurse provides care to these women, it is important to know their life stories, their suffering and their needs (Doucet et al., 2009; Gaskell, 1999; Semprevivo, 1996).

Key concepts in the client-nurse domain are categorized as: *contact, communication and interaction* (Kim, 2000a). Contact concepts include providing comfort, therapeutic touch, distancing, interpersonal presence, as well as interpersonal energy transfer. It is important to note that nurse-client encounters are the medium through which the nurse provides nursing care. The encounters relate to the physical as well as the emotional meeting between the nurse and the client and the exchange of information which serves as the basis for good health care from the perspective of the client and the nurse.

Communication concepts include communicative conflicts, communicative styles, and therapeutic communication. In her work, Kim (2000a) stresses the importance of appropriate communication. For clients to gain comprehensive health care information, the nurse needs to be clinically competent, which requires continuing professional development. Much of the nurse's work includes communicating with others, educating the client, her husband and relatives about the disease, the progress and the potential outcomes after the woman is discharged from the hospital (Höye & Severinson, 2010; Jarrett & Payne, 2000; Nilsson, Lundgren & Furåker, 2009). These nursing responsibilities are emphasized in the Swedish national description of nurses' competences (The Swedish National Board of competence description of a nurse, 2005-105-12005).

Interaction concepts include mutuality, empathetic relationships, transactions and the therapeutic alliance. Peplau (1952; 1988; 1997) emphasizes that nurses as well as clients can grow from their interaction with

each other. This knowledge is significant for nursing care from a client perspective as well as from a nursing perspective (Schout, de Jong & Zeelen, 2010). The nurse's behavior might influence how she/he communicates and could affect the client's state of health and wellbeing (Cleary, Edwards & Meehan, 1999). The nurse's conscious awareness of her/his own behavior can also affect nursing care (Eriksson & Nilsson, 2007). For the client to achieve a better understanding of his/her treatment there must be an interaction between the client and the nurse (Kim, 2000a). According to Kim (2000a), respect, understanding and empathy form the bases of the therapeutic relationship.

The Practice Domain

The practice domain (Kim, 2000a) contains phenomena and concepts that are related to what nurses do or perform in the "name of nursing." Nursing practice includes cognitive, behavioral, social and ethical aspects of professional actions and activities performed by the nurse and/or experiences by the nurse in relation to nursing care. This domain refers to how the nurses make decisions about their nursing actions to meet the individualized needs of their clients. In the context of this dissertation, the focus is on how nurses provide care to women suffering from PPP (Robertson & Lyons, 2003; Semprevivo, 1996).

According to Kim (2000a), nursing practice involves: "a) knowledge of how to arrive at good outcomes of nursing; b) knowledge of what is good for the client; and c) performance of prescribed nursing actions in reality" (Kim,

2000a; p. 130). An interpretation of Kim's description is that nurses caring for women suffering from PPP need to have knowledge of the signs and symptoms of PPP in order to provide care for each woman as a unique individual. The nurse's assessment of the woman's health status and decision-making capacity is extremely important when caring for women with PPP, as there is an impending danger of suicide and infanticide (Comtois et al., 2008; Currid, 2004a; Doucet et al., 2009; Koenen & Thomsen, 2008; Knops, 1993; Oates, 2003; Pfuhlmann et al., 2002; Spinelli, 2001). Nurses also provide medical treatment in accordance with the psychiatrists' prescriptions (The Swedish National Board of competence description of a nurse, 2005-105-12005), consult with the clients' families, physicians and other members of the health care team and collaborate with agencies that will provide community based and follow up care (Brockington, 2004a; 2004b; Chaudron, 2006; Currid, 2004b; Ebeid et al., 2010; Engqvist et al., 2010).

Nurses coordinate their care based on two philosophies of practice: the philosophy of therapy and the philosophy of care (Kim, 2000a). The philosophy of therapy focuses on the client's problems, while the philosophy of care focuses on giving care to the client as a person. Care provided to women with PPP who present with suicidality and aggressive behavior (Brockington, 2004b), can be classified under the philosophy of therapy as the care focuses is on the client's problems (Kim, 1994). Nursing care that takes into account the woman as an individual with her own unique history,

experiences and personhood (Glavin et al., 2010; Harlow et al., 2007) would be categorized under the philosophy of care (Kim, 1994).

Kim (2000a) further describes nursing practice as having two dimensions, *deliberation* and *enactment*. Deliberation occurs when the nurse focuses on the assessment she/he has made, as well as judgments about the assessment. To be able to carefully assess their clients, nurses need the ability to recognize changes in the clients' status and be alert to subtle cues that may lead to suicide and infanticide (Currid, 2004a; Doucet et al., 2009). This requires that nurses have a good understanding of the process of the disease, good assessment skills, flexibility, compassion, and the capacity to develop trusting therapeutic relationships with clients in very difficult clinical situations (Comitz et al., 1990; Kim, Ellefsen, Han & Alves, 2008).

The enactment dimension refers to the actual performance of activities that involves the client (Kim, 2000a; Kim, et.al, 2008). Enactment means that when people act, they bring structures and events into existence and set them in action. Enactment also means acting, behaving and responding. Once the nurse has thought and reflected on what actions to perform, she/he puts them into practice. As mentioned earlier, Kim (2000a) and Kim et al. (2008) assert that a nurse should care for the whole person, which includes the physical, emotional, existential and spiritual needs of the client. As the nurse assesses the client (which is an ongoing process) she/he makes judgments about the nature of the information that is available and considers specific types of nursing strategies to respond to the client's problems that

have been identified. The nurse then selects strategies that would best meet the needs of this specific client at that point in time (Kim et al, 2008).

When a client with PPP is admitted to a psychiatric unit, the nurse consistently observes and assesses the woman (Cleary et al., 1999). The assessment process (Kim, 2000a) implies that the nurse collects and processes information from the woman (client), considers possible actions, and sets goals for a specific situation. This process may be conscious or unconscious. Intentionally observing the clients' responses and behaviors are components of an initial assessment. Carefully observing the client's emotional responses, behaviors, and interactions are other aspects of a nursing assessment (Kim et al., 2008; Pillitteri, 2009). In psychiatric mental health nursing, a mental status assessment also includes the client's general appearance, mood and affect, quality of speech, perceptual and sensory disturbances, thought content and processes, memory, insight and judgment (Hagberg et al., 2008; Pillitteri, 2009). In the early phase of the illness, the nurse's strategies are based on how to protect the woman from self-destructive behavior (Cantwell & Cox, 2006; Spinelli, 2009). This may require that the nurse remains physically close to the woman as probation (forced care) could be necessary (Olofsson & Norberg, 2001). According to Kim (2000a), the nurse focuses on the client's holistic needs, including quality of support systems, present and past coping skills, spiritual and cultural needs.

Kim (2000a) and Kim et al. (2008), state that the nurse draws on both public and private knowledge. Public knowledge refers to knowledge

developed in the discipline of nursing and is initially acquired in nursing education. Private knowledge includes knowledge of oneself that can be enhanced from clinical experiences and reflections on one's practice. For example, psychiatric nurses with years of clinical experience may have experienced based knowledge (Roca, 2007) that they use constantly.

Johansson (1989) makes a similar distinction between public and private knowledge. According to this author, the traditions in health care with its roots in women's work will support the health care workers' individual knowledge. This knowledge is in contrast to scientific knowledge which often, is not critically analyzed. But if private knowledge is critically reviewed and analyzed, it can contribute to scientific knowledge (Johansson, 1989).

Kim (2000a) states that the gap between theory and nursing practice occurs when there is a lack of correspondence between what is available in public knowledge and what nurses use in their practice or private knowledge. As mentioned earlier, there are few studies in nursing concerning women with PPP from the perspectives of clients and nurses (Edwards & Timmons, 2005; Gaskell, 1999; Robertson & Lyons, 2003; Semprevivo, 1996). This dissertation hopes to contribute to public knowledge in an effort to fill the existing knowledge gap related to different views of PPP and therefore improve nursing practice with this population.

Chapter Four

Aims

The overall aim of this research was to develop a better understanding of the experience of postpartum psychosis from both the women's perspective and the perspective of psychiatric nurses caring for these women during their inpatient psychiatric hospitalization.

The specific aims of this dissertation were:

- To gain a deeper understanding of the experience of women who were diagnosed with postpartum psychosis (Paper I).
- To explore psychiatric nurses' descriptions of women with postpartum psychosis; and to explore nurses' responses to these women when providing care to women with postpartum psychosis. (Paper II).
- To explore strategies used by nurses in caring for women with postpartum psychosis by nurse inquiries from three hospitals in the Southwest of Sweden (Paper III).
- To explore RPNs descriptions of presence when caring for women with postpartum psychosis (Paper IV).

Chapter Five

Methodology

Design

This chapter begins with a description of the research methodology used with the four papers (manuscripts) presented in this dissertation, i.e. the qualitative design, the use of interviews and written narratives, and methods of analysis. This is followed by a description of the implementation phase, i.e. the sampling, data collection, and finally the analysis of the narratives and the interviews.

The empirical studies in this dissertation all have a qualitative design. In contrast to quantitative research designs, where the focus is mainly on the generalization of data, qualitative designs are used when the researcher seeks a deeper understanding and meaning of the phenomenon being explored (Morse & Field, 1995; Polit & Beck, 2008). According to Larsson (1986) qualitative designs, are employed when the researcher searches for descriptions, categories, or models that best describe phenomena or context. Other authors assert that qualitative designs are used when the researcher has the intention to understand the characteristics of a phenomenon or meanings that are attributed to a phenomenon (Kvale & Brinkmann, 2009; Sandelowski, 2000; Seale, 2004).

Qualitative design, often used in social sciences, is a generic term for different approaches. What is common to them all is that the researcher is positioned in social reality and is thus part of the reality that is being studied.

Data collection and analysis occur interactively and often simultaneously; the researcher seeks to capture both people's actions as well as the meanings of these actions (Morse & Field, 1995; Polit & Beck, 2008; Streubert & Carpenter, 1999).

The qualitative design is based on the premise that we can share each other's inner worlds through language (Morse & Field, 1995; Patel & Davidsson, 2003). The researcher's values and experiences help her/him get close to the people she/he would like to receive information from. The researcher's inside perspective is essential in order to interpret the information that is being collected.

In this dissertation, an explorative qualitative design was chosen to study the experiences of PPP because it provides an avenue for describing and interpreting the life-world of the participants involved. In order to describe and interpret how women and nurses experience the illness of postpartum psychosis – taking into consideration their experiences, points of view, relationships and values – a holistic approach was required. A qualitative design can address many facets in relation to possible interpretations. In this dissertation, the qualitative design provided opportunities to study women's and nurses' experiences expressed in their own words. The use of a qualitative design considered the participants' statements within a context, thus providing an understanding of what they say about something, and how and why they say it (Crabtree & Miller, 1992; Miller & Crabtree, 1994; Polit & Beck, 2004; Silverman, 2001).

The study design was based on the research questions, the literature review and the theoretical conclusions. It has been argued that interview studies and studies of written accounts provide the greatest chance of understanding the implications of the questions (Seidman, 1998).

Interviews as a Method of Data Collection

Interviews are suitable when the research questions deal with knowledge about the experiences of the participants, as well as studies concerning how these experiences are influenced by factors in the life-world (Kvale & Brinkmann, 2009). An interview presupposes that there is an interaction between the researcher and the interviewee; therefore there is an element of dialectic between the methods and the researcher making the interpretations (Kvale & Brinkmann, 2009; Seidman, 1998). In this interaction the researcher takes an active interpretative role to create pictures of conditions, experiences, situations, relations and how they might be understood (Polit & Beck, 2004; Silverman, 2001; Streubert & Carpenter, 1999). It is the researcher's duty to organize and create a new entirety of the participants' experiences of the phenomenon in focus (Morse & Field, 1995); in this dissertation the focus is the phenomenon of PPP.

The goal of a qualitative research interview is to obtain comprehensive and multifaceted descriptions of various qualitative aspects (Kvale & Brinkmann, 2009; Rubin & Rubin, 1995). Qualitative interviews emphasize the meaning and the importance of questions and answers, and they are contextually based and mutually constructed (Mishler, 1984, 1986; Seidman,

1998). According to Mishler (1986), an interview is a discourse between speakers which is performed in such a way that the meaning of questions and responses are contextually grounded and jointly constructed by the interviewer and the respondent.

The advantage of the qualitative interview is that it is open and flexible, which in turn allows the researcher to follow up interesting perspectives that arise and ask supplementary questions (Polit & Beck, 2008; Rubin & Rubin, 1995). However, this requires the researcher to be well prepared and familiar with the subject (Kvale & Brinkmann, 2009). In qualitative research, interviews are usually unstructured or semi structured (Kvale & Brinkmann, 2009; Polit & Beck, 2008; Rubin & Rubin, 1995). Unstructured interviews are used when the researcher does not have a clear idea of what it is they do not know. Therefore the researcher does not begin with a set of prepared questions; rather participants are encouraged to tell their stories with very little interruption (Kvale & Brinkmann, 2009; Polit & Beck, 2008). Semi-structured interviews are used when researchers know what they want to ask. This type of interview allows the researcher to obtain all the information required, and also allows participants to respond in their own words, use as much detail as they desire, and provide examples or explanations (Kvale & Brinkmann, 2009; Polit & Beck, 2008).

In order to obtain rich detailed information, the interviews required an interview situation with an environment where the informants can talk freely about their experiences (Silverman, 1993; 2001; Streubert & Carpenter, 1999). The kind of information gained from the interviews depends on how

the interaction develops between the participant and the interviewer (the researcher). The interviewer and the interviewee are always actively engaged in the construction of meaning and content of the interview (Mishler, 1984, 1986; Seidman, 1998). Accordingly, it is the reciprocal action between both individuals that contributes to the content of the data.

Written Narratives as a Method of Data Collection

A narrative is a distinct entity in the frame of a conversation or other linguistic production. For Paper I of this dissertation, written narratives published on the Internet were collected. Narratives describe an episode occurring in a specific context, which is caused by something, experienced and told by someone (the narrator), and might possibly address existential qualitative experiences such as despair, hope, grief, and pain. The narrative typically follows a pattern consisting of preamble and a final summary. In between, there is a description of events that occur in a particular context, and are caused by something or perceived by someone. The narrative points to something that should be explained and is always told by someone (Agar, 1985; Hydén, 2008; Hydén & Hydén, 1997).

Computer technology has greatly enhanced the ability to communicate or even interact with others around the world. Any place where text is available on the Internet provides opportunities for researchers to conduct qualitative studies (Cotton, 2003; Gaiser & Schreiner, 2009). Research on the Web has been mainly quantitative but there is increasing interest in using the Web for qualitative studies with sensitive topics and vulnerable groups

(Cotton, 2003). According to Polit and Beck (2004) as well as Handy and Ross (2005), the Internet is a source of rich data including written narratives. Internet narratives tend to be more detailed in contrast to verbal narratives, and the secure feeling of being anonymous allows the person to reveal her/his inner thoughts and encourages a rich flow of text relating to different events (Robinson, 2001). Narratives are, for example, used in nursing research to understand the nursing work environment (McGillis Hall & Kiesners, 2005), to understand contact persons' work with women with breast cancer (Carlsson, Nilbert & Nilsson, 2005), patients' experiences of ECT treatment (Vamos, 2008), and suffering from cancer (Midtgaard, Stelter, Rörth & Adamsen, 2007). These previous applications support using narratives as a data source.

Methods of Analysis

The following two sections provide an overview of the methods of analysis. The implementation of these methods will be described in a later section dealing with the implementation phase.

Cross-case analysis.

Cross-case analysis was used to analyze the Internet narratives (Paper I). This is a method of analyzing and comparing the different cases, where the procedure identifies similarities, differences and what is unique in the different cases (Miles & Huberman, 1994). First of all, the research questions need to be formulated and from them it is possible to compare the cases. The researcher examines raw data using different interpretations in

order to find connections between research topics and results, with reference to the original research questions. Throughout the evaluation and analytic process, the researcher is open to new possibilities and insights (Yin, 1984). Cross-case analyses emphasize detailed contextual analysis of a limited number of events, conditions or cases and their relationships (Miles & Huberman, 1994).

Content analysis.

Content analysis was used to analyze the data for Papers I-IV. This method developed from the analysis of communication and media studies in the social sciences, is defined as a systematic, dynamic form of analysis of verbal data (Graneheim & Lundman, 2004; Kondracki, 2002; Krippendorff, 1980, 2004). Krippendorff (2004) further defines content analysis as a research technique for making replicable and valid inferences from texts (or other meaningful matters) to the contexts of their use. He asserts that content analysis can be used for any kind of analysis where communication content (speech, written text, interviews, images etc) is categorized and classified. In this analytic approach, data is broken down into smaller units, coded and then grouped according to shared concepts (Polit & Beck, 2008).

Graneheim and Lundman (2004) described this method as initially being objective and systematic, describing the manifest content of communication in a quantitative manner. Manifest content, refers to what the text says, and is often presented in categories. They expanded the method to include the analysis of latent content as did Krippendorff (2004) in his later work. Analyzing latent content, i.e. what the text is talking about involves

interpretation, reading for meaning and taking the context into account.

They presume the text always has multiple meanings and that there always is some degree of interpretation. These authors also emphasize that content analysis is not a linear process, in the sense that the researcher goes back and forth between the whole and parts when analyzing the text.

Content analysis is an effective analytic approach that has come to be widely used in healthcare research in recent years. Although there are different approaches to qualitative content analysis, they all require a similar analytical process of steps which include formulating the research questions, selecting the samples that are to be analyzed, defining the categories to be applied, outlining the coding process, implementing the coding process, determining trustworthiness, and finally analyzing the results of the coding process (Hsieh and Shannon, 2005). This process differs depending on the specific approach used. According to Kondracki (2002), the use of content analysis might present several challenges, as there are so many options and no straightforward guidelines. Kondracki points to inferences to be drawn are limited by using content analysis and it is difficult to assess causality, but it might be possible to identify relationships between the analyzed data.

Content analysis is unique each time the method is used and requires customized approaches to fully explore the richness of the data. Morse and Field (1995) discuss content analysis as an approach that can be used to analyze interviews. They briefly describe this analytical approach as an analysis by topic, and each interview is first segmented by topics and then into categories. This is an active process and approaches will depend on

whether a latent or a manifest method is selected. Morse and Field's (1995) implied definition differs from that of Krippendorff (2004) in that they describe qualitative content analysis as an analysis by topic. This description has some similarities with grounded theory, as they write that the researcher could make descriptions of the categories and look for relationships between the categories. There are also similarities between Morse and Field's (1995) and Graneheim and Lundman's (2004) descriptions of the method, as the focus is on the subject and context, and emphasizes differences between and similarities within the codes and categories. The method deals with manifest as well as latent content in the text.

Content analysis can be used for different purposes when analyzing qualitative data (Graneheim & Lundman, 2004; Kondracki, 2002). It has been increasingly used in nursing research; for example in analyzing the construction of nursing leadership (Nilsson, 2003), night nursing (Nilsson, Campbell & Pilhammar, 2008), nursing student motivation (Nilsson & Warrén Stomberg, 2008), psychiatric nursing (Hellzen, Asplund, Gilje, Sandman & Norberg, 1998), caring for older persons (Kihlgren, Nilsson & Sørli, 2005) and the experience of violence (Lundström, Åström & Graneheim, 2007).

In this dissertation, different forms of content analysis were used to analyze the data (Graneheim & Lundman, 2004; Krippendorff, 2004; Miles & Huberman, 1994; Morse & Field, 1998). Since numerous references to presence emerged in the data analysis of Paper III, a secondary analysis was conducted for Paper IV. Qualitative secondary analysis can be used to

examine new questions in the original data (Polit & Beck, 2008; Thorne, 1994). Since the data analysis irrespective of which variation of content analysis is used, the analytic process starts with a familiarization phase. The transcribed interviews provide the text for analyzing and interpreting the interview content (Linell, 1994).

Implementation Phase

In Table 1, an overview of the different papers is presented, regarding design, data collection and analysis.

Table 1. Overall picture of the studies with regard to design and methods of analysis

Paper	Method	Data collection	Method of analysis
I	Qualitative	Life-stories taken from the Internet	Cross-case analysis, content analysis
II	Qualitative	Interviews	Secondary analysis Content analysis
III	Qualitative	Interviews	Content analysis
IV	Qualitative	Interviews	Secondary analysis Content analysis

Sampling

An overview of the samples in the different papers is given in Table 2. The participants in Paper I were the narrators of the Internet narratives. The psychiatric nurses who were interviewed was the sample for Papers II-IV.

Table 2. An overview of the participants

Paper	Participants		
	Women	Men	Total
I	10	-	10
II	8	1	9
III	9	1	10
IV	9	1	10

Paper I

As mentioned earlier, the plan for this dissertation was originally to interview women who had suffered from the illness of PPP about their experiences both during and after the illness. Since these women were hard to find, the decision was made to search the Internet for narratives written by women who had suffered from this illness. As it was impossible to interview women with PPP, the Internet was explored. To find these narratives the keywords used were: ‘postpartum psychosis’, ‘postnatal psychosis’, ‘narratives’, and ‘stories’; and the search engines used were Google, Alta-Vista and Yahoo. The same search engines were used to search on several websites where postpartum women described their experiences postpartum. Twenty-eight narratives were found and carefully read to determine which of them met the criteria for PPP (ICD, 1992; APA, 2002) and showed a depth of experiences of the illness; a total of ten narratives were considered to fulfill these conditions.

Papers II-IV

Data for Papers II-IV was collected from April to September 2003, at three hospitals in the south-west of Sweden. First the department heads (3) were contacted to obtain their approval for the study, and then all the head nurses (6) of the various psychiatric units were contacted. These head nurses informed the nurses on their wards about the studies to determine if there was an interest in participating in interviews. Inclusion criteria for participation were that the nurses were to have had specialist education in psychiatric nursing and at least five years of professional experience in this area. The criteria for participation were announced, and 13 out of approximately 75 nurses met the criteria and were interested. An introductory letter was sent to each of the interested nurses, and they were subsequently contacted by telephone one by one to decide on a time for an interview. One of these nurses declined, but the remaining 12 were all interviewed. The first interview was a pilot interview which gave little substance and was subsequently excluded. Another two of the nurses mostly had contact with, and cared for, patients with schizophrenia, and were excluded.

Accordingly, the study samples for Paper II-IV were strategically chosen to represent those with the specific experience of having met patients with PPP who were also working with PPP patients at the time of the interviews. They were all Registered Psychiatric Nurses with varying experience of caring for patients with PPP. The informants ranged in age from 35 to 60 years. Of the informants (9 females, 1 male), eight were very experienced (\geq

10 years of professional experience), and two were experienced (<10 years of experience). All together the nurses had provided care for approximately 30 women with postpartum psychosis, ranging from caring for one woman to ten. According to Benner, Tanner and Chesla (2009) nurses with ≥ 5 years of experience in a certain area are considered experts.

In Paper II the sample consisted of nine registered nurses (8 female and 1 male). The participants ranged in age from 39 to 60 years. One of the interviews was excluded as this nurse's experience mostly referred to her experience with one patient who had schizophrenia. Paper II was a secondary analysis of data in Paper III. In Paper III the sample consisted of ten nurses (9 females and 1 male), i.e. all participants. A secondary analysis of the data in Paper III was conducted for Paper IV.

Data Collection

Data collection will be presented below related to Paper I-IV.

Paper I

Three professionals, a psychiatric nurse from Sweden, a psychiatric clinical nurse specialist from the U.S. and a psychiatrist from Sweden, examined the individual narratives in order to ensure that they were as consistent as possible with the diagnosis of postpartum psychosis. This was done in accordance with the criteria for PPP (ICD, 1992; DSM III, APA, 1980 and DSM IV TR, APA, 2000). Only the narratives where all three professionals agreed on the diagnosis of postpartum psychosis were included. Ten narratives met the criteria for inclusion and became the study sample.

These narratives ranged in length from 306 words to 4140 words, and did not follow a standard format. The women's narratives of their experiences of being stricken by PPP might be seen as a broader narrative, including a series of narratives clarifying what happened during their illness.

Papers II-IV

The interviews took place in three different hospitals in the south-west of Sweden. The interviews were all collected in a quiet area of the nurses' workplace. Before their interview, the informants received information about the purpose of the study and were given the opportunity to decline. The audio-taped interviews lasted 45 to 75 minutes and were carried out with the support of a semi-structured interview guide, based on the research questions for each of the papers. The data were gathered by one of the authors (IE) through interactive and exploratory interviews to help the nurses recall and fully articulate their experiences and understanding of caring for patients with PPP. They were also asked to describe the symptoms of women with PPP they had identified in their clinical practice, as well as their responses to the women with these symptoms. During the interviews the atmosphere was open and friendly; the researcher was well acquainted with the environment and the interviewees and the interviewer were comfortable. However, it should be emphasized that in these interviews, the focus was on the content of the interviews, not on the interaction between the nurses and the researcher (Edwards, 1997). The interviews were conducted in Swedish and later translated into English.

Data Analysis

Data analysis will be presented for Papers I-IV.

Paper I

Each narrative was read several times to get a sense of the whole, and then individual descriptions of each case were formulated and written down. Cross-case analysis (Miles & Huberman, 1994) was used to identify similarities, differences and what was unique in each case. Keeping the purpose of the study in mind, data were examined by identifying relevant sentences, phrases or specific examples to reveal the experience of the illness. The next step in the coding phase was the organization of data into themes. The descriptions of the themes were examined until the women's experience of the illness was captured. Attempts were made to include sufficient quotations to support these descriptions. The final description derived from reflection on the data that led to intuitive insight, and a universality of meaning in the context of this experience.

Paper II

Content analysis according to Krippendorff (2004) was used to analyze the data with the intention of also quantifying quality. The analytical work began by listening to the interviews in order to be familiar with the data. The transcribed text was read several times to get a sense of the entire interview, and then data were examined line by line with the identification of the descriptions of women with PPP, as well as the nurses' responses to the women's illness. The next step was to organize the descriptions and

reactions of nurses into categories. Two major categories were identified in the last step. Quotations from the interviews were used to illustrate the content of the categories describing the nurses' descriptions and their responses to the women.

Examples of a meaning unit, condensation as well as coding are given in Table 3.

Table 3. Examples of meaning units, condensed meaning units, and codes

Meaning unit	Condensed meaning unit	Code
Security is important, “the mother will feel so bad if she hurts the baby”	Mother will feel bad if she hurts the baby	Importance of security
If I give my presence in the early encounter, then I can later on more easily build an alliance or relationship	Presence creates an alliance or relationship	Presence to establish relationships

Paper III

As before, the analytical work began by listening to the interviews, to become familiar with the data. In order to be familiar with the latent content, the transcribed texts were read and re-read (Graneheim & Lundman, 2004; Morse & Field, 1998). For this paper the purpose was to examine strategies

psychiatric nurses used when providing care to women with PPP on an inpatient psychiatric unit. Data were examined by identifying relevant sentences, phrases or specific examples. The next step in the coding phase was used to organize data into two emerging themes and counted. The descriptions of the themes were examined until they captured the nurses' experiences of caring for women with PPP. Quotations were then used to support these descriptions.

Paper IV

When reading and analyzing Paper III, it was found that the nurses often used the word presence when describing their interventions with the women. They described the importance of staying and sitting with their patients and giving them their time. It was therefore decided to conduct another secondary analysis, and analyze how nurses experienced being present with their patients. This analysis was based on the following question: "How do registered psychiatric nurses describe nursing presence when caring for women with PPP?" Manifest (i.e. what the text says) and latent (i.e. what the text is about) content analysis was used (Graneheim & Lundman, 2004). In the first step of the analytic process, the audiotapes were listened to a number of times to get an overview of the interview in its entirety in relation to the research question. In the second step, the transcribed interviews were read several times to identify what was said about presence. In the third step, meaning units (i.e. relevant words, phrases and sentences) were identified. The analysis then continued by condensing meaning units, making them shorter and easier to understand. The condensed text was abstracted and

labeled with a code. The codes were then compared for differences and similarities, and were divided into groups. Through this comparison process, three categories with additional subcategories were identified. The descriptions of the categories were examined until they captured the nurses' experiences of their nursing presence. Finally, sufficient data to support these descriptions were included.

Ethical Considerations

Study I (Paper I) was submitted to the University Institutional Board, University of Rhode Island, USA in 2007 who stated that the Internet is not within their purview. Even if this study was outside the Institutional Board's area of responsibility, the data from the Internet narratives have been treated with respect to the women, who were the authors.

Approval was obtained from the Ethics Committee of the University of Gothenburg (No. 0. 155-03) for Study II (Paper II-IV). Written informed consent was obtained from all the participants, in accordance with the Declaration of Helsinki. This means that they were informed about the aim of the study, method of data collection, voluntary participation, opportunity to withdraw at any time, and the fact that data would be treated confidentially (World Medical Association, 2002). All participants gave their consent.

The ethical considerations in this dissertation have followed the ethical principles of clinical research, respect for autonomy, beneficence, and respect for human dignity and justice (Beauchamp & Childress, 1994; Polit & Beck, 2008). The principle of respect for autonomy implies the right to

autonomy, participation and integrity, and also the power to independently decide whether to participate in the study. The principle of beneficence means freedom from harm and exploitation, and the benefit that will come from research. The researcher must carefully weigh the risks and benefits for the participants against the potential benefits to society. The principle of respect for human dignity implies the right to self-determination, full disclosure and respect. Informants have the freedom to control their own activities, including their voluntary participation. The principle of justice implies the right to fairness, and integrity must be maintained through the formal confidentiality procedures (Beauchamp & Childress, 1994; Polit & Beck, 2008).

Chapter Six

Women's Experience of Postpartum Psychotic Episodes – Analyses of Narratives from the Internet

Paper I

This research study was designed to increase our understanding of the experiences of women diagnosed with postpartum psychosis. As was stated in the introduction, the philosophy of care orientation is concerned with clients as human persons. In order to develop effective nursing strategies, clear conceptualizations of phenomena related to the health and well being of the individual person are essential (Kim, 2000a). Since little is known about the woman's experience of PPP, further investigation of postpartum psychosis, categorized as a problematic concept in the client domain, was warranted.

Although postpartum psychosis occurs in a small population of women, it is a very acute, grave illness (Brockington, 2004a; Levy, Sanders & Sabrow, 2002) and considered a psychiatric emergency (Hornstein et al., 2006; Howard, Goss, Leese, Appleby & Thornicroft, 2004), requiring inpatient hospitalization (Lanczik et al., 2006; Murray et al., 2003; Noorlander et al., 2008). Serious concerns associated with postpartum psychosis are infanticide (Chandra et.al, 2002; Friedman et.al, 2005;

Friedman et.al, 2009; Putkonen et.al, 2007; Spinelli, 2009) and suicide (Appleby et al., 1998; Comtois et al., 2008).

Given the acuity and potential life threatening outcomes of PPP, it is crucial for nurses to have a good understanding of how women experience this illness and how they typically present in the acute care setting. Assessment of psychosis, suicidal ideation and delusions associated with harming the newborn demands not only knowledge of the presenting signs and symptoms but also what the women might be experiencing internally but not demonstrating through their behavior and communication.

As was stated in the introduction, accessing this population to conduct in-depth interviews was unsuccessful. The Internet has been identified as a good source of data that can be used to analyze women's experiences (Ahern, 2005; Anderson & Klemm, 2008; Robinson 2001; Wesemann & Grunweld, 2008; Ziebland, Chapple, Dumelow, Evans, Prinijha and Rozmovits, 2004). A number of websites contained narratives of women who had experienced PPP. The narratives were collected in different ways; four of the narratives were published in nursing journals, and the remaining six were collected from an Internet website (ppdsupportpage, npr.com, app-network.org.). Many of the stories posted on these websites were gripping and resulted in a differentiated picture of the illness.

Since the Internet is in the public domain, the Institutional Review Board stated they did not need to approve the study nor was informed consent necessary.

Women's Experience of Postpartum Psychotic Episodes – Analyses of Narratives from the Internet

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ABSTRACT

The aim of this study was to gain insight into women's experiences of postpartum psychosis (PPP). Ten narratives taken from the Internet that met the definition of PPP according to the DSMIV were analyzed using cross case and content analysis. The result emphasized the women's experience of having unfulfilled dreams, being enveloped by darkness, having disabling symptoms and being abandoned. The women's experiences point to the importance of further education of nurses and doctors concerning PPP. It is vital not only for those working in psychiatric health care but also for midwives and nurses working in maternity wards and child welfare centers. This would facilitate early recognition of signs and symptoms of the disorder. That in turn would make early treatment possible, which will support the recovery. Furthermore deepened knowledge could contribute to providing more effective and compassionate care for these women.

INTRODUCTION

POSTPARTUM PSYCHOSIS (PPP) is the most serious type of mental disorder in connection with childbirth (Brockington, 2004; Brockington, Macdonald, & Wainscott, 2006). Of every 1000 newly delivered women, between 1 and 2 develop a PPP episode that is severe enough to require hospital psychiatric care (Brockington, 2004; Lanczik, Bergant, & Klier, 2006; Murray, Cooper, & Hipwell, 2003). In the past, PPP had its own classification, but in recent versions of the DSMIII and DSMIVTR, postpartum onset is used as a specifier and applied to a number of different disorders. These include Schizoaffective Disorder, Major Depressive, Manic, or Mixed Episode of Major Depressive Disorder, or Bipolar I Disorder with psychotic features, or Brief Psychotic Disorder and Psychotic Disorder Not Otherwise Specified (American Psychological Association, 2000). In this study we focus on this specific onset, using the women's own narratives about being stricken by PPP.

PPP occurs very abruptly and in most cases after 1-2 days postpartum. However, it can appear up to 4 weeks after delivery (Halbreich, 2005; Heron, McGuinness, Blackmore, Craddock, & Jones, 2008). The disorder occurs frequently after a first delivery, increasing maternal age, after a long and difficult delivery, caesarean section and a pregnancy short for date, or in connection with low birth weight (Jones & Craddock, 2007; Nager, Johansson, & Sundquist, 2005; Nager, Sundquist, Ramirez-Leon, & Johansson, 2008; Ndosu & Mtawali, 2002). According to Schopf and Rust (1994), early onset of the disorder more often has an affective trajectory, a

psychosis with signs of confusion and an abrupt onset. Women diagnosed with PPP typically present with insomnia for a couple of nights, delusions of guilt, grandiosity or worthlessness, hallucinations, confusion, over-activity or motor retardation and delusions about their child (Brockington, Macdonald, & Wainscott, 2006; Chandra, Venkatasubramanian, & Thomas, 2002; Seyfried & Marcus, 2003; Sharma, Smith, & Khan, 2004; Sit, Rothschild & Wisner, 2006). Suicidal and infanticidal thoughts are not uncommon (Friedman, Resnick, & Rosenthal, 2009; Friedman, Horwitz, & Resnick, 2005; Putkonen, Weizmann-Henelius, Collander, Santtila, & Eronen, 2007; Spinelli, 2009). Even though PPP is a disabling disorder, in most cases the prognosis is favorable and patients usually recover within some months (Cantwell & Cox, 2006).

Literature review

For women who have had PPP, the lack of normal emotions during their illness persists long after their recovery. These women often describe the disorder as a life-changing experience (Robertson & Lyons, 2003). Feelings of anxiety, panic, and uncontrollable fear for their own safety due to suicidal ideation have also been described as symptoms of PPP (Semprevivo, 1996). The stigma of this severe postnatal disorder (PPP) can also lead to isolation, withdrawal, and a feeling of being labeled (Edwards & Timmons, 2005). The feeling of being labeled derived from being seen as mentally ill.

Treatment must be adjusted to the type and severity of the psychosis (Freyne, Nguyen, Allen, & Rampono, 2009; Yonkers et al., 2004). The main care objective must be to have as little disturbance as possible in the initial

mother-child bonding period (Chaudron, 2000; Jones & Venis, 2001; Menon, 2008).

In two qualitative studies, both carried out in the UK, women's experiences of PPP have been described. In one study three women participated (Edwards & Timmons, 2005) and in the other ten participated (Semprevivo, 1996). Resentment towards their babies, thoughts of harming their babies, not feeling love for their babies, feelings of guilt for being bad mothers, and loss of identity were described (Edwards & Timmons, 2005; Semprevivo, 1996). In another UK study (Robertson & Lyons, 2003), consisting of ten women diagnosed with PPP, it was found that the women felt guilty for not being able to fulfill their maternal roles. Since their babies had to be cared for by hospital staff, some women were afraid that their babies' hospitalization could have detrimental effects on them. Due to the shifting relationship with their partners and being torn between caring for their babies and attending to their partner after their illness, some women described feeling lonely and conflicted (Robertson & Lyons, 2003).

The impact of the healthcare system and professional staff on the women has also been described. Robertson and Lyons (2003) reported that some women in their study described feelings of anger and frustration toward the healthcare system because of their perceived lack of information and support. Edwards and Timmons (2005) found that women described healthcare workers' lack of knowledge about the disorder and this consequently led to greater stigmatization.

The rationale for this study is based on that the literature review revealed

that PPP has mostly been studied from an outside perspective, i.e. a medical perspective. Few studies explore the women's own thoughts, feelings and experience of the disorder. In these studies the women's experiences of their treatment by the health care system have been described in terms of their dissatisfaction. The women's experiences during illness need to be more in-depth reviewed as the women's own experiences might contribute in developing care and treatment during their illness. Therefore the aim of this study is to explore women's experience of postpartum psychosis described in narratives published on the Internet.

METHODS

Design

To describe the women's perceived experience of the disorder, an inductive explorative qualitative design using the Internet as a data source was chosen (Polit & Beck, 2006). Computer technology has greatly enhanced the ability to communicate or even interact with others around the world. Any place where text is available on the Internet provides opportunities for researchers to conduct qualitative studies (Gaiser & Schreiner, 2009).

In the past few years there has been an increased use of the Internet by individuals, to share personal narratives, obtain support, and seek reassurance from others with similar experience (Anderson & Klemm, 2008; Wesemann & Grunwald, 2008; Ziebland et al., 2004). The choice of using the Internet as a data source is supported by Robinson (2001), who states that Internet

narratives tend to be more detailed in contrast to verbal narratives, and the secure feeling of being anonymous allows individuals to share their innermost thoughts and feelings. Polit and Beck (2006), mention that the Internet can be a rich source of qualitative data including written narratives. They write “In some cases data that can be analyzed qualitatively are simply ‘out there’, as when a researcher enters a chat room or goes to a bulletin board and analyzes the content of existing, unsolicited messages” (Polit & Beck, p. 346). Given the anonymity of Internet communication, individuals may be freer to discuss their experiences (Robinson, 2001), particularly in the light of the stigma associated with mental disorders (Edwards and Timmons, 2005).

Data collection

This study was submitted in 2007 to the University Institutional Board at the University of Rhode Island, USA, who stated that the Internet was not within their purview and is in the public domain. All narratives can be accessed by all visitors to the Internet, where they can be read and used by everyone. Narrators probably use a pseudonym if they do not want their own names used, and since personal narratives on the Internet can be read by anyone, informed consent is not required. In keeping with the established practice in qualitative research, there is no reference in this paper to information that might allow the women to be identified.

On several of the Internet sites concerning information, support and assistance to women suffering from postpartum mood disorders, it was possible to find narratives written by women who had suffered from PPP.

The words ‘postpartum psychosis’, ‘puerperal psychosis’, ‘postnatal psychosis’, ‘narratives’, and postpartum psychosis sites were used on the search engines Google, Alta-Vista and Yahoo to search for life narratives concerning PPP. Twenty-eight narratives were found (Online PPD Support Group, Postpartum experience.com, Adams, 1985; Atkinson, & Atkinson, 1983; Gray, 1988; Jilbert & Williams, 1994).

Each of the 28 narratives was read closely to determine which narratives met the definition of PPP, in respect of DSMIII and DSMIVTR (American Psychological Association, 2000). Three professionals independently read the individual narratives for their compatibility with the described definition of postpartum psychosis. Ten narratives, varying in length from 306 to 4140 words, met the conditions described in DSMIII and DSMIV and were selected for the study. DSMIV, as described earlier, state an onset within 4 weeks postpartum, with psychosis denomination, and excluding other ‘reasons/contexts’ such as earlier known schizophrenia and bipolar disorder.

Data analysis

Cross-case analysis (Miles & Huberman, 1994) was conducted to identify the similarities and differences across the cases and content analysis (Krippendorff, 2004) was used to analyze the content of the narratives. This analysis was performed by the research team.

The process of analysis began with reading and re-reading the narratives and writing down individual descriptions of each case. The reading and writing were performed to become acquainted with the data and obtain a

sense of the whole as well as to identify similarities and differences in the narratives on a comprehensive level.

Keeping the aim of the study in mind, the basic narratives were examined by identifying relevant sentences, phrases or particular examples which revealed the experience, i.e. the texts was decontextualized and meaning of units identified. These meaning units were then labeled with a code correlated to the content of the units. The codes were brought up from the narratives and abstracted to higher logical level. The next phase of the analysis was recontextualization by identifying themes. This was made by bringing codes (and meaning units) with similar content together. The description of the discerned themes was then examined to explore the variation in the themes and thereby form sub-themes. Direct quotes taken from the texts were then used to support the descriptions.

Methodological considerations

The Internet narratives were sampled according to the definitions described, i.e. definitions from DSMIII and DSMIVTR. By selecting in this manner, the content of the narratives follows the logical order of a medical textbook. Due to the data collection method, it is the richness and fullness in the women's descriptions of their experiences that is of interest rather than whether or not they conform with medical descriptions of the symptoms. We have come to the conclusion that the descriptions are genuine experiences of the disorder. Although the small sample size (Polit & Beck, 2006) could be regarded as a limitation of this study, the Internet narratives were rich,

describing the women's experiences of the disorder of PPP and providing a deep understanding of the phenomenon in question. Using narratives from the Internet might be questioned as we cannot guarantee the narratives were written by the women themselves. But the penetrating and substantial narratives indicate that this was the case. People always tell what they want to tell also if the narrative is told face-to-face, therefore one can expect the narratives were build on the women's experiences.

The participating authors in the data analysis have different backgrounds. To enhance the study's credibility (Lincoln & Guba, 1985) three professionals, a psychiatric nurse and certified midwife (IE) and a psychiatrist with a PhD (AA), both from Sweden and with long experience in the field, and a certified psychiatric clinical nurse specialist with a PhD (GF) from the USA, examined the individual narratives for their compatibility with the definition of postpartum psychosis and decided which narratives were to be chosen. Dependability (Lincoln & Guba, 1985) in this study was obtained in that the psychiatrist (AA) validated the results of the analysis and found them trustworthy. The fact that the three authors are used to the context of psychiatry might imply pre-understandings that are difficult to disregard. However, to reduce potential pitfalls, we tried at all times to be aware of our pre-conceptions. Furthermore, the fourth author (KN) has no experience of psychiatry, but is associated professor with a PhD and with long experiences of qualitative analysis, and therefore provided objectivity in the analytical process. Credibility measures how sincere and faithful the description of the theme is, and this was provided through direct quotations

from the narratives. These quotations give voice to the women's experience in their own words. Conformability (Lincoln & Guba, 1985) of this study was achieved by the fact that the narratives were used and analyzed carefully and transparently. Detailed descriptions of data collection and analysis methods were provided and different perspectives were included in the analysis due to the varied experience of the research team.

RESULTS

The women's descriptions of their experiences are described in themes. Four overarching themes emerged from the data: unfulfilled dreams, enveloped by darkness, disabling symptoms, and feeling abandoned. An overview of the findings is presented in Table 1.

Table 1 – Overview of the results

Themes	Sub-themes	Number of narratives containing this content
Unfulfilled dreams	Disappointment with the delivery	8
	Inability to take care of the baby	9
	Pervasive paranoia and guilt	8
Enveloped by darkness	Overwhelming fear	9
	Being in an unreal world	10
	Being controlled	7
	Disorganized thinking	9
Disabling symptoms	Feeling ill at ease	10
	Loss of sleep	9
	Self-destructive behavior	5
Feeling abandoned	Lack of concentration	9
	Distrust of everyone	5
	Detachment from the baby and the world	8
	Dissatisfaction with staff and care	7

*Unfulfilled dreams**Disappointment with the delivery*

The delivery was described as something to look forward to, and the delivery was planned in advance for it. Labor was approached as a challenge, a number of books about pregnancy and delivery were read, and participating in physical aerobics made them feel very prepared.

...we were eagerly awaiting the birth of our first child,
 approaching labour as a challenge, preparing ourselves mentally

through antenatal education and physically through regular aerobic exercise (1).

The expectations were shattered. Five of the women had difficult deliveries or a birth that ended with a c-section or a forceps. The difficulties were not just related to the delivery itself, but were also due to deaths of relatives, and a pregnancy with preterm labor and hypertension.

...I was left until the evening for my waters to break and then they gave me pain relief // Towards the end of my 24-hour labor I was exhausted. Finally my beautiful son was (painfully) delivered with forceps. I put him to my breast and my husband and I just gazed at him, delighted, while my torn perineum was stitched. I later learned that I had a postpartum hemorrhage and a very low hemoglobin level (7).

Eight of the women were very disappointed with the delivery. When it was over they were exhausted and needed to sleep; however, there was little time for that. The baby was to be breastfed and the staff expected the mothers to take care of the diaper-changing and the feeds. When they requested help from the staff but were refused, they felt disillusioned and helpless, considering themselves poorly treated. This made them tearful and unhappy; they felt as if the staff did not recognize their individual needs.

I was disappointed not to have had a natural delivery but felt that I had coped well with my labor //... (1).

Inability to care for the baby

While they were ill the baby was not important to all the women, in the sense that they were unable to take care of their baby, or were in need of help from nursing staff or relatives to provide the care. Being afraid of hurting the baby accidentally contributed to their reluctance to handle the baby. Being unable to meet the baby's needs and feed the baby, pick the baby up, or give him/her a bath were examples of inability to care for the baby. A mother of three described being incapable of caring for her other children, wishing her newborn had never been born, stating that if 'he' was just gone everything would go back to normal again.

When my perfect baby boy was born I found myself unable to meet his needs as I wished. I was afraid to pick him up or bathe him and could not feed him satisfactorily (5).

Five of the women described they were afraid of their babies, because they did not know how to care for them. They feared killing the baby, being afraid of their impulses and their inability to control them. Disturbing obsessive thoughts of throwing the baby out of the window, down the stairs or onto the pavement occupied their thoughts, instead of thinking of how to care for the baby.

I was fearful, I was afraid of becoming psychotic and I was afraid that I would harm my baby. The ward was many floors up and the window was usually open. I was tormented (5).

The women feared that the baby would be taken away from them if they shared these disturbing thoughts and feelings. As they kept silent, their

anxiety peaked. One woman experienced a sense of horror, as she thought that her hospitalization would demonstrate that she was irresponsible and, since she was a single mother that her baby would be taken away from her.

I was a prisoner [in the hospital] and my illness took a grip. I believed that my daughter had actually died and the hospital wanted to prove me an unfit single-mother to take away any responsibility (3).

Because of fear, and fear that nobody else was able to care for the baby, three women could not leave the baby alone, nor leave the baby out of their sight. For similar reasons they were very protective of the baby and had no confidence in somebody else caring for him/her; there were descriptions of three women who did not want anybody even to touch their baby.

I was reluctant to handle the baby for fear of accidentally hurting him and although I knew my husband and the staff were very competent to take over I was protective of the baby and resented their involvement (1).

During hospitalization trusting the staff to care for the baby was not always the case, and several had thoughts that the staff were trying to take and/or keep the baby away.

I had incredible fears, including that the baby was kept from me or would be taken from me; that I would die or become insane and be trapped in an insane mind (1).

Pervasive paranoia and guilt

Eight of the women experienced embarrassment during their illness when they had short periods of freedom from their psychosis, and they also experienced shame after they were discharged from the hospital.

I was paranoid that someone would hurt me. For almost two months no one knew what was wrong with me. I'm 24 now and I'm still embarrassed and upset that no one helped me sooner. I went around saying things that were absurd... (2).

They felt guilty and responsible for their illness and for burdening their families; two of them even experienced failure and guilt because a caesarean delivery had been necessary.

One of my primary concerns was that I had somehow failed in my labor by having a caesarean section delivery and I resolved to speak to my doctor during his morning visit (6).

Not all of the women described these feelings of shame and guilt. Two women said they had strong bonds with the baby, and had no negative feelings related to the baby, as in the following description:

Throughout the experience I always felt strongly bonded to my baby and never had any negative feelings towards him (7).

Enveloped by darkness

Overwhelming fear

Nine of the women described an overwhelming and unbearable feeling of fear, for example being terrified of becoming trapped in an insane mind or feelings of great horror that they had never experienced before. They

mentioned that they understood very little of what was happening to them, and did not think they received any information or explanation from the staff.

The fear was described as *a deep, dark, desperate fear* (8).

I never knew this kind of fear or darkness existed. // I had been trying to thwart all their efforts to get me on medication. // The one prescribed was called 'Zyprexa' and when I rearranged the letters, it spelled rape xyz. I assumed it was a scary phony name for a drug that didn't really exist, fabricated especially to kill me (6).

Nine of the women felt as if they were in hell and described the illness as the most traumatic experience in their lives. They had thoughts of being locked up forever, sometimes stuffed with food and sometimes starved. Five of them were severely depressed, not being able to differentiate day from night and not being able to eat or sleep. Fellow patients were perceived as terrifying; they all looked like devils with horns and manic eyes. During the psychosis the women could visualize themselves sitting and screaming, and were therefore given injections by force. One woman described being surrounded by all the staff, imagining them laughing and saying "It served her right" (3).

I was admitted to the hospital // and while I was being driven there, I thought I was on the way to hell on earth – an idea that was reinforced when I saw the patients, some of them fat and leering at me. I was led to an interview room and was

frightened to go in, imagining that the walls would be lined with photos of family and friends that I had hurt (10).

Being in an unreal world

All of the women described that they had delusions; for example, that something was wrong with the baby, or that the baby was ill or dying. These delusions were manifested in thoughts such as having killed somebody, believing it was the baby, and writing on the walls over and over again “*The baby is dead*” (7), and trying to understand if this was right or not. The women felt totally rational but at the same time they did not know what year it was and could loudly burst into song.

...//...everything seemed to be hilariously funny. I was filled with love and light. I felt that I had been invited to a party in my honour at Buckingham Palace. I rummaged through my wardrobe to find something suitable to wear, selected a straw hat with a pink ostrich feather, lace gloves and a size eight two-piece suit (8).

Two of the women imagined that their sons were Jesus reborn or that they had been chosen to bear the Christ child.

On one occasion I confided in him (her husband) that our son was in fact Jesus reborn (5).

Six of the women experienced elation and in affection, for example that the world was wonderful and brightly shining, and that they were in control of the world. Being admitted to hospital, they could have a feeling of being very ‘high’. Everything seemed to be great fun: for example, dressing up in

bright clothes and walking out in the garden, and later on cleaning the house and polishing everywhere.

A few days later I began to feel very 'high'. I put on my brightest clothes and went into the back garden to breastfeed my baby. // The next day I frantically cleaned my house.

Everything had to be cleaned and polished. // I was desperately searching for the meaning of life. Is there a God? Suddenly, I felt that I had solved all the problems of the universe (7).

The women often believed something could happen to their baby; for example, they were unable to sleep beside the baby for fear that he/she was going to die of sudden infant death syndrome (SIDS) while sleeping. When they could not hear the baby they thought he/she had stopped breathing. The women described doubting whether their baby was going to live at all although he/she was healthy. These thoughts made them feel remote from their baby.

With my first child I believed she was unwell but when I took her to the hospital, the staff were only interested in me. In the end, having spent a whole day at the hospital with no tests performed on her, I knew I would have to leave or she would not be treated (3).

Five of the group of women had infanticidal thoughts, which made them extremely anxious and afraid; for instance, they were unable to pass a window without having a horrible desire to throw the baby out. They kept thinking about taking the baby to the 2nd floor, putting him/her outside the

window, and seeing the baby '*go splat into pieces on the pavement*' (8).

None of the women acted on these thoughts, but they were terrified by them, and also felt shame and guilt.

The day before my mother-in-law left, I was carrying my baby past the top of the stairs when I got an incredible urge to throw her down the stairs. I was appalled that I could have such an awful thought (9).

Being controlled

Six of the women were paranoid and felt controlled by 'somebody' or 'something', although they could not specifically identify who or what. Telephone calls and all contacts with the outside world were understood as being controlled by 'something', and they described that the staff were dishonestly keeping information about the baby from them. They imagined that someone wanted to hurt them or the baby, but they did not know who it was. When two of them had blood tests taken they thought it was a 'device' for broadcasting television program about them, and one described being on a train travelling around the world where the speed was controlled and nobody would let her off. One woman described being certain that her husband was "out to get her", so he could get a divorce and take the child away from her.

This man must have been one of their spies, sent to intimidate me, I wasn't completely sure yet who they were. I thought maybe my former employer had powerful connections and was the mastermind behind an organized crime ring trying to extort

money from me. I had become extremely suspicious of him and had made ridiculous accusations towards him (3).

Five of the women experienced being possessed, and two of them believing that their house was possessed by demons, and needed to be blessed in order to be free of them.

I went around saying things that were absurd and right before I got sent to a hospital, I started to have hallucinations of people's eyes being crossed and felt like a demon was taking control of me (2).

Disorganized thinking

Nine women described being confused; not knowing what was going on, or what to believe. In the narratives they described feeling increasingly confused and forgetful, having trouble differentiating between present and past events. They also saw this confusion leading to psychosis and staying insane for the rest of their life.

My brother had been a patient at this psychiatric clinic a few years earlier. And so I imagined that he was here now.

Actually, I found it rather comforting to believe that he was here, to think that I was not alone. I went around looking for my brother, trying to figure out what room was his. I asked the staff again and again where my brother was (4).

Disabling symptoms

Feeling ill at ease

All of the women described anxiety, sometimes experiencing it constantly during the time of their illness, or in attacks, coming and going. Feelings expressed included being very lonely, anxious and suspicious, or being anxious and restless.

As the days went by, I became more anxious and restless, had episodes of breathlessness, and was less and less in control of my feelings. I was fearful, I was afraid of becoming psychotic and I was afraid of harming my baby (5).

They also described being restless, unable to stop walking or settle down, and stomping from room to room, crying out in despair.

My nerves were on edge // I was given practical help and support, but in spite of this I could not rest (10).

Loss of sleep

Nine of the women described serious lack of sleep; for example, being elated about breastfeeding and for this reason not able to sleep, or being given some sleeping tablets and then eventually managing to settle and go to sleep. They also described pacing all the time, constantly crying, not being able to sleep or eat.

Despite sedation I slept very badly. I was too elated with the birth of our son // feeling better in the evening with visitors, again I could not sleep. All the babies were crying and they sounded like mine... (7).

Self-destructive behavior

Five women had suicidal thoughts and two of them displayed self-destructive behaviors, such as cutting their wrists or legs with a knife, or taking an overdose of medication. These attempts were made because they thought the family was better off without them.

When a doctor offered help I mistook his intentions and replied “No, I don’t want to commit suicide”. I did not want to but thought that I must as I was evil, the Antichrist. I was sitting on the staircase, having minutely cut my wrists, fascinated but afraid (10).

Lack of concentration

Eight women suffered from lack of concentration, were not able to read or watch TV, and could not concentrate on a discussion or a conversation.

No one knew that I couldn’t really follow a television program. I left the TV on for comfort and escape, but I couldn’t follow a program, so I got annoyed and upset. I couldn’t read. The letters would be readable for a few words or so, but then they began to look like hieroglyphs - I couldn’t read them. That was particularly scary because I had never heard of such a thing... (9).

Two of the women described being forgetful, and could not keep anything in their minds.

Over time I became more and more confused and forgetful. I had difficulty distinguishing between the past and the present.

When my husband left me I soon forgot his appearance. But if I had his photo I remembered what he looked like (4).

Feeling abandoned

Distrust of everyone

All of the ill women had feelings of uneasiness, six of them distrusting everybody, and five were very suspicious. They were resentful of staff, husbands or other people, and they did not know who was a friend or an enemy. Their relations with and perceptions of their husbands varied. They were sometimes distrusted, sometimes looked upon as the Antichrist, and other times out to 'get her', and take the baby away.

For in my paranoia I was certain that my husband (who really is one of the world's greatest men and husbands) was out to get me. I thought he wanted to divorce me and take our child. I thought he was probably sabotaging our efforts to get help.

This man, who I trust more than anyone in the world, I felt I could not trust (9).

Four women continued to trust their spouses. Woman 1, for example, stated: 'I telephoned my husband as the only person I felt I could trust'. Another woman described having no real affection for anyone except her husband, since he was always there for her. One woman experienced loneliness during her illness.

On day 3, I believe I first experienced symptoms of the psychosis as I became very lonely, anxious and suspicious... (1).

Detachment from the baby and the world

Three women felt detached or disconnected from their baby and four had no interest or time to give to them. They were totally involved in their psychotic world, and this made them forget about the baby; and at other times they lacked concentration to care for the baby. The women reported that they only fed their baby when they had to, but without any real sense of connection or attachment. They described asking for the baby to be brought, but once the baby was there they were unable to respond and wanted the baby taken away.

Indoors people were clustered around the baby, but I had no time to concentrate on him. // I fed him, bathed him, changed him and was able to make up his feeds, but I had no real affection for him... (5).

Seven women felt detached from the world and their surroundings; all of them were very uneasy and sensed that everything was wrong. Losing touch with reality and feeling that everything was out of their control made them detach themselves from the baby. They described a sense of unreality and disorganized thinking.

I couldn't decide if I was at home or at the local hospital as a patient on a long-stay ward. // I held onto the wall, I asked my father-in-law if it was real. It was and I couldn't leave it.

Every time I tried to I was lost, so backwards and forwards I went, throwing myself against the wall over and over again (5).

Dissatisfaction with staff and care

Seven women were angry and distrustful of the staff. They experienced their hospital stay as very stressful, feeling trapped and without information; in words like: *'It also angers me that the medical field failed me'* (2).

...the situation worsened as I became more and more paranoid and suspicious of the staff and of their handling of the baby. I believed that the staff were not being honest with me as there were inconsistencies between what I was told and what was in the baby's notes (1).

One woman was hurt of the way the staff treated her and gave this description:

I was so tired and my perineum was so sore, I asked the auxiliary nurse to pass me the baby from his cot. It appeared to me that she gave me a filthy look before condescending to pass me my baby. I felt hurt (8).

Another one wanted to speak to her doctor on his morning visit, to tell him about the way she felt and her inside turmoil, but the talk with him was too fast and he did not have time to listen.

...Although I did see him [the doctor] in the morning, his visit was too rushed to allow me to talk to him about my anxieties (6).

One woman was being strapped and felt abused by the staff. This treatment gave her feelings of bitterness and resentments towards the staff.

At that point I was involved in a fight between me and three male members of staff who eventually managed to get me into the 'pink' room where my trousers were pulled down and haliperidol was injected into my bum (3).

There were only two women who described having some sense of satisfaction; one was satisfied with the psychiatric care, but very dissatisfied with the staff at the postnatal care unit where she felt they were understaffed with too little knowledge of postpartum care and treated her very poorly. The other woman was satisfied with her hospital stay at both the postnatal care and the psychiatric care units; she trusted the hospital staff and felt well taken care of.

It was incredibly comforting and nice to have someone sitting in my room when I had gone to bed. I had a feeling they really cared for me (4).

DISCUSSION

The aim of this study was to gain a deeper insight into the experience of women who described they were diagnosed with PPP, with the goal of improving the quality of healthcare and decreasing the suffering that often accompanies this psychiatric disorder. Four categories were described in the results: *unfulfilled dreams*, *enveloped by darkness*, *disabling symptoms*, and *feeling abandoned*, and these will be discussed below. All of the women had delusions and found themselves in an unreal world. This was very strange and confusing for them, as they did not know what was real. Many women had delusions about their children, e.g. two of the women expressed religious

ideas about their baby being Jesus or that the woman herself was God, the Creator. This is commonly described in connection with the disorder of PPP (Doucet, Dennis, Letourneau, & Blackmore, 2009). Five of the women had infanticidal ideas, and it is known that 4% of women with PPP without treatment commit infanticide (Knops, 1993; Spinelli, 2009). In an earlier study (Engqvist, Ferszt, & Nilsson, 2010) was found that if the nurse was present when the baby was taken care of by the mother in the early phase of the illness, this procedure was a way of protecting the baby and to prevent a tragedy to happen.

The women were detached from their baby and the world. This was also pointed out by Semprevivo (1996), who maintained that women did not care for their children due to delusions and because they were too involved in their psychotic world, with no time and thoughts for their baby (Semprevivo, 1996). All women stated that they had a constant feeling of being ill at ease, or of anxiety that was hard to cope with. This is in accordance with Robertson and Lyons (2003), who maintained that the disorder removes the ability to experience normal feelings and emotions. Six of the women had made great plans for their delivery but all preparations had failed, and they were very disappointed; this is in line with results from a study by Semprevivo (1996), where the women described that they felt like somebody else and completely depersonalized. All except one of the women stated that they had strong sensations of fear – that there was something wrong with the baby, that the child or the woman herself would die – and expressed an undefined feeling that something was wrong. According to Brockington et

al. (2006), fear and anxiety are common in women with postpartum psychiatric disorders.

All except one of the women reported a feeling of not being able to take care of the baby, the feeling of not wanting the baby or not being interested. This led to a pervasive sense of shame and guilt, and a fear that the baby would be taken from them. This experience was pointed out by Edwards and Timmons (2005) in their study of women's experience of stigma in suffering from postpartum mental disorder. More than half of the group of women stated that they felt detached from the baby and the world. In a study (Noorlander, Bergink, & van den Berg, 2008) of the mother's bonding to the child, the result shows that women with PPP have a closer bond to their child than women with postpartum depression have, and the negative effect on the child is greater for children with a mother with postpartum depression than for children to mothers with PPP. This is not borne out in the present study.

All but one reported loss of sleep, which is a prominent symptom of PPP. It has been verified that nearly fifty percent of women with PPP suffer from sleep disturbances (Heron, McGuinness, Blackmore, Craddock, & Jones, 2008). In relation to other studies concerning this disorder surprisingly many women in this present study experienced loss of sleep. Lack of concentration was a prominent symptom in this study, where nine of the women stated that they were incapable of watching TV, reading a paper or concentrating in a talk or discussion. Lack of concentration was found in approximately 29% of women with PPP, where 127 women were interviewed (Heron et al., 2008).

It is interesting to note that so many of the women reported a lack of satisfaction with the staff that cared for them. In an earlier Swedish study (Engqvist, Nilsson, Nilsson, & Sjostrom, 2007) it was found that nurses caring for women with PPP stated that they gave support, hope and confirmation to the women, and worked very hard to create a good relationship with them. But the present study confirms what was noted by Robertson and Lyons (2003): that patients with PPP were generally angry and frustrated with the healthcare system due to lack of information and support during their time of illness. Here it is necessary to take into account the inability of these patients to accept support and comprehend information that is given to them during their illness, knowing that this is a psychosis which causes disorientation, as well as feelings of guilt and inadequacy. It has been confirmed that if nurses were present with the woman during her hospital stay, this presence gave the woman and her child protection, as well as facilitating the woman's recovery (Engqvist et al., 2010). Consequently the nurses' experiences of caring for women with PPP differ from the women's description. It points to the importance of using different perspectives to describe a phenomenon, i.e. the patients' as well as the nurses' perspective.

This paper could be read by anyone with an interest in gaining an in-depth insight in the internal experience of women recovering from PPP. Different kinds of health care professionals often observe only a small part of the disorder, mainly in the acute phase and early recovery, and when improving the women will be cared for by another colleague.

CONCLUSIONS

Postpartum psychosis is experienced as a devastating and crippling disorder by the women. Given the knowledge that women feel misunderstood, neglected, and not well taken care of, there is clearly a need to further educate nurses and doctors concerning PPP, so that they can provide effective and compassionate care for these women. Psychiatric nurses specially trained and educated in postpartum mental disorders can play a critical role in facilitating the recovery of women experiencing PPP by early recognition of signs and symptoms of the disorder, they can provide emotional presence and anticipatory guidance to the women; they can educate the women and their families about PPP as well as educate other nurses like child health care nurses and midwives to recognize prodromal symptoms and the importance of facilitating the newly delivered mother's sleep. Psychiatric nurses can with deepened knowledge empower these women to achieve optimal recovery from PPP.

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Competing interests

The authors declare that they have no competing interests.

Authors' contributions

IE: Study design, data collection, analysis, and manuscript preparation

AA: Study design, and analysis

GF: Study design, analysis, and manuscript preparation

KN: Study design, analysis, and manuscript preparation

REFERENCES

- Adams, J. (1985). I'm normal, I cried. *Nursing Times*, 16, 44-45.
- American Psychological Association. (2000). *Diagnostic and statistical manual of mental disorders (4th ed.)*. Washington, DC.
- Anderson, A. S., & Klemm, P. (2008). The Internet: friend or foe when providing patient education? *Clin J Oncol Nurs*, 12(1), 55-63.
- Atkinson, S., & Atkinson, T. (1983). Puerperal psychosis – a personal experience. *Health Visitor*, 56, 17-19.
- Brockington, I. (2004). Postpartum psychiatric disorders. *Lancet*, 363(9405), 303-310.
- Brockington, I. F., Macdonald, E., & Wainscott, G. (2006). Anxiety, obsessions and morbid preoccupations in pregnancy and the puerperium. *Arch Womens Ment Health*, 9(5), 253-263.
- Cantwell, R., & Cox, J. (2006). Psychiatric disorders in pregnancy and the puerperium. *Curr Obstet Gynaecol*, 16(1), 14-20.
- Chandra, P. S., Venkatasubramanian, G., & Thomas, T. (2002). Infanticidal ideas and infanticidal behavior in Indian women with severe postpartum psychiatric disorders. *J Nerv Ment Dis*, 190(7), 457-461.

- Chaudron, L. H. (2000). When and how to use mood stabilizers during breastfeeding. *Prim Care Update Ob Gyns*, 7(3), 113-117.
- Doucet, S., Dennis, C. L., Letourneau, N., & Blackmore, E. R. (2009). Differentiation and clinical implications of postpartum depression and postpartum psychosis. *J Obstet Gynecol Neonatal Nurs*, 38(3), 269-279.
- Edwards, E., & Timmons, S. (2005). A qualitative study of stigma among women suffering postnatal illness. *J Ment Health*, 14(5), 471-481.
- Engqvist, I., Nilsson, A., Nilsson, K., & Sjostrom, B. (2007). Strategies in caring for women with postpartum psychosis--an interview study with psychiatric nurses. *J Clin Nurs*, 16(7), 1333-1342.
- Engqvist, I., Ferszt, G. & Nilsson, K. (2010). Swedish registered psychiatric nurses' descriptions of presence when caring for women with postpartum psychosis – an interview study. *Int J of Ment Health Nurs*, 19(5), 313-321.
- Freyne, J., Nguyen, T., Allen, S., & Rampono, J. (2009). Motherhood and mental illness. Part 2 - management and medications. *Aust Fam Physician*, 30(9), 688-692.
- Friedman, S., Resnick, P., & Rosenthal, M. (2009). Postpartum psychosis: strategies to protect infant and mother from harm. *Curr Psychiatr*, 8, 1-9.
- Friedman, S. H., Horwitz, S. M., & Resnick, P. J. (2005). Child murder by mothers: a critical analysis of the current state of knowledge and a research agenda. *Am J Psychiatry*, 162(9), 1578-1587.

- Gaiser, T. J., & Schreiner, A. E. (2009). *A guide to conducting online research*. London: Sage.
- Gray, P. (1988). Dream or nightmare? *Nursing Times*, 84, 63-65.
- Halbreich, U. (2005). Postpartum disorders: multiple interacting underlying mechanisms and risk factors. *J Affect Disord*, 88(1), 1-7.
- Heron, J., McGuinness, M., Blackmore, E. R., Craddock, N., & Jones, I. (2008). Early postpartum symptoms in puerperal psychosis. *BJOG*, 115(3), 348-353.
- Jilbert, A., & Williams, A. (1994). Postnatal psychosis: A patients experience with comments by the consulting psychiatrists. *Australian College of Midwives Incorporated Journal*, 7(2), 26-30.
- Jones, H. W., & Venis, J. A. (2001). Identification and classification of postpartum psychiatric disorders. *J Psychosoc Nurs Ment Health Serv*, 39(12), 23-30.
- Jones, I., & Craddock, N. (2007). Searching for the puerperal trigger: molecular genetic studies of bipolar affective puerperal psychosis. *Psychopharmacol Bull*, 40(2), 115-128.
- Knops, G. (1993). Postpartum Mood Disorders. *Postgraduate Medicine*, 93, 103-116.
- Krippendorff, K. (2004). *Content analysis. An introduction to its methodology*. Thousand Oaks, California: Sage Publications.
- Lanczik, M., Bergant, A., & Klier, C. (2006). Are severe psychiatric disorders in childbed of endogenous or organic nature? German contributions to the biological, nosological and psychopathological

- research in postpartum psychosis in the 18(th) and 19(th) century.
Arch Womens Ment Health, 9(5), 293-299.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park:
SAGE Publications.
- Menon, S. J. (2008). Psychotropic medication during pregnancy and
lactation. *Arch Gynecol Obstet*, 277(1), 1-13.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative Data Analysis An
expanded Source-book* (2: ed ed.). Thousand Oaks, Calif.: Sage
Publications.
- Murray, L., Cooper, P., & Hipwell, A. (2003). Mental health of parents
caring for infants. *Arch Womens Ment Health*, 6 Suppl 2, S71-77.
- Nager, A., Johansson, L. M., & Sundquist, K. (2005). Are sociodemographic
factors and year of delivery associated with hospital admission for
postpartum psychosis? A study of 500,000 first-time mothers. *Acta
Psychiatr Scand*, 112(1), 47-53.
- Nager, A., Sundquist, K., Ramirez-Leon, V., & Johansson, L. M. (2008).
Obstetric complications and postpartum psychosis: a follow-up study
of 1.1 million first-time mothers between 1975 and 2003 in Sweden.
Acta Psychiatr Scand, 117(1), 12-19.
- Ndosi, N. K., & Mtawali, M. L. (2002). The nature of puerperal psychosis at
Muhimbili National Hospital: its physical co-morbidity, associated
main obstetric and social factors. *Afr J Reprod Health*, 6(1), 41-49.
- Noorlander, Y., Bergink, V., & van den Berg, M. P. (2008). Perceived and
observed mother-child interaction at time of hospitalization and

release in postpartum depression and psychosis. *Arch Womens Ment Health*, 11(1), 49-56.

Online PPD Support Group. Homepage:

<http://www.ppdsupportpage.com/groupmembers.html> .

Polit, D. F., & Beck, C. T. (2006). *Nursing Research. Principles and Methods* (7th ed.). Philadelphia: Lippincott Williams & Wilkins.

Postpartum experience.com. Homepage:

<http://www.postpartumexperience.com/stories.html>.

Putkonen, H., Weizmann-Henelius, G., Collander, J., Santtila, P., & Eronen, M. (2007). Neonaticides may be more preventable and heterogeneous than previously thought - neonaticides in Finland 1980-2000. *Arch Womens Ment Health*, 10(1), 15-23.

Robertson, E., & Lyons, A. (2003). Living with puerperal psychosis: A qualitative analysis. *Psychol Psychother*, 76, 411-431.

Robinson, K. M. (2001). Unsolicited narratives from the Internet: a rich source of qualitative data. *Qual Health Res*, 11(5), 706-714.

Schopf, J., & Rust, B. (1994). Follow-up and family study of postpartum psychoses. Part II: Early versus late onset postpartum psychoses. *Eur Arch Psychiatry Clin Neurosci*, 244(3), 135-137.

Semprevivo, D. (1996). *The lived experience of postpartum mental illness*. PhD, Rush University, USA.

Seyfried, L. S., & Marcus, S. M. (2003). Postpartum mood disorders. *Int Rev Psychiatry*, 15(3), 231-242.

- Sharma, V., Smith, A., & Khan, M. (2004). The relationship between duration of labour, time of delivery, and puerperal psychosis. *J Affect Disord*, 83(2-3), 215-220.
- Sit, D., Rothschild, A. J., & Wisner, K. L. (2006). A review of postpartum psychosis. *J Womens Health*, 15(4), 352-368.
- Spinelli, M. G. (2009). Postpartum psychosis: detection of risk and management. *Am J Psychiatry*, 166(4), 405-408.
- Wesemann, D., & Grunwald, M. (2008). Online discussion groups for bulimia nervosa: an inductive approach to Internet-based communication between patients. *Int J Eat Disord*, 41(6), 527-534.
- Yonkers, K. A., Wisner, K. L., Stowe, Z., Leibenluft, E., Cohen, L., Miller, L., et al. (2004). Management of bipolar disorder during pregnancy and the postpartum period. *Am J Psychiatry*, 161(4), 608-620.
- Ziebland, S., Chapple, A., Dumelow, C., Evans, J., Prinjha, S., & Rozmovits, L. (2004). How the internet affects patients' experience of cancer: a qualitative study. *BMJ*, 328(7439), 564.

Chapter Seven

Psychiatric Nurses' Descriptions of Women with Psychosis Occurring Postpartum and the Nurses' Responses – an Exploratory Study in Sweden

Paper II

The findings of the first study provided graphic descriptions of the enveloping fear that the women experienced during their hospitalization with postpartum psychosis. A number of other prominent symptoms were also described. An additional finding was the report by some women that they felt abandoned by the nursing staff, who were caring for them during the acute phase of their illness. A logical consequence of these findings is the following important questions: (1) What is the nurses understanding of the nature of this illness? (2) How do nurses respond to women with PPP when they provide nursing care on the inpatient psychiatric unit?

There is evidence in the psychiatric literature that nurses have different responses to their patients. Lundström et al. (2007) discuss descriptions of nurses' feelings of sadness and anxiety in relation to patients. Määttä (2006) examined closeness and distance in relationships between patients and nurses and discovered that nurses can be overwhelmed by their closeness to their patients, and may find it difficult to maintain the professional distance and objectivity that sometimes is necessary.

The practice domain (Kim, 2000a) refers to the different nursing actions performed by the nurse in a given nursing care situation and for the good of the patient; i.e., how nurses provide care to women suffering from PPP (Robertson & Lyons, 2003; Semprevivo, 1996). Nursing actions related to caring for women with PPP involve two dimensions of nursing practice: deliberation and enactment (Kim 2000a); nurses need to assess the women's status before developing nursing interventions.

In order to explore the questions raised by the first study, another investigation was designed to interview psychiatric nurses working on acute inpatient psychiatric units in Sweden. Given the low incidence of women who are diagnosed with PPP, nurses were estimated to need a minimum of five years of clinical experience in this specialty. To participate in the study the nurses needed to be specialized psychiatric nurses. Hospital chief psychiatrists and the head-nurses in the different departments were contacted to obtain names of potential nurse participants who met the inclusion criteria. Subsequently the selected nurses were contacted by telephone and an interview time was decided. The process of obtaining participants took about one month. Interviews were completed over a six month period. Selected hospitals for this study were located in the Southwest of Sweden. Participants were easy to find and to interview.

**Psychiatric Nurses Descriptions of Women with Psychosis
occurring Postpartum and the Nurses' Responses
– An Exploratory Study in Sweden**

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Postpartum psychosis is the most serious type of psychiatric illness related to childbirth. This interview study with nine psychiatric nurses in Sweden aims to explore psychiatric nurses' descriptions of women with psychosis occurring in the postpartum period and nurses' responses when providing care to these women. Content analysis was used to analyze the data. The nurses described delusions, disconnection, aggression, changed personality, self-absorption, insomnia, chaos, quietness, suicidal ideation, and 'strange eyes'. The description of 'strange eyes' noted by the nurses has not been found in the literature, warranting further investigation. When providing care, the nurses responded with sadness, sympathy, empathy and compassion, discomfort, anger, anxiety, and happiness. These findings underscore the importance of recognizing negatively charged emotions, which could interfere with providing compassionate and effective nursing care to this population.

Although childbirth is one of the most striking life-events for many women, it may also be a time of increased vulnerability for psychiatric illness (Munk-Olsen, Laursen, Pedersen, Mors & Mortensen, 2006). Various emotional and mental health disturbances can be experienced following childbirth with the most serious being postpartum psychosis (PPP). The classification of PPP has changed over time. The diagnosis of PPP was considered its own entity in earlier versions of the c.f. International Classification of Disorders, ICD 9 (ICD, 1974) and the Diagnostic and Statistical Manual of Mental Disorders. However, the new edition of the ICD 10 (ICD, 1992) and recent versions of the (DSM III and IV), the word postpartum onset is used as a specifier and applied to a number of different disorders including Major Depression, Manic, or Mixed Episode of Major Depression or Bipolar I Disorder or Bipolar II Disorder with psychotic features, or to a Brief Psychotic Disorder. The onset occurs within 4 weeks after delivery (APA, 2000). In this study, the focus was on psychosis occurring in the postpartum period, and the designation of PPP was used.

Approximately one or two childbearing women in 1000 are stricken with PPP typically in the first two weeks after delivery (Brockington, 2004; Heron, Robertson Blackmore, McGuinness, Craddock & Jones, 2007; Munk-Olsen et al., 2006; Tschinkel, Harris, Le Noury & Healy, 2007). The onset is usually rapid and can occur as early as 1-3 days immediately after childbirth with 22 % on the 1st postpartum day (Heron et al., 2007; Okano et al., 1998). Most researchers agree that PPP is often influenced by genetic vulnerability and hormonal factors in conjunction with psychological stress

(Glover & Kammerer, 2004), frequently following a number of nights with disturbed sleep. The woman develops paranoid, grandiose, or bizarre delusions usually associated with the baby, has mood swings, confused thinking, anxiety and/or panic, and grossly disorganized behaviour that represents a dramatic change from her previous level of functioning (Chandra, Bhargavaraman, Raghunandan & Shaligram, 2006; Ross, Murray & Steiner, 2005). In many circumstances the woman lacks an awareness of the seriousness of the illness (Sit, Rothschild & Wisner, 2006).

The combination of psychosis, lapsed insight and poor judgment can lead to devastating consequences whereby the safety and well-being of the mother and her baby are jeopardized (Friedman, Horwitz & Resnick, 2005; Hornstein, Trautmann-Villalba, Hohm, Rave, Wortmann-Fleischer & Schwarz, 2006; Oates, 2003; Seeman, 2004; Stocky & Lynch, 2000). It is estimated that the risk for suicide is 5 % and 4 % for infanticide. In addition, 50% are likely to have PPP following subsequent pregnancies (Austin, Kildea & Sullivan, 2007; Cantwell & Cox, 2006; Jones & Craddock, 2005; Levy, Sanders & Sabraw, 2002; Lindahl, Pearson & Colpe, 2005; Robinson, 1998; Robling, Paykel, Dunn, Abbott & Katona, 2000; Spinelli, 2005).

PPP is considered a psychiatric emergency and can have long term implications for the woman and her whole family (Hornstein et al., 2006; Howard, Goss, Leese, Appleby & Thornicroft, 2004). Given the risk for suicide and/or infanticide, knowledge of the risk factors, early identification of the signs and symptoms and rapid treatment are important. In some cases, early detection can prevent a major episode (Born, Zinga & Steiner, 2004).

Since nurses have a key role in promoting the psychological wellbeing of their patients, they must possess adequate knowledge and understanding of this serious disorder (Currid, 2004; Marmion, 2000; Nicholls & Cox, 1999).

The above descriptions of the symptoms of PPP originated from the medical literature. No studies describing symptoms of PPP from the nursing perspective have been found. However, Ugarriza (1992) pointed to the importance of nurses' awareness of the severity of symptoms of PPP. Therefore it is essential to investigate psychiatric nurses' descriptions of women with this diagnosis.

Disturbing and aggressive behaviour in connection with mental illnesses can be dangerous for the patients and the staff around them (Kaliski, 2002; Torrey, 1994). When nurses first meet patients with disturbing behaviour, it is important for them to establish a 'loving-giving relationship'. However, when nurses do not feel appreciated by their patients, they can sometimes respond negatively towards them. Their attitude can change from one of interest and concern to avoidance (Hellzen, Asplund, Gilje, Sandman & Norberg, 1998; Hellzen, Asplund, Sandman & Norberg, 2004). In an observation study in Sweden examining the interaction between patients with leukemia and their nurses Bertero (1998) discovered that nurses used 'distancing' to protect themselves from emotional exhaustion resulting from caring for this very ill population. Recognizing that nurses' responses to patients can impact their nursing care, it is important to explore their responses to women with PPP.

The aim of this study was to (1) explore psychiatric nurses' descriptions

of women with postpartum psychosis; and to (2) explore nurses' responses to these women when providing care to women with postpartum psychosis.

METHOD

A descriptive approach using semi-structured interviews was selected for this study. A descriptive investigation is a suitable research approach to study phenomena about which little is known (Polit & Beck, 2006). The semi-structured interview ensures that the researchers still obtain all the information required yet gives participants the freedom to respond in their own words (ibid, 394). The outcomes of interviewing are dependent on the interviewee's and the interviewer's assumptions about understandings of cultural tacit presumptions about reality, experiences, feelings and intentions. Furthermore, the interview is a face-to-face meeting where the interviewer intends to discover the interviewee's point of view and experiences related to the phenomena being explored (Kvale, 1996). In this study, the content i.e. the outcome of the interviews was the focus, not the interaction.

Participants

Nine registered nurses (eight female and one male) were voluntarily recruited from psychiatric departments in three hospitals in the Southwest of Sweden. Inclusion criteria were: (1) special education in psychiatric nursing; (2) a minimum of 5 years of professional experience in this speciality; and (3) experience caring for women with PPP. Specialist education in mental health nursing in Sweden is a one year graduate studies on advanced level after Bachelor in nursing. The participants ranged in age from 39 to 60 years (mean 53.3). Of the participants 7 were very experienced (≥ 10 years of

professional experience), and 2 were less experienced (5-10 years of experience), the mean year of experience was 17.8. Most of the nurses' experiences of women with PPP were from the last 0-10 years. All together the nurses had provided care for approximately 30 women with postpartum psychosis. All participants were Caucasian and eight had children (See table 1).

Table 1.

Socio-demographic and clinical characteristics of the psychiatric nurses
(*n*=9)

<i>Age (years)</i>	
Average age	53.3
30–39	1
40–49	1
50–59	5
60–65	2
<i>Gender</i>	
Male	1
Female	8
<i>Education</i>	
Basic nursing education	5
Psychiatric nursing education	9
<i>Type of care</i>	
Inpatient	7
Outpatient	2
<i>Amount of women with PPP cared for</i>	
1-5	5
6-10	4
<i>Years in profession</i>	
Average length	17.8
5–10	2
11–20	4
21-30	2
>30	1

Data collection

The nurses were interviewed in 2003, from April to September. Prior to contacting potential participants, permission was obtained from the hospital chief psychiatrists in three hospitals. Following his/her approval, nine head-nurses from different psychiatric units in these hospitals were contacted via a letter of introduction informing them of the nature and aim of the study. This letter also explained the methodology, which included audio-taped interviews with experienced psychiatric nurses. Within a week, these head-nurses were contacted by telephone and asked to request participation from their most experienced nurses. The potential participants (9 nurses) were contacted by telephone and an interview time was scheduled. Before the interview started, the participants once again received information about the aim of the study and informed consent was obtained. The audio-taped interviews lasted 45 - 75 minutes. The data was collected by the first author through interactive and probing semi-structured interviews aimed at helping the nurses to describe the symptoms of women with PPP they had identified in their clinical practice. They were also asked to discuss their responses to the women presenting with these symptoms. The interviews were conducted in Swedish and the quotations later translated by the first author into English and later on reviewed by a native-born American. The interview began by asking the nurses to reflect on a situation when they had provided nursing care for a woman with PPP. They were then asked to describe how this woman presented. Following these descriptions, the nurses were asked to explore how they responded to women diagnosed with this disorder.

Data Analysis

Content analysis was used to analyze the data as the method allows quantifying quality. Content analysis is a systematic, dynamic form of analysis of verbal data and when focusing on the manifest content is oriented toward summarizing the informational content. The process of analysis began with listening to the audiotapes, in order to become acquainted with the data. The transcribed texts were then read and re-read to obtain a sense of the whole interview (Krippendorff, 2004). The data was then examined line by line with the identification of descriptions of women with PPP as well as the nurses' responses. The next step was to organize the descriptions and the nurses' responses into categories. In the final step, descriptions and responses were counted and placed in the established categories across the interviews. Quotations from the interviews were used to illustrate the content of the categories.

Ethical approval

The recommended ethical considerations for qualitative research were considered in this study. The fundamental ethical demands for the participants included obtaining informed consent, and maintaining confidentiality. Approval for this research was obtained from University of Gothenburg's Ethical Committee (No. 0. 155-03).

FINDINGS

The nurses' descriptions of women with the illness of PPP and their responses to the women are described in categories. The statements made by the nurses about women with PPP emerged from their contact with approximately 30 women.

Descriptions of PPP

All of the participants identified delusions and disconnection from the baby. Aggression and changed personality were identified as important symptoms by six participants and self-absorption by more than half of the participants. Insomnia was less dominant in the nurses' descriptions as well as other descriptions described below.

Delusions

All of the nurses identified symptoms of delusions. The delusions were described as being about the baby, i.e. the baby was dangerous or the baby was an "it" or a doll. One nurse described a woman who did not believe the baby was hers and consequently did not want to take care of somebody else's child. Sometimes she stated that her husband was not the father.

...//..Well, her delivery had been very difficult and she was convinced that something was wrong, and that there were some happenings around the time of her delivery that actually hadn't occurred and so on. There were lots of delusions like that.

Disconnection

The disconnection described by all nurses took the form of not wanting to hold or touch the baby, or care for the baby. Six of the informants

described “being afraid of the baby” and five of them described feeling no joy for the baby. Consequently none of the women described by the nurses were able to breastfeed their babies. The nurses noted that the lack of breastfeeding was a result of the women not wanting to breastfeed but also might have been due to the use of antipsychotics. Two women did not remember that they had delivered and consequently did not want to breastfeed.

She gave so little contact, and she was not interested in the child. Yes, really, she was neither interested in her child nor in us ..//.. she didn't say very much, she was almost apathetic ..//.. and her behavior was like one with psychotic depression.

Only one nurse described a woman who accepted her child. This woman was calm and quiet and was sad that she could not be admitted to the hospital with her child.

.. she did accept her child ..//.. not everybody does that, but she did. She was sad that she couldn't keep her baby with her, but at the same time she was easily tired out.

Aggression

Six of the nurses noted that aggression is a common symptom of PPP. Patients were described as “attacking staff”, “screaming and throwing things” and running around “naked”. One of the nurses referred to this symptom as the woman being regressed. Only one nurse (male participant) noted mania when describing aggression.

She was aggressive, she was frightened because she was attacking us often ... this fear and fright and confusion ... she wanted to leave us the whole time, she was close to attacking, when we were near her ... but there was a fear from her, a fear for something we could not understand.

Changed Personality

Six of the nurses stated that the women had a changed personality when becoming ill. According to husbands and relatives the woman's whole personality was changed, and they could not recognize their roles as wives or daughters. The nurses stated that relatives often were afraid and surprised at the dramatic change in their loved one and asked what was happening.

Well, often there is such a drama. Both for the Mom and the whole family and they are all wondering what is happening. Well, they notice the change...a completely personality changed wife or daughter.

Self-absorption

Five of the nurses noted that the women were self-absorbed. One of the nurses stated that one of the women might have been self-absorbed because she was afraid of the baby and seemed overwhelmed by her new role as a mother and parent. Only one of the women, described as being self-absorbed was also noted as being paranoid. This woman was also described as being manic in the beginning of the hospital stay, was discharged and then readmitted; on her second admission she showed signs of depression and was very quiet and committed suicide while hospitalized.

...She didn't say much, at least not about her baby. She didn't react much at all – she was more apathetic. She stayed in bed much.../... we didn't need to restrict her...she restricted herself. She was not interested in her baby nor in us.

Insomnia

Four nurses identified insomnia as a symptom that their patients had, and described it as the women having a couple of nights without or with very little sleep in the initial phase.

...//.. In general, well, she usually is suffering from insomnia //.. Yes, she had not slept well, I know that. She hadn't slept much at all after the delivery, for several nights, I know that.

Chaos

Four nurses used the word “chaos” to describe the women who were “out of control”, but not aggressive. The chaos was related to the intense fear, disorientation, and anxiety that some women with PPP experienced combined with a total lack of awareness of their delivery and the birth of their newborn. Women described as being ‘chaotic’ frequently needed forced care (i.e. restrained, involuntary commitment).

Yes, she was in total chaos and wouldn't accept her child ..// .. she just ran around naked ..//. .had forgotten that she had just delivered and wanted to go back to the delivery department and deliver again ..//.. I couldn't talk to her, but it ended so that we had to put her in a restraining belt.

Quietness

Four nurses also noted that sometimes women can be quiet. These participants also associated quiet with being calm. One of the women, described as quiet, drowned her baby on a pass from the hospital. Another quiet woman, also described as paranoid, afraid and “panic stricken,” had tried to put her child in the freezer prior to her hospitalization and she committed suicide during her hospitalization.

Well, when she was at our unit, nothing happened – she was quiet and calm. She was one of the calmest we had at that time.

Suicidal ideation

Four of the nurses noted that some women were suicidal, demonstrated through a variety of behaviours including “breaking glass and trying to cut herself”, “trying to burn herself”, “wanting to jump out the window”. Three of the suicidal women were also described as aggressive and self-absorbed.

Well, she became more and more depressed and quiet; she probably had many thoughts inside her that she never told anyone. From the beginning she had extrovert behaviour and later she became the opposite. She shut herself up, and one day she went outside and committed suicide by walking in front of the train.

“Strange eyes”

One further finding was the description of the women’s “strange eyes”. Three participants described this phenomenon as follows: the woman had “black eyes”, “strange look toward the baby”, looked at the baby with a

“black glance”, and “you can see it in the woman’s eyes”. These “strange eyes” disappeared when the women recovered.

...you can see it in the look, in the eyes, this look of fear and fright and confusion, and so...she didn't talk so much but she was pondering about something, the way she looked at the baby was so strange. And there was something strange with her eyes when she looked upon the child... Yes, when she started to bond with her child then the look was changed in a way. And one can have different ways of expression, she looked less “black eyed” when watching the child. Yes, at the end of her hospitalization she took her child and held it and the “black look” was gone. She seemed to be pondering why the child was there.

Nurses’ responses

Eight of the nurses described having strong responses when providing care for women with PPP. These responses included sadness, sympathy, empathy and compassion, discomfort, anger, anxiety, and happiness. One nurse described having no such strong feelings and emotions, because she had to keep her professional distance from her patients.

Sadness

Eight of the nurses described sadness. This was related to observing the lack of connection between the women, their new baby, partner and/or other family members. These nurses recalled the joy of parenthood they had experienced in their own lives and were deeply affected by the absence of happiness, joy, contentment and satisfaction that normally follows childbirth.

The nurses were sorrow-stricken when thinking about the potential effects of the illness on the newborn and other children.

...sadness ..//.. that is what I wish for this new family to feel well in its new parenthood as well as everybody else I see, those who feel well in becoming a new family. Yes, I want them to have it well and to feel well, as everybody else.

Sympathy, Empathy and Compassion

Six of the nurses described sympathy, empathy and compassion for the women and their families when the women were suffering from delusions and aggression. One nurse described a couple that had been waiting a long time for their baby. After the childbirth everything became so difficult shattering their hopes and dreams.

.. so there are feelings of compassion in me. I feel compassion and sympathy for the family, and I have much empathy. And the thought, why should this happen, when things could be so much better?

Discomfort

Six of the nurses described great discomfort when providing care for women who were 'chaotic' and forced care was needed (involuntary commitment, restraints). The forced care was related to aggression, attempted suicide or infanticide. When forced care was necessary, the nurses described experiencing a great deal of uneasiness; however, under the above circumstances these interventions are often required to keep the woman, baby and staff safe.

..injection by force ..//.. it was uncomfortable, yes, it was, but of course, I had worked for some years ..//.. but it was so dramatic, feelings of uneasiness.

Anger

Two of the nurses described feelings of anger at the Mom. One nurse experienced a great deal of anger in response to the woman who drowned her baby. This nurse also described feelings of guilt because the drowning occurred while the Mom was on a pass from the hospital. The second nurse described the anger she had in response to a woman's rejection of her child and her husband.

But we could not have noticed anything special with her, and we had so many thoughts and questions, and..."Good Lord, if we just had seen and understood... then we would have ..//.. well, what comes to you.. What the hell.. didn't I see this before it happened? Somehow that's the way you think... Oh, my God, here we are a lot of staff and nobody notices anything.

She also described the terrific burden and sense of responsibility the staff felt.

.. anger towards the patient too, that's how I felt, yes. And how is it possible to do so to her child ..//.. so we had much feelings against her, anger, and sorrow also. And we were also sad that we did not understand what was going on.

Anxiety

Two nurses expressed anxiety regarding their responsibility to keep the women and their babies safe. These feelings were described particularly when the women rejected their babies.

But often the women have a very extroverted chaotic behavior, hard to work with, creating much anxiety in both me and others .. //.. I had a lot of mixed feelings for her and these were creating anxiety in me ..//.. I think that a woman with post partum psychosis is able to create a lot of anxiety ..//.. I have learned to work with my own anxiety.

Happiness

One nurse described feelings of happiness when the women began to accept their babies and were able to return home. All of the nurses gave expressions of happiness and contentment with providing care for patients in general the more experienced they became.

But it gives me a great pleasure to see the family return home. Then I am happy as a nurse. And then it feels very, very good! Or when I see the mother, when she holds her baby the first time, and she cuddles her baby, and she doesn't treat the baby like a pillow or as something that is not there.

DISCUSSION

The aim of this study was to (1) explore psychiatric nurses' descriptions of women with PPP and to (2) explore nurses' responses to these women when providing care to women with PPP. The analysis of the interviews

included expected and unexpected descriptions of women with PPP, which are discussed below. Although the majority of the nurses had negative responses, some positive responses were also experienced.

Although a small sample from one culture can be considered a limitation the findings are illuminating. The open-ended approach of interviewing made it possible for the participants to speak freely about their experiences of providing care for women suffering from PPP. The sample size in qualitative research is less important than the content in the interviews as is the case in this study (Kvale, 1996). The nurses' descriptions were varying and rich, which could be explained by using the open-ended approach.

Since researchers' pre-conceptions can influence the analysis of interviews, the authors consistently tried to be conscious about their pre-conceptions during the analytic phase (Kvale, 1996). The interviewer was familiar with the research field and comfortable with the content (Morse & Field, 1998). One of the authors had no experience in psychiatric nursing which can be seen as an advantage during the analytic phase. Despite a strategically selected sample, the nurses had a rather limited experience of providing nursing care for women with PPP. The participants all together only had provided care for approximately 30 women with this illness. Therefore the range and frequency of symptoms described may have been affected as well as their description of their responses. However, this study does not claim to make any generalizations, but nevertheless the results can be transferred to similar situations and contexts.

All of the participants identified delusions as a symptom of women with PPP. This is one of the most prominent and classic symptoms (Brockington, 2004; Sit et al., 2006). It is not uncommon for delusions to be accompanied by confusion and aggression (Chandra et al., 2006; Hodelet, 2001). For women with PPP bizarre delusions frequently are related to the baby (Chandra et al., 2006; Ross et al., 2005). Another prominent symptom of PPP is disconnection with the newborn baby (Hornstein et al., 2006). It is possible that the nurses were able to identify these prominent symptoms because of their educational background and knowledge based on current literature. In an earlier study (Engqvist et al, 2007) the nurses stated that they try to assist the women in connecting with reality. Some of the women's delusions were reduced as a result of the sustained efforts by the nurses to interact with them and their babies.

The participants described the Moms as "being afraid of the baby" and "feeling no joy for the baby". Consequently none of the women described by the nurses were able to breastfeed their babies. It is important to note that breastfeeding is a cultural norm and expectation of women in Sweden (Ekstrom & Nissen, 2006). Since the maternal-infant bond is so important in this culture, women in Sweden with PPP and their newly born infants are sometimes able to be admitted together to support and maintain this bond.

Nurses stated the women could attack them. Violence on psychiatric units has been associated with a lack of the nurses' engagement with patients and an appreciation for their psychiatric disorders (Secker, Benson, Balfe, Lipsedge, Robinson & Walker, 2004). Following an incident on a

psychiatric unit where violence occurred, Secker et al. suggested a three-step approach: providing emotional support to the staff, facilitating critical reflection of the incident, and identifying new learning.

Another symptom five nurses recognised was self-absorption. This finding is consistent with earlier findings (Semprevivo, 1996). In an interview study conducted by this author with ten women diagnosed with PPP, the women described themselves as being totally self-absorbed and preoccupied with their delusions. This self-consuming experience overpowered any consideration of their relationship with their baby. Only one of the nurses described the connection between self-absorption, depression, suicidality and responses to internal stimuli.

Insomnia is a common symptom often seen when the psychosis is about to occur (Sharma, 2003). It is surprising that only two nurses described this symptom. One explanation for this finding might be that the nurses were not caring for the women at the initial point in their illness. Furthermore suicidality is a common symptom of this illness, even though only 5 % of the women actually act on their suicidal thoughts (Austin et al., 2007; Spinelli, 2005). Four nurses in this study identified this symptom and one can imagine that the symptom made great demands both on the nurses and the health care organization.

The nurses used the word “chaos” when describing the women. This term has not been found in the medical or nursing literature. This description is an important finding that may have relevance for other nurses caring for this population and may reflect the nurses’ clinical experience versus what

was learned in their formal education (White, 1995). Another interpretation is that it is an expression for the ‘voice of medicine’, used by Mishler (1984) as a metaphor for the medical discourse, the nurses are socialized to. In an earlier study (Engqvist et al., 2007), nurses described therapeutic interventions used when women with PPP were in ‘chaos.’ Some nurses used presence and sat next to the women with a quiet demeanor. One of the nurses stated that she calmed the patient down by being there and engaging her in communication related to her immediate needs.

An unexpected and interesting finding was the nurses’ description of some women having ‘strange eyes.’ This symptom has not been identified in the literature. Since the nurses who described this symptom had more than 10 years of experience, it is possible that these nurses observed this subtle symptom based on their clinical experience (Benner, 1984).

The nurses in this study identified a number of symptoms as well as other presentations not yet described in the literature. Given the severity of this illness it is important for nurses to build on their knowledge base and develop competencies to provide comprehensive nursing care. In addition to formal educational offerings, systematic clinical supervision has been an important vehicle for promoting critical reflection of nurses’ clinical practice. In the process of clinical supervision, the supervisor can provide ongoing education related to specific patients that the supervisee discusses. In the context of this trusting relationship, nurses also experience support which can decrease strain and burnout (Rice, Cullen, McKenna, Kelly, Keeny & Richey, 2007).

The nurses in this study described strong emotional responses towards the women with PPP. Eight participants described feeling sad when they cared for women who were disconnected from their babies. Descriptions of nurses' feelings of sadness and anxiety in relation to patients has been found in other contexts (Lundstrom, Astrom, & Graneheim, 2007). Caregivers' experiences of exposure to violence when providing services for people with learning disabilities, pointed to feelings of sadness. The nurses' feelings of frustration, anger and anxiety in this study contradict the positive attributes that nurses are expected to manifest according to nursing theories such as Watson's (1990) theory of caring or Peplau's (1997) theory of interpersonal relations. It is important to address these issues in nursing education and in clinical practice. Nurses must be prepared to recognize when they have negative responses towards patients and have systems in place to assist them when this occurs.

The nurses also experienced a great deal of anxiety given their responsibility of keeping the mother and baby safe. Although strong responses of sympathy, empathy and compassion were described by participants, the nurses' negative responses toward the women raises key questions about the need for education and supervision of nursing staff caring for this fragile population. Schroder, Ahlstrom & Larsson (2006) noted the importance of nurses having empathy and compassion for psychiatric patients. Communicating respect, understanding, and being a good listener were also identified as essential dimensions of nursing care.

These strategies of caring were also found in a study by Engqvist, Nilsson, Nilsson and Sjoström (2007).

When patients are self-absorbed, it is difficult for them to respond to nurses trying to connect with them on an emotional level. Maatta (2006) examined closeness and distance in relationships between patients and nurses. This author discovered that nurses can be overwhelmed by their closeness to their patients, and may find it difficult to maintain the professional distance and objectivity that sometimes is necessary. Psychiatric nursing arouses strong feelings and demands a great commitment from nurses. In this study, the nurses gave much of themselves, were committed to delivering high quality care, and experienced a range of emotions when providing care to women with PPP. The nurses stated that caring for this population was both challenging and rewarding.

CONCLUSION AND IMPLICATIONS

The nurses in this study recognized a kaleidoscope of symptoms of PPP. Most symptoms have been described in earlier literature except the description of 'strange eyes'. This finding might be a general psychotic symptom warranting further investigation. Since early detection of this illness is crucial for the women and their recovery, it is essential that psychiatric nurses providing care for this population have a solid knowledge base.

The nurses had a range of positive and negative emotional responses towards the women. This finding points to the importance of developing a structured systems approach, such as clinical supervision, to promote critical

reflection of nurses' clinical practice in psychiatric facilities. Through this process, psychiatric nurses can continue to build on their knowledge base, deepen their understanding of their responses to patients, and expand their repertoire of therapeutic nursing strategies to provide comprehensive nursing care to women with PPP.

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CONTRIBUTIONS

IE: Study design, data collection, analysis, and manuscript preparation

GF: Study design, co-analyser, and manuscript preparation

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REFERENCES

- APA. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychological Association.
- Austin, M. P., Kildea, S., & Sullivan, E. (2007). Maternal mortality and psychiatric morbidity in the perinatal period: challenges and opportunities for prevention in the Australian setting. *The Medical Journal of Australia*, 186(7), 364-367.

- Benner, P. (1984). *From novice to expert : excellence and power in clinical nursing practice*. Menlo Park, Calif: Addison-Wesley.
- Bertero, C. M. (1998). Transition to becoming a leukaemia patient: or putting up barriers which increase patient isolation. *European Journal of Cancer Care*, 7(1), 40-46.
- Born, L., Zinga, D., & Steiner, M. (2004). Challenges in Identifying and Diagnosing Postpartum Disorders. *Primary Psychiatry*, 11(3), 29-36.
- Brockington, I. (2004). Postpartum psychiatric disorders. *Lancet*, 363(9405), 303-310.
- Cantwell, R., & Cox, J. L. (2006). Psychiatric disorders in pregnancy and the puerperium. *Current Obstetrics & Gynaecology*, 16(1), 14-20.
- Chandra, P. S., Bhargavaraman, R. P., Raghunandan, V. N., & Shaligram, D. (2006). Delusions related to infant and their association with mother-infant interactions in postpartum psychotic disorders. *Archives of Women's Mental Health*, 9(5), 285-288.
- Currid, T. J. (2004). Improving perinatal mental health care. *Nursing Standard*, 19(3), 40-43.
- Ekstrom, A., & Nissen, E. (2006). A mother's feelings for her infant are strengthened by excellent breastfeeding counseling and continuity of care. *Pediatrics*, 118(2), e309-314.
- Engqvist, I., Nilsson, A., Nilsson, K., & Sjostrom, B. (2007). Strategies in caring for women with postpartum psychosis--an interview study with psychiatric nurses. *Journal of Clinical Nursing*, 16(7), 1333-1342.

- Friedman, S. H., Horwitz, S. M., & Resnick, P. J. (2005). Child murder by mothers: a critical analysis of the current state of knowledge and a research agenda. *The American Journal of Psychiatry*, *162*(9), 1578-1587.
- Glover, V., & Kammerer, M. (2004). The biology and pathophysiology of peripartum psychiatric disorders. *Primary Psychiatry*, *11*(3), 37-41.
- Hellzen, O., Asplund, K., Gilje, F., Sandman, P. O., & Norberg, A. (1998). From optimism to pessimism. A case study of a psychiatric patient. *Journal of Clinical Nursing*, *7*(4), 360-370.
- Hellzen, O., Asplund, K., Sandman, P. O., & Norberg, A. (2004). The meaning of caring as described by nurses caring for a person who acts provokingly: an interview study. *Scandinavian Journal of Caring Sciences*, *18*(1), 3-11.
- Heron, J., Robertson Blackmore, E., McGuinness, M., Craddock, N., & Jones, I. (2007). No 'latent period' in the onset of bipolar affective puerperal psychosis. *Archives of Women's Mental Health*, *10*(2), 79-81.
- Hodelet, N. (2001). Psychosis and offending in British Columbia: characteristics of a secure hospital population. *Criminal Behaviour and Mental Health*, *11*(3), 163-172.
- Hornstein, C., Trautmann-Villalba, P., Hohm, E., Rave, E., Wortmann-Fleischer, S., & Schwarz, M. (2006). Maternal bond and mother-child interaction in severe postpartum psychiatric disorders: is there a link? *Archives of Women's Mental Health*, *9*(5), 279-284.

- Howard, L. M., Goss, C., Leese, M., Appleby, L., & Thornicroft, G. (2004). The psychosocial outcome of pregnancy in women with psychotic disorders. *Schizophrenia Research*, 71(1), 49-60.
- ICD. (1974). *ICD-9-CM. International Classification of Diseases Clinical Modification - Mental Disorders and Glossary (9th revision)* WHO.
- ICD. (1992). *ICD 10. International Statistical Classification of Diseases and Health Related Problems (10th Revision)*: WHO.
- Jones, I., & Craddock, N. (2005). Bipolar disorder and childbirth: the importance of recognizing risk. *The British Journal of Psychiatry : The Journal of Mental Science*, 186, 453-454.
- Kaliski, S. Z. (2002). A comparison of risk factors for habitual violence in pre-trial subjects. *Acta Psychiatrica Scandinavica*, 106(s 412), 58-61.
- Krippendorff, K. (2004). *Content Analysis: An Introduction to Its Methodology* (2nd ed.). Beverly Hills, Calif.: Sage.
- Kvale, S. (1996). *Interviews : an introduction to qualitative research interviewing*. Thousand Oaks, Calif.: Sage.
- Levy, M., Sanders, D., & Sabraw, S. (2002). Moms who kill – when depression turns deadly. *Psychology Today*, 35(6), 60-66.
- Lindahl, V., Pearson, J. L., & Colpe, L. (2005). Prevalence of suicidality during pregnancy and the postpartum. *Archives of Women's Mental Health*, 8(2), 77-87.
- Lundstrom, M., Astrom, S., & Graneheim, U. H. (2007). Caregivers' experiences of exposure to violence in services for people with

- learning disabilities. *Journal of Psychiatric and Mental Health Nursing*, 14(4), 338-345.
- Maatta, S. (2006). Closeness and distance in the nurse-patient relation. The relevance if Edith Stein's concept of empathy. *Nursing Philosophy*, 7(1), 3-10.
- Marmion, S. (2000). Reflections on emotional disturbances after childbirth. *British Journal of Midwifery*, 8(9), 539 - 543.
- Mishler, E. G. (1984). *The discourse of medicine. Dialectics of medical interviews*. Norwood, NJ: Ablex.
- Morse, J. M., & Field, P. A. (1998). *Nursing research: the application of qualitative approaches* (2nd ed.). Cheltenham: Stanley Thomes Ltd.
- Munk-Olsen, T., Laursen, T. M., Pedersen, C. B., Mors, O., & Mortensen, P. B. (2006). New parents and mental disorders: a population-based register study. *JAMA : The Journal of the American Medical Association*, 296(21), 2582-2589.
- Nicholls, K. R., & Cox, J. L. (1999). The provision of care for women with postnatal mental disorder in the United Kingdom: an overview. *Hong Kong Medical Journal* 5(1), 43-47.
- Oates, M. (2003). Perinatal psychiatric disorders: a leading cause of maternal morbidity and mortality. *British Medical Bulletin*, 67, 219-229.
- Okano, T., Nomura, J., Kumar, R., Kaneko, E., Tamaki, R., Hanafusa, I., et al. (1998). An epidemiological and clinical investigation of postpartum psychiatric illness in Japanese mothers. *Journal of Affective Disorders*, 48(2-3), 233-240.

- Peplau, H. E. (1997). Peplau's Theory of Interpersonal Relations. *Nursing Science Quarterly*, 10(4), 162 - 167.
- Polit, D. F., & Beck, C. T. (2006). *Nursing research. Generating and assessing evidence for nursing practice* (8th ed.). Philadelphia: Lippincott Williams & Wilkins.
- Rice, F., Cullen, P., McKenna, H., Kelly, B., Keeney, S., & Richey, R. (2007). Clinical supervision for mental health nurses in Northern Ireland: formulating best practice guidelines. *Journal of Psychiatric Mental Health Nursing*, 14(5), 516-521.
- Robinson, J. (1998). Suicide: a major cause of maternal deaths. *British Journal of Midwifery*, 6(12), 767-767.
- Robling, S. A., Paykel, E. S., Dunn, V. J., Abbott, R., & Katona, C. (2000). Long-term outcome of severe puerperal psychiatric illness: a 23 year follow-up study. *Psychological Medicine*, 30(6), 1263-1271.
- Ross, L. E., Murray, B. J., & Steiner, M. (2005). Sleep and perinatal mood disorders: a critical review. *Journal of Psychiatry & Neuroscience*, 30(4), 247-256.
- Schroder, A., Ahlstrom, G., & Larsson, B. W. (2006). Patients' perceptions of the concept of the quality of care in the psychiatric setting: a phenomenographic study. *Journal of Clinical Nursing*, 15(1), 93-102.
- Secker, J., Benson, A., Balfe, E., Lipsedge, M., Robinson, S., & Walker, J. (2004). Understanding the social context of violent and aggressive incidents on an inpatient unit. *Journal of Psychiatric and Mental Health Nursing*, 11(2), 172-178.

- Seeman, M. V. (2004). Relational ethics: when mothers suffer from psychosis. *Archives of Women's Mental Health*, 7(3), 201-210.
- Semprevivo, D. (1996). *The lived experience of postpartum mental illness*. (PhD. Diss.). Chicago: Rush University, USA.
- Sharma, V. (2003). Role of sleep loss in the causation of puerperal psychosis. *Medical Hypotheses*, 61(4), 477-481.
- Sit, D., Rothschild, A. J., & Wisner, K. L. (2006). A review of postpartum psychosis. *Journal of Women's Health*, 15(4), 352-368.
- Spinelli, M. G. (2005). Infanticide: contrasting views. *Archives of Women's Mental Health*, 8(1), 15-24.
- Stocky, A., & Lynch, J. (2000). Acute psychiatric disturbance in pregnancy and the puerperium. *Baillière's best practice & research. Clinical Obstetrics & Gynaecology*, 14(1), 73-87.
- Torrey, E. F. (1994). Violent behavior by individuals with serious mental illness. *Hospital & Community Psychiatry*, 45(7), 653-662.
- Tschinkel, S., Harris, M., Le Noury, J., & Healy, D. (2007). Postpartum psychosis: two cohorts compared, 1875-1924 and 1994-2005. *Psychological Medicine*, 37(4), 529-536.
- Ugarriza, D. N. (1992). Postpartum affective disorders: incidence and treatment. *Journal of Psychosocial Nursing and Mental Health Services*, 30(5), 29-32.
- Watson, J. (1990). Caring knowledge and informed moral passion. *ANS. Advances in Nursing Science*, 13(1), 15-24.

White J. (1995). Patterns of knowing: review, critique, and update. *Advances in Nursing Science* 17(4), 73–86.

Chapter Eight

Strategies in Caring for Women with Postpartum Psychosis – an Interview Study with Psychiatric Nurses

Paper III

Knowing how women with PPP experience their illness and how nurses perceive these women as well as their responses to the women's behavior, the next study was designed to seek knowledge about the strategies nurses used when caring for women with PPP. The aim of this study was to explore nursing strategies used by psychiatric nurses when they provided care for women with postpartum psychosis.

Knowing the seriousness of this illness (Brockington et al., 1988; Klompenhouwer et al., 1995; Schopf & Rust, 1994), it is important to understand how psychiatric nurses describe their strategies when caring for this population. Nearly two in 1000 newly delivered women are stricken by PPP (Kendell et al., 1987; Terp & Mortensen, 1998; Valdimarsdottir et al., 2009). While earlier studies point to the need for psychiatric care for these women to recover (Buist, 1997; Hagberg et al., 2008), knowledge of specific nursing strategies in caring for women with PPP remains limited (Gaskell, 1999; Ugarriza, 1992). This study was an attempt to fill the existing knowledge gap that exists.

As for the interview study described above, the criteria for participation was the same, i.e. psychiatric nurses, five years experience working on a psychiatric inpatient ward. Interviews with ten experienced psychiatric nurses were carried out.

**Strategies in caring for women with postpartum
psychosis – an interview study with psychiatric nurses**

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Abstract

Aim and objective. The aim of this study was to explore strategies in caring for women with postpartum psychosis used by nurses.

Background. The most serious type of psychiatric illness in connection with childbirth is postpartum psychosis. Nearly two in 1000 newly delivered women are stricken by postpartum psychosis. Most of these patients need psychiatric care to recover. While earlier studies point to the need for psychiatric care, knowledge of specific nursing strategies in caring for postpartum psychosis patients remains limited.

Methods. Interviews with ten experienced psychiatric nurses were carried out, transcribed verbatim, and an inductive content analysis was made.

Result. The main strategies for care found in this study were: a) To create a patient-nurse relationship and, b) To apply nursing therapeutic interventions. Presence, continuity and nurse-patient partnership contributed to create a relationship and incorporate the rest of the care team. To satisfy the patients' basic needs and feeling of security was the foundation of the nursing therapeutic interventions. Confirmation and giving hope were also used as nursing therapeutics as well as information to the patient and her relatives about her illness.

Conclusion. The conclusion of the study is that strategies used by nurses are a combination of general and psychiatric nursing approaches but there is a lack of specificity in caring knowledge for caring patients with PPP requiring further development.

Relevance to clinical practice: The result of the study indicates that it is important to organize the patient care for postpartum psychosis with continuity and consistency and to support the nurse to create a relationship and therapeutic intervention with the patient. The present study shows the importance of further developing specific nursing theories that can be applied when caring for patients with postpartum psychosis. It also shows the need for further pedagogical education for mental health nurses.

Keywords: caring, nursing, postpartum psychosis, puerperal psychosis, qualitative content analysis

INTRODUCTION

The most serious type of psychiatric illness in connection with childbirth is postpartum psychosis (PPP). This illness occurs in 1-2 women out of 1000 newly delivered women (Kendell *et al.* 1987, Okano *et al.* 1998), and is consistent across cultures (Brockington *et al.* 1988, Kumar 1994). According to Knops (1993), 5 percent of mothers with PPP commit suicide and 4 percent infanticide (Robinson 1998, Spinelli 2004, Lindahl *et al.* 2005). While pregnancy is generally a time of lowered risk for psychosis, the first month after childbirth shows greatly elevated risk (Brennan 1991, Buist 1997, Bewley 1999). Once afflicted with this illness, the risk if repeated incidents may reach as high as 50 percent for a subsequent childbirth (O'Hara 1987, Balcombe 1996, Terp *et al.* 1999, Robling *et al.* 2000, Jones & Craddock 2001). Adequate professional nursing care of women with PPP is of great concern for recovery and return to a normal life.

A characteristic of PPP is that it appears 1-8 weeks postpartum (mainly within the first 2-4 weeks after the delivery) and is a reactive psychosis, meaning that it begins in conjunction with a stressful life-situation, sometimes in combination with physical exhaustion. The onset usually occurs unexpectedly and abruptly without other warning signs except sleeping disturbances lasting a few nights (Ugarriza 1992, Bewley 1999, Sharma 2003, Sharma *et al.* 2004). Most researchers agree that PPP is often due to biological, hereditary, and hormonal factors (Kumar 1990). Clinical features for the illness are characterized by having great fear of caring for her baby and the woman may voice religious ideas that she usually does not. She

might also have “strange thoughts” such as fear of kitchen utensils, food, water or medicine combined with a constant intense feeling of not wanting her baby (Comitz *et al.* 1990). The mood may vacillate between agitation and despair sometimes within minutes. Aggressive fits with delusions about her child or her own body and hallucinations are often present (Jones & Venis 2001). Other symptoms are depression with suicidal and infanticide thoughts or mania.

The treatment must be adjusted to the type and severity of the psychosis. This could mean that some patients will recover spontaneously at home with support of relatives combined with outpatient care. Others may need admission to a psychiatric hospital (Klompshouwer *et al.* 1995). Generally administering of antipsychotic in small doses is used (Nonacs & Cohen 1998, Llewellyn & Stowe 1998). If the psychosis gets more serious, electric convulsive therapy (ECT) might be considered, especially if the woman is suicidal (Buist 1997).

The objective of care is to minimize interruptions in the initial mother-child bonding period in order not to disturb the child’s cognitive and emotional development (Jones & Venis 2001). Additionally, the relationship to her partner as well as to older children can be negatively influenced by the illness (Kumar 1990, Bågedahl-Stridlund & Ruppert 1998). The prognosis for PPP is generally good especially for those where the condition has developed within the first month postpartum. According to Balcombe (1996), Bewley (1999), Terp *et al.* (1999) most patients with PPP recover completely in a

matter of two to six weeks although some may develop chronic schizophrenia.

Robertson and Lyons (2003) found in an interview study that women who had had PPP experienced lack of normal feelings during their illness which persisted long after recovery. The interviewees described the illness as a life-changing experience and they used words like “old sense of self” as a marker for recovery. The women felt guilty that they could not fulfil their maternal role and also felt guilty that hospital staff rather than themselves or their family cared for their babies. They were afraid of the potentially detrimental effects the hospitalization could have on their infant’s development. The women also expressed shifting in their relationship with their partner and felt torn between caring for the baby and attending to their partner after illness. The relationship between the woman and her partner could change drastically along with their other family members and friends. The women generally felt lonely and isolated and described feelings of anger and frustration towards the health care system because of perceived lack of information and support for them and their families. The researchers presume that added support and information regarding the illness may help to reduce the stress on the relations with family members.

Gaskell (1999) describes in an eight article review that women with PPP often feel frustration and a sense of loss over discontinued breastfeeding when compelled to take medication, such as a mood stabilizer or Lithium. Women also felt guilty for not taking part in the baby’s earliest life due to their loss of memory. It is presumed that keeping the women and their babies

together may reduce this guilt. In this case, there needs to be a repeated risk assessment of this procedure. The nurse can support the bonding between the mother and her child through involving the mother by keeping a photo-journal and encouraging the mother to be present when events occur with her baby. Gaskell (1999) emphasizes the importance of giving intensive nursing care to help with hygiene and self care and to make sure the woman gets the food and fluid intake. Nursing care also should consist of imparting information about the illness, for the woman may feel a loss of identity and of low self-esteem due to the changes in mood and loss of memory which occurred. To give the woman a possibility of understanding herself and what has happened is an important part of her recovery. Also important is to involve the partner in the care and for the partner to have a role caring for the baby. Before the patient is discharged from the hospital the nurse should join the mother with the community psychiatric health teams.

According to Peplau (1952) the interaction between the nurse and patient is very important. Quality nursing care assumes a safe and supportive relationship with the patient and that both partners can communicate and understand each other's thoughts and feelings. For Peplau nursing should be a mature force and an instrument for education as well as a therapeutic process in the interpersonal relationship between patient and nurse (1988). A patient with psychiatric illness needs to have a nursing style characterized by trust in the patient's own capacity to develop and communicate confidence in her ability to change. Nursing should reflect feelings of acceptance, respect and for her "to be seen" (Peplau 1997).

In-depth knowledge of nurses' strategies in caring for patients with PPP remains limited in spite of the literature on this illness. The aim of this study was to explore strategies used by nurses in caring for women with PPP by nurse inquiries from three hospitals in the Southwest of Sweden.

METHODS

To study psychiatric nurses' experiences caring for patients with PPP, an explorative qualitative study was chosen focusing on the nurses' understanding of caring for these patients (Kvale 1996).

Informants

Ten nurses (nine female and one male) were voluntarily recruited from psychiatric departments in three hospitals in the Southwest of Sweden. Inclusion criteria were that the nurses were to have had special education in psychiatric nursing and at least 5 years of professional experience in this area. The study samples were strategically chosen to represent the specific experience of having met patients with PPP and were at the time of the interviews working with PPP-patients. They were all Registered Psychiatric Nurses with varying experience of nursing patients with PPP. The informants ranged in age from 35 to 60 years. Of the informants (9 females, 1 male), 8 were very experienced (≥ 10 years of professional experience), and 2 were experienced (< 10 years of experience).

Patients with PPP are usually admitted to the psychiatric ward, very seldom they are cared for at the maternity ward. The forms of caring for the PPP patients are mainly similar at the three hospitals. At admission the hospitals try to admit the child and the father as well, but if not so the father

cares for the baby at home. Rarely the baby is cared for at the maternity ward or the children's ward. The family could visit the mother regularly and for any length of time, and were encouraged to visit daily and to stay the whole day. With this mode of care the mother was encouraged to participate in her baby's care. The nurse assessed daily the woman's condition and how much she was able to be involved in the baby's care. The length of institutional care is usually between three weeks and three months.

Data Collection

To get in contact with the interviewees the head hospital psychiatrist initially were contacted and subsequently were given permission for the study. The next step was to contact the head-nurses in different departments via a letter of introduction which informed them of the nature and aim of the study. This letter also explained the methodology which included audio-taped interviews with experienced mental health nurses to later be transcribed verbatim and analysed. Within a week these head-nurses were contacted and asked for their voluntary nurses participating in the study. The interested nurses were contacted by telephone and an interview time was decided upon. The interviews took place in three different hospitals in the South West of Sweden. Before the interview started, the informants once again received information about the aim of the study and were given the possibility to withdraw. The audio-taped interviews lasted from 45 - 75 minutes. The study data were collected by one of the authors (IE) through interactive and probing semi-structured interviews aimed at helping the nurses recall and articulate fully her or his experience and understanding of caring for patients with PPP.

The informants were first asked some general questions about previous professional experience followed by open-ended questions concerning their subjective experience of caring for patients with PPP: Some examples of the questions asked were, “Describe what you did in an incidence in which you cared for a patient with PPP.” “What have situations where you have cared for women with PPP taught you?” These questions were followed up by a series of direct short-ended questions used to probe for accuracy, clarity, and further detail when needed. In subsequent questions the interviewer tried to receive an answer to how caring for patients with PPP differ from caring for other psychiatric patients.

Data Analysis

The interviews were analysed by a content analysis (Morse & Field 1998, Graneheim & Lundman 2004). The process of analysis began with listening to the audio-tapes, acquainting oneself with the data and then reading and re-reading the transcribed texts to identify the meaning of what was said. Keeping the aim of the study in mind data was examined by identifying relevant sentences, phrases or particular examples and anecdotes. The next step in the coding phase was used to arrange data into emerging themes. The description of the discerned themes was explored until it captured the nurses’ experiences of their caring for the PPP patients. Attempts were then made to include sufficient data to support these descriptions. The final description was derived from reflection upon the data that lead to intuitive insight, and a universality of meaning related to this experience.

Ethical approval

The recommended ethical considerations for qualitative research have been considered in this study. The fundamental ethical demands for the individuals such as informed consent, confidentiality, and right use of the findings has been followed. Approval for this research was obtained from University of Gothenburg's Ethical Committee (No. 0. 155-03).

RESULTS

The result describes how nurses use their knowledge in nursing when caring for women with PPP. To give a deeper description of the result it is presented in two themes with accompanying sub-themes (see table 1).

Table 1 Nurses' strategies in caring for patients with postpartum psychosis

Main themes	Sub-themes
To create a patient-nurse relationship	Being continuously present
	Form a partnership with the patient
	Connecting the patient to the care team
To apply nursing therapeutic interventions	Satisfy basic needs and provide a sense of security
	Giving confirmation and hope
	Reconnect the patient to reality
	Informing the patient and her relatives about PPP

To create a patient-nurse relationship

Being continuously present

The nurses said that it is important to be physically present and close to the patient, to sit beside her, give physical touch and by putting her arms around her so that the patient can see and feel the presence of the nurse.

Psychological presence is to show interest in the patient and to give her full attention, even through periods of silence. The nurse would be at hand for the patient's needs such as when she acts out emotionally. One of the nurses in the study said that she calms the patient down by being there and engaging in communication with her, or staying there just being quiet. These behaviours are important for the patient according to the nurses.

...and I try to be close ...//.. and are touching them and so, as I have been ...//..not to abandon the woman when she comes to the hospital, but to be close as much as possible, you need not talk or inquire too much, but only to be there...//..they just don't have any strength, they are just there.

Nursing care for the patient also consists of being the person that stands for continuity. For example, the same nurse who comes with food and drinks also administers the medication. When the patient is conferring with the doctor, the nurse is present but also speaks privately with the patient. In conferences with the doctor, patient, spouse, nurse and others, and in chaotic situations, the patient will have a sense of continuity by the nurse's continued presence.

..what we did there was to be continuously present - just

there...and I have to be sure where I stand myself, so I have the strength to remain, where I am. And the more experienced I become, the more stability I can give.

Form a partnership with the patient

According to the nurses in this study, a partnership between the patient and nurse is crucial to reach a beneficial therapeutic result. This partnership facilitates the patient's participation in planning care and treatment such as decisions about privileges she might receive and whether she may go for walks alone.

Every patient has her own treatment plan which is done with the patient, the doctor and nurse. This is good for you, this you can get help with, and this is done together, a working alliance...then she gets a working alliance to take walks by herself, she has to tell us if she feels well, and if she doesn't feel well she is supposed to tell the nurse so we can help her.

The nurses find that they need to address the relationship between the woman and her child. By the nurse setting an example when changing diapers and holding and talking with the baby, she becomes a model for the patient of how to care for her baby and helps her to feel more secure in caring for her child. The nurse can improve the relationship between the mother and child through talking to the patient about her child and by so doing shows how much the baby is in need of her mother.

..in the beginning I don't say so much about the baby, but I wait until she says something first...the husband has been here with the

child, so I say... "oh, how sweet he is" or "what a fine little boy",
and by so doing I try to encourage this type of contact.

Connecting the patient to the care team

Cooperation among several participants in the treatment team is needed to care for the patient. In the beginning of the illness there should be cooperation between the psychiatrist and the gynaecologist, the nurse and the midwife and other staff at the maternity ward. As the psychiatric nurse's specialty is not breast-feeding and cares of the baby, she then turns to the midwife for support in these areas. In this way, the nurse acts as a link between the patient and the midwife by exhibiting close cooperation for the mother and baby's sake.

Rather immediately we started a collaboration with the delivery ward, which was situated just across us...so the doctors talked to each other and we with the midwives...and the best was, I think that it is possible to cooperate around a patient's sake with all the different staff and the varied areas of expertise...they could give us a call so we could support them, when they cared for the baby...the woman was admitted to the maternity ward, they had a room outside the ward itself, so you didn't enter the ward.

At the last part of the patient's hospital stay the nurses in the study said they serve as links to several people such as psychiatric outpatient care staff and the paediatric nurse in order to ease the situation for the patient when it is time for non-institutional care. The nurse gives very thorough descriptions to these professionals about the patient and her child's condition and

discusses how to help and support the woman after being discharged. The nurse may also suggest treatment in a mother-infant treatment center or psychiatric rehabilitation center after discussing with the psychiatrist. If the patient is in need of social welfare such as domestic aid, the nurse will contact the social worker in charge to discuss additional aid and support. The nurse tries to build a network of support and help for the woman and her family.

We have a team at the outpatient care only for patients with psychoses, and she got in contact with this team...there she was assigned a nurse to take care of her, and she could coordinate if there was a need for communal help, and so...and that becomes a personal contact for her.

To apply nursing therapeutic interventions

Satisfy basic needs and provide a sense of security

At the beginning of the illness, the patient, according to the nurses in the study, generally has difficulty taking care of her basic needs and therefore needs extra support. The nurse assists in extracting excess breast milk from the woman, helps with hygiene, and makes sure that the patient looks presentable. The nurse is responsible for the patient's meals and brings it to the patient in her room. The nurse is involved in helping with the shopping and other tasks. In general, the more the patient recovers, the less the nurse needs to support these basic needs.

Yes, in the beginning we helped her to take showers, to wash her hair and we made sure she looked nice, we helped her to extract the

breast milk because she didn't do this herself. //..and we helped with her food, and then she had to eat in her room and we sat with her, the whole time.//..they don't manage to dress, they don't manage to take a shower, and these are women who have been well functioning before.//.. we have to help them with everything. Later we made sure that she had fresh air and took walks. But the whole time, almost, we made sure to look after her.

According to the studied nurses, a part of their job is to create a secure environment for the patient. The nurse's aim for the patient is to have a single room, the surroundings of which should be calm and quiet in a secluded area of the ward. The nurses report that they try to restrict the patient to fewer stimuli, meaning that she is less disturbed by others, except for the presence of the nurse. Other restrictions that make the patient feel secure are for her to stay in her room, eat her meals there and have all activities during the day in isolation. This is done to protect the patient from potential shameful behaviour, which she might later regret, and feel embarrassed by. A psychotic patient might say things and behave in a way she would never do when she is well, and this restriction can be done not only to patients with PPP, but to every psychotic patient. This can be done without offending the patient. A nurse tells about a patient rushing on to the ward naked, in and out in other patient's rooms, shouting and screaming using an abusing language. Also patients wanting to jump from windows, wanting to tear her hair off and with behaviour like this finally confined to her room. In cases like this there is always one of the staff keeping close

observation beside the patient constantly, and sedative medication is given. In creating a secure environment, the nurse gives time and attention to the patient which may entail just being and sitting silently with her.

..to create a secure surrounding...it has to be calm around, rather quiet with few stimuli...a single room...to give her time and to stay with her...maybe not always through a lot of talk, but through being with her.

Reconnect the patient to reality

The nurse frequently speaks with the patient trying to reconnect her to reality when psychotic. The nurse attempts to have the patient understand what is going on here and now hopefully bringing her back to reality. The nurse may suggest that her experiences and delusions may be due to recent sleep disturbances. The patient's delusions can be reduced by the nurse's attempt to have the patient reconnect with reality. She may explain that these experiences are temporal and connected with her illness and that other people see reality different from the way she does in her present state.

..when they are not in reality...maybe I say that this is the way you experience it now, but I don't see it that way...I try to neutralize it a bit, not to talk about what is right or wrong, such that the patient is wrong, but to try in another way to explain to her, that this is not the way we see it. But this is the way you see it now when you are not feeling well. Or because you have not slept for three nights, then you can have experiences like this.

Giving confirmation and hope

According to the nurses in the study, a great deal of time is spent communicating with the patient. By so doing, the nurse affirms the patient's experience as a woman, mother and human being. The nurse reminds the patient that she is a mother and this is her child and she is the best one to care for her own child. The nurse can sit with the patient in her room just chatting, and then she takes the opportunity to tell her that she is the best mother and the only mother to her child. Also encourages her to have confidence in how important she is to her spouse. The nurse also reminds the patient about her older children, if she has any, and about her family. By so doing, the nurse gives the patient new courage and confirmation of how important she is for her child and family.

Yes, we confirmed the woman the whole time, not only as a mother, but also as a woman and a human being. You can not put another burden on somebody, who already carries a heavy load...and we confirmed her as a mother to the older child as well.

The nurse's contact with the patient entails giving a sense of hope for the future and for her recovery. This sense of hope extends to her partner as well as significant others. The nurse tries to convey her own experience in dealing with this illness and that the illness has an end.

..yes, my thoughts as a nurse is of course that I know this illness will end, this I have with me the whole time, and then I will try to infuse hope in her, both to the woman, her husband and her relatives.

Informing the patient and her relatives about PPP

One important aspect of communication is imparting information to the patient and her relatives. When the patient is transferred or admitted to the psychiatric outpatient care, the nurse generally gives information about the illness to the woman's partner. The information given to the husband and others in the family is imparted in order to reduce the fear that can accompany the knowledge of the loved one having this illness. The nurse "paints" a picture of the illness addressing the causes, symptoms, treatment and prognosis, and puts emphasis on the fact that when the woman is recovered she will be back to normal again. The nurse informs both the patient and her partner at the initial and later stages of the illness. This may include advice both before the patient is given a short leave from the hospital and before the patient is discharged. Nurse's guidance aims to reduce the husband's fear and might consist of recommendations to let the patient be in charge of her baby's care at home, or information about not being overprotective of the patient during her stay at home.

...he [the husband] gets, so to speak, information about psychosis. And how this illness starts, and what symptoms there are...if relatives want information as well, then they get it, BUT I always ask the husband first...I always put an effort on to inform so the mother wouldn't be too overprotected when she returns to her home. Yes, when the psychosis is over the person is normal, and that is important to see, and not be so afraid that the psychosis may return, and overprotect, but to give her the responsibility.

DISCUSSION

The aim of the study was to explore strategies used by nurses in caring for patients with PPP. Two main strategies were identified: a) To create a patient - nurse relationship and b) To apply nursing therapeutic interventions. The more detailed description of these strategies presented in the sub-themes show the complex qualifications of competent care that is needed in dealing with this particular group of patients.

While the described strategies for care may be seen to be too idealistic, it is necessary to remember that these strategies are the result of the nurses' statements during interviews, not what they may do in actual practice. In an interview, people say what they want to say at that moment (Silverman 2001). The sample size in this study could be seen as a limitation. The extensive and varying content in the interviews, however, contradict this risk of limitation. The semi-structured interview had an open approach which allowed the interviewees speak freely about their experiences. This fact is a good basis for assuming that the results are trustworthy (Silverman 2001). According to Kvale (1996), the analysis of the interviews can be affected by the researcher's prior understanding of the research field. Given that two of the authors had experience in psychiatric care prior to this study this could have been a problem with the analysis of the results. This risk was somewhat minimized by our awareness of this problem as well as the fact that two of the authors was devoid of any preconceptions given no prior experience in the field. Understandably, the authors' collaboration in the analysis demanded awareness of the researchers' subjective preconceptions as well as

of the preconceptions' potential effect on the interpretation of the interview text. This awareness helped to minimize the risk of reducing the variation of content of the themes and sub-themes when the authors strived for consensus during analysis (Morse & Field 1998).

Nurses should logically be using caring strategies for PPP patients that use specific theories relating to this illness. Considering the relative lack of well-articulated and research-based nursing theories for PPP patient care, the present study could be seen as helping to fill this need.

Creating a patient-nurse relationship is valuable (McCabe 2004, Dearing 2004, Shattell 2004, Hewitt & Coffey 2005) and in accordance with Peplau (1988) where she points to the importance of having a good relationship with the patient which acts as a therapeutic force. The nurse uses the relationship and applies a nursing therapeutic intervention of which communication with the patient is a crucial element. This communication often consists of imparting information to the patient and her relatives before the patient's discharge from the hospital. Communication as a basic tool for nurses (Kim 2000) could be seen as a general theory in nursing rather than a specific one guiding caring for patients with PPP. Communication in this study is used as a tool to bridge the gap between the patient and her child, partner and significant others as well as other members of the treatment team. Concerning caring for patients with PPP the communication does not only deal with information, explaining, reconnection to reality and confirming being a woman and a mother but also be about being quiet and just touch the woman's hand or give a hug (Gleeson & Timmins 2005). In that sense

communication could be seen as a specific therapeutic intervention caring for patient with PPP.

The nurse can benefit the patient through her knowledge and experience. From the nurses' statements in this study, a disparity was evident between how they imparted information and how they dealt with their interpersonal interactions. When talking about their interactions with the patient, their descriptions seem to indicate a more equal connection with her and an understanding for the patients needs. However, when talking with the patient and others about details concerning the illness, this close connection between the nurse and patient recedes and the information is relayed in a more formal and clinical way. According to what nurses report, it is not clear how sensitive they are about the patients' prior knowledge of the illness or if any attempt is made to gauge this when they inform the patients about PPP. The description in the sub-theme *Informing the patient and her relatives about PPP* indicates that the nurses inform patients instead of educating them. According to Peplau (1988) and Falk and Allebeck (2002), dealing with patients having a psychiatric illness should consist of building an interpersonal relationship in conjunction with the educating process. The importance of the nurses informing their patients about PPP is confirmed by Gaskell's review (1999). The lack of patient education reveals the nurses' shortcomings in pedagogic competence. These limitations in pedagogic competence relating to nurses have been observed earlier by Gedda (2001). The pedagogical relationship (the relationship of patient and nurse) includes, according to Gadwo (1999), embodiment, improvisation and

interdependence. This indicates the importance of teaching and finding ways of teaching in this reciprocal relationship. Consequently there is an obvious need for nurses to attain a more pedagogical attitude and to develop a pedagogical relationship in order to create a better patient-nurse relationship.

As could be seen in the sub-themes *Form a partnership with the patient* and *Informing the patient and her relatives about PPP* the nurses aimed for meaningful and extensive connections with the patients, the patient's children and their families. When applying nursing therapeutic interventions, the nurses used their knowledge to try to meet the patients' needs. This is in accord with what Lütznén and Nordin (1993) consider important. When the patient is first hospitalized, the nurse should use her knowledge and experience to make the patient's time in the hospital as comfortable as possible. The nurse should address the patient's basic needs and make an effort to initiate a relationship as a part of creating a beneficial patient-nurse relationship. She should do this in a detail-oriented way. Fulfilling the patient's needs such as hygiene and nutrition is confirmed by Gaskell's findings (1999). To make the patient feel more secure calls for communicative interaction and an interpersonal relationship between nurse and patient (Hyvönen & Nikkonen 2004). This nursing style facilitates a trustful relationship (Peplau 1997) and thereby gives the patient a possibility to recover from PPP. But the close relationship to the patient with PPP also calls for awareness and caution relating to the distance and closeness in connection between her and the patient in relation to her retaining her objectivity and professionalism in dealing with the patient. Carlsson *et al.*

(2004) found in their study of patients with violent behaviour problems in balancing between closeness and distance. Transferring this, one can see the potential importance in dealing with patients with PPP. The balance between presence and distance is needed in order to initiate and maintain a relationship in the encounter with patients with PPP, and which also require professional competence.

The results of the study points to the importance of helping the patient accept her child, assisting her in building a good relationship and creating a strong early bond with her child. This result is confirmed by Semprevivo and McGrath (1990) who finds that mother-child bonding and reducing time of forced mother-child separation is crucial. At time of discharge, the nurse should cooperate, according to Gaskell (1999), with different people such as the outpatient care team, the pediatric nurse and social welfare workers.

Several of the respondents have indicated the situation of an illness relapsing within a few weeks. This shows the importance of keeping a close eye on the patient and her baby. On the other hand, this might compromise the integrity of the patient which the nurse must be aware of when performing care (Meleis 2005). The nurses in this study are generally aware of the suffering PPP entails as well as the patient's typical initial disinterest in her child. The nurses try to diminish this problem by involving the patient in the care of her baby. The patient may improve her relationship with her child resulting in as little disturbance as possible in the initial mother-child bonding period (Jones & Venis 2001). According to Robertson and Lyons (2003) patients with PPP were generally angry and frustrated towards the

health care system due to lack of information and support during their time of illness. The present study indicates that the nurses' informing the patients and their next of kin should contribute to the patient's positive experience of the health care system and its staff. But according to Robertson and Lyons (2003) this is not the case as the patients think they get too little support while according to our study the nurses spoke about much support, affirmation and giving hope. What the nurses said they gave, the patients do not experience they get according to the Robertson and Lyons study.

The result emphasizes the complexity of the nursing therapeutic relationship when caring for patient with PPP. In caring for the patient, the nurses' negative reactions towards their patients had a significant and sometimes intense impact. Despite them doing this, the nurses point out the significance of not additionally burdening the women more than necessary. Normally, the nurses said they tried to create an environment full of compassion, sympathy, and tenderness. That shows that the nurses have intention to use their psychiatric nursing knowledge in a professional way. Peplau (1997) also mentions not insulting or ignoring a patient, but to give care that demonstrates feelings of acceptance, respect, and for her "to be seen." The results of the study show nurses' continuing contentment with this kind of work increasing over the years despite the psychiatric nurse being the one who is placed in the middle of all the commotion.

The conclusion of the study is that strategies used by nurses when caring for patients with PPP are a combination of general nursing and psychiatric nursing approaches but there is a lack of specificity requiring further

development. The nurses' knowledge in this study was general psychiatric knowledge directed to all psychiatric patients but knowledge specifically directed to PPP-patients has not been identified in detail. The nurses met these patients mainly in the same way as they met other patient with psychosis. The strategies used by nurses seem from the nurses' perspective to be adequate and functional for patients with PPP. Future studies are needed that relate to nurses' knowledge and strategies and to the adequacy of outcome from the patients' point of view. Different aspects of support and nursing therapeutic interventions need to be investigated further, and a deeper analysis of the impact of a patient-nurse relationship is required as well.

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CONTRIBUTIONS

Study design: IE, closely supervised by AN; Data collection: IE, with supervision by AN; Data analysis: IE, AN, KN. BS; and manuscript preparation: IE, KN, BS.

REFERENCES

- Balcombe J (1996) Postnatal depression: how can the distress be alleviated?
Nursing Times **19**, 29-33.

- Bewley C (1999) Postnatal depression. *Nursing Standard* **16**, 49-56.
- Brennan A (1991) The enigma of puerperal psychosis. *Nursing Standard* **6**, 33-36.
- Brockington I, Margison F, Schofield E & Knight R (1988) The clinical picture of the depressed form of puerperal psychosis. *Journal of Affective Disorders*. **15**:29-37.
- Buist A (1997) Postpartum Psychiatric Disorders: Guidelines for Management. *CNS Drugs* **8**, 113-123.
- Bågedahl-Stridlund M & Ruppert S (1998) Parapartum Mental Illness: A Long-Term Follow-up Study. *Psychopathology* **31**, 250-259.
- Carlsson G, Dahlberg K, Lützen K & Nyström M (2004) Violent Encounters in Psychiatric Care: A Phenomenological Study of Embodied Caring Knowledge. *Issues in Mental Health Nursing* **25**, 191-208.
- Comitz S, Comitz G & Semprevivo D (1990). Postpartum Psychosis: A Family's Perspective. *NAACOG's clinical issues in perinatal and women's health nursing*, **1**(3) 410-418.
- Dearing K (2004) Getting it, Together: How the Nurse Patient Relationship Influences Treatment Compliance for Patients with Schizophrenia. *Archives of Psychiatric Nursing*, Vol. **XVIII**, 5, 155-163.
- Falk K & Allebeck P (2002) Implementing assertive community care for patients with schizophrenia. *Scandinavian Journal of Caring Sciences* **16**; 280-286.
- Gadow S (1999) Relational narrative: the postmodern turn in nursing ethics. *Scholarly Inquiry for Nursing Practice* **13**, 57-70.

- Gaskell C (1999) A review of puerperal psychosis. *British Journal of Midwifery* **7**, 172-175.
- Gedda B (2001) *Den offentliga hemligheten. En studie av sjuksköterskans pedagogiska funktion och kompetens i folkhälsoarbetet.* [The official secret. A study of nurses' pedagogical function and competence in public health care.] (Diss). Acta universitatis Gothoburgensis, Göteborg.
- Gleeson M & Timmins F (2005) A Review of the use and clinical effectiveness of touch as a nursing intervention. *Clinical Effectiveness in Nursing*, **9**(1-2), 69-77.
- Graneheim U H & Lundman B (2004) Qualitative Content Analysis in Nursing Research: Concepts Procedures and Measures to Achieve Trustworthiness. *Nurse Education Today* **24**, 105-112.
- Hewitt J & Coffey M (2005) Therapeutic working relationships with people with schizophrenia: literature review. *Journal of Advanced Nursing* **52**(5), 561-570.
- Hyvönen S & Nikkonen M (2004) Primary health care practitioners' tools for mental health care. *Journal of Psychiatric and Mental Health Nursing* **11**, 514-524.
- Jones J & Craddock N (2001) Familiality of the Puerperal Trigger in Bipolar Disorder: Results of a Family Study. *American Journal of Psychiatry* **158**, 913-917.
- Jones H & Venis J (2001) Postpartum Psychiatric Disorders *Journal of Psychosocial Nursing* **39**, 23-30.
- Kendell RE, Chalmers JC & Platz C (1987) Epidemiology of puerperal

- psychoses. *Br J Psychiatry* **150**:662-673.
- Kim S (2000) *The Nature of Theoretical Thinking in Nursing*. 2nd ed.
Springer Publishing Company, New York.
- Klompshouwer J, van Hulst A, Tulen J, Jacobs M, Jacobs B & Segers F
(1995) The clinical features of postpartum psychoses. *European
Psychiatry*. **10**, 355-367.
- Knops G (1993) Postpartum Mood Disorders. *Postgraduate Medicine* **93**, 103-
116.
- Kumar R (1990) An Overview of Postpartum Psychiatric Disorders.
NAACOG's clinical issues in perinatal and women's health nursing. **1:3**,
351-358.
- Kumar R (1994) Postnatal mental illness: a transcultural perspective. *Soc
Psychiatry Psychiatr Epidemiolog*. **29**, 250-264.
- Kvale S (1996) *Interviews: an introduction to qualitative research
interviewing*. Sage, Thousand Oaks, Calif.
- Lindahl V, Pearson J & Colpe L (2005) Prevalence of suicidality during
pregnancy and the postpartum. *Archives of Women's Mental Health*.
8:77-87.
- Llewellyn A & Stowe Z (1998) Psychotropic Medication in Lactation.
Journal of Clinical Psychiatry, **59**(2) 41-52.
- Lützn K & Nordin C (1993) Benevolence, a central moral concept derived
from a grounded theory study of nursing decision making in psychiatric
settings. *Journal of Advanced Nursing* **18**, 1106-1111.
- McCabe C (2004) Nurse-patient communication: an exploration of patients'

- experiences. *Journal of Clinical Nursing*, **13**, 41-49.
- Meleis A I (2005) *Theoretical Nursing: Development & Progress* (3 ed.). Lippincott, Philadelphia, New York.
- Morse J M & Field P A (1998) *Nursing Research, The application of qualitative approaches*. WestKey Limited, Falmouth, Cornwall.
- Nonacs R & Cohen L (1998) Postpartum Mood Disorders: Diagnosis and Treatment Guidelines: *Journal of Clinical Psychiatry*, **59** (2) 34-40.
- O'Hara M (1987) Postpartum "blues", depression and psychosis: a review. *Journal of Psychosomatic Obstetrics and Gynaecology* **7**, 205-227.
- Okano T, Nomura J, Kumar R, Kaneka E, Tamaki R, Hanafusa I, Hayashi M & Matsuyama A (1998) An epidemiological and clinical investigation of postpartum psychiatric illness in Japanese mothers. *Journal of Affective Disorders* **48**, 233-240.
- Peplau H (1952) *Interpersonal Relation in Nursing. A Conceptual Frame of Reference for Psychodynamic Nursing*. MacMillian Education, London.
- Peplau H (1988) The Art and Science of Nursing: similarities, differences and relations. *Nursing Science Quartely* **1**, 8-15.
- Peplau H (1997) Peplau's theory of interpersonal relations. *Nursing Science Quartely* **10**, 162-167.
- Robertson E & Lyons A (2003) Living with puerperal psychosis: A qualitative analysis. *Psychology and psychotherapy: Theory, Research and Practice* **76**, 411-431.
- Robinson J (1998) Suicide: a major cause of maternal deaths. *British Journal of Midwifery* **6**, 767-768.

- Robling S, Paykel E, Dunn V, Abbot R & Katona C (2000) Long-term outcome of severe puerperal psychiatric illness: a 23 year follow-up study. *Psychological Medicine*, **30**, 1263-1271.
- Semprevivo M & McGrath J (1990) A select Psychiatric Mother and Baby Unit in Britain: Implications for care in the United States. *NAACOG's clinical issues in perinatal and women's health nursing* **1**, 402-409.
- Sharma V (2003) Role of sleep loss in the causation of puerperal psychosis. *Medical Hypotheses* **61**, 477-481.
- Sharma V, Smith A, & Khan M (2004) Brief report. The relationship between duration of labour, time of delivery, and puerperal psychosis. *Journal of Affective Disorders* **83**, 215-220.
- Shattell M (2004) Nurse-patient interaction: a review of the literature. *Journal of Clinical Nursing*, **13**, 714-722.
- Silverman D (2001) *Interpreting Qualitative Data Method for Analysing Talk, Text and Interaction*. Sage Publications, London.
- Spinelli M (2004) Maternal Infanticide Associated with Mental Illness: Prevention and the Promise of Saved Lives. *American Journal of Psychiatry* **161**:9, 1548-1557.
- Terp I, Engholm G, Moeller H & Mortensen P (1999) A follow-up study of Postpartum Psychosis: Prognosis and Risk factors for Readmission. *Acta Psychiatrica Scandinavica* **100**, 40-46.
- Ugarriza D N (1992) Postpartum Affective Disorders: Incidence and Treatment. *Journal of Psychosocial Nursing* **30**, 29-32.

Chapter Nine

Swedish Registered Psychiatric Nurses’ Descriptions of Presence when Caring for Women with Postpartum Psychosis – an Interview Study

Paper IV

When conducting the study exploring psychiatric nurses’ descriptions of women with PPP and their responses while providing care, as well as the study describing the strategies used when caring for women with PPP, it was determined that the word presence was used frequently by the nurses during their interviews. Therefore it was decided to conduct a secondary analysis of the data to examine how nurses described their use of presence.

Nursing presence is a concept that has been used and studied in different nursing contexts (Chase, 2001; Engebretson, 2000; Fingfeld-Connett, 2006, 2008a; Osterman & Schwartz-Barcott, 1996). Furthermore, this concept is an essential component in nursing, and has been described as a significant nursing strategy (Fingfeld-Connett, 2008b). Moreover, this strategy is utilized in all types of nursing (DeLashmutt, 2007).

The use of presence is considered very important in psychiatric nursing since patients are fragile, vulnerable and very dependent on nursing care (Handsley & Stocks, 2009; Semprevivo, 1996). Since PPP is one of the most serious types of psychiatric disorders (Brockington, 1996, 2004a, 2006;

Brockington et al., 1988; Cantwell & Cox, 2006; Grigoriadis & Romans, 2006), it is important to develop knowledge about nursing presence in relation to the context of caring for women with this disorder.

**Swedish registered psychiatric nurses’
descriptions of presence when caring for women with
postpartum psychosis – an interview study**

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ABSTRACT: *The concept of nursing presence has been widely used in nursing and is a significant component of nursing practice. In order to increase our understanding of nursing presence it needs to be studied in different contexts. In this study a secondary analysis of interviews with ten registered psychiatric nurses (RPNs) in Sweden was conducted to explore nurses' descriptions of presence when caring for women with postpartum psychosis. Based on the research question 'How do RPNs describe nursing presence in the context of caring for women with PPP?' content analysis was used to analyze the data. Three categories emerged: the use of presence to protect, the use of presence to facilitate recovery and the use of presence for learning. The findings underscore the importance of recognizing nursing presence as a strategy to improve psychiatric nursing for the benefit of the woman and her child, and as an important part of psychiatric nursing when providing compassionate and effective nursing care to this population.*

KEY WORDS: caring, nursing, nursing presence, post-partum.

INTRODUCTION

The concept of presence has been widely used in nursing. It is a component of several nursing frameworks, and is recognized as extremely significant in nursing practice (Chase 2001; Engebretson 2000; Fingfeld-Connett 2008a; Osterman & Schwartz-Barcott 1996). Nevertheless, it is a concept that is still poorly understood and often combined with other concepts such as nursing and caring (Fingfeld-Connett 2008a; Osterman 2002). Fingfeld-Connett (2008a) completed a qualitative meta-synthesis of presence, in order to further clarify this concept, where presence and caring were identified as being essentially the same processes. From the nurses' perspective, the antecedents of the process of presence were found to be willingness, personal and professional maturity, moral underpinning and a conducive work environment. Furthermore, the attributes of the interpersonal process of presence were characterized by sensitivity, holism, intimacy, vulnerability and uniqueness. Presence combined with caring can be seen as a deliberate therapeutic process, resulting in the patient's improved mental and physical wellbeing. Based on her work related to the concept of presence, Fingfeld-Connett (2008b) asserts that nursing presence needs to be studied in different contexts, as different practices include various patient-nurse interactions as well as nursing activities.

Furthermore, presence has been described in the nursing literature as increasing patients' feelings of safety and security (Osterman 2002), facilitating positive coping (Fingfeld-Connett 2006) and contributing to

patients' recovery (Covington 2003). Patients have also described feeling "cared for" when nurses use presence (Finfgeld-Connet 2008a).

Only a few research studies have been conducted to examine the use of presence in nursing practice. In an empirical study of women with high-risk deliveries, Berg (2005) reported that emotional and physical nearness and availability of the nurse was necessary to maintain the women's dignity. Presence meant closeness in a physical, psychological, emotional and spiritual sense, and included nearness in terms of time, space and amount. Hegedus (1999) conducted a study using a questionnaire that concerned patients' opinions of nurses' caring behaviours. Patients ranked nursing presence, i.e. staying with the patient, or comforting them by talking, or in silence, as a very important item and this enhanced recovery from illness. In an interview study of women with postpartum psychosis, Semprevivo (1996) found that the presence of the registered psychiatric nurse gave women a sense of security when they felt disoriented and unable to care for their infants. The women felt that it was possible to cope with their difficult situations when the nursing staff were present, and identified nursing presence as one of the most helpful components in the treatment of their illness. The use of presence by the nursing staff provided the women with a safe and secure haven in the midst of their destructive thoughts about harming themselves or their infants. In an earlier study by Engqvist et al. (2007), Swedish registered psychiatric nurses (RPNs) described being continually present as a strategy when caring for women with postpartum psychosis (PPP). Therefore, a secondary analysis of the interview data was

completed in order to contribute to a deeper understanding of nursing presence as a strategy used by the psychiatric nurses when caring for women with PPP.

It is important to develop knowledge concerning nursing presence in relation to caring for women with PPP, as this illness is one of the most serious types of postpartum psychiatric disorders. PPP occurs in 0.1-0.2 % of newly delivered women (Brockington 2004; Valdimarsdottir et al. 2009; Spinelli 2009), with an incidence of 5% for suicide and 4% for infanticide (Knops 1993; Lindahl et al. 2005). The onset of PPP is usually rapid, as early as 1-3 days immediately after childbirth, with 22% occurring on the first postpartum day (Heron et al. 2007; Okano et al. 1998). The woman presents with paranoid, grandiose, or bizarre delusions that are usually associated with the baby, mood swings, confused thinking, anxiety and/or panic, and grossly disorganized behaviour that represents a dramatic change from her previous level of functioning. The combination of psychosis, lapsed insight and poor judgment can lead to devastating consequences, whereby the safety and wellbeing of the mother and her baby are jeopardized (Friedman et al. 2005; Hornstein et al. 2006; Seeman 2004).

The aim of this study was to explore RPNs descriptions of presence when caring for women with postpartum psychosis.

METHOD

A secondary analysis was conducted on the data collected from an earlier study that described the strategies used by Swedish psychiatric nurses caring for women with postpartum psychosis (Engqvist et al. 2007). The reason for

this secondary analysis was that the RPNs' utterances gave an impression that questions concerning nursing presence could be answered. The original study investigated care of women with PPP from the RPNs' experiences. The qualitative design in the original study was chosen, as this approach provided the opportunity to describe an unknown phenomenon in natural settings and from an emic perspective (Silverman 2001; Polit & Beck 2006).

Participants

The convenient sample in the original study (Engqvist et al. 2007) consisted of ten RPNs (nine females and one male) who were voluntarily recruited from three psychiatric centers in Sweden. In order to participate in the study, the RPNs needed to be specially trained in psychiatric nursing (at Master's level) with at least 5 years of professional experience in this area. These RPNs were strategically chosen to represent the specific experience of having cared for patients with PPP. The nurses' average age was 54 years and average years in the profession 16 years. The number of patients with PPP they had cared for ranged from 2 up to about 10.

Data Collection

The original study (Engqvist et al. 2007) was approved by the Ethics Committee of Göteborg University (No. 0. 155-03). Informed consent was obtained from all the participants, in accordance with the Declaration of Helsinki. This means that they were informed about the aim of the study, method of data collection, voluntary participation, opportunity to withdraw at any time, and the fact that data would be treated confidentially (World Medical Association 2002).

After the chief psychiatrists at the centres had been contacted and had subsequently given their permission for the study, an introductory letter describing the study was sent to the head nurses in the different departments. This letter explained the aim and methodology of the study. They were then contacted by telephone one week later and asked if they could inform the RPNs at their units about the study. A list of ten interested RPNs was provided by the head nurses. These RPNs were contacted by telephone and individual interviews were scheduled. The audio-taped interviews, lasting 45-75 minutes, were conducted in a private room at the RPNs' clinical units.

In the initial study, the participants were first asked some general questions about previous professional experience, followed by questions concerning their experience of caring for patients with PPP. To make the descriptions of caring more explicit, supplementary questions were asked, such as: 'Can you explain?' or 'Can you tell me more about that?'

Data Analysis

The secondary analysis of the transcribed interviews was based on the following research question: 'How do RPNs describe nursing presence in the context of caring for women with PPP?' Manifest (i.e., what the text says) and latent (i.e., what the text is about) content analysis were used (Graneheim & Lundman 2004). In the first step of the analysis process we began by listening to the audiotapes to obtain an overview of the interview in its entirety in relation to the research question. In the next step, the transcribed interviews were read a number of times to identify what was said about presence. In the third step, meaning units (i.e. relevant words, sentences and

phrases) were identified. The analysis then proceeded by condensing the meaning units, making them shorter and easier to understand.

Table1. Examples of meaning units, condensed meaning units and codes.

Meaning unit	Condensed meaning unit	Code
I was present as a protection for the woman herself, she was so sick	Nurse's presence as protection for the woman	Presence as protection for the woman
If I give my presence in the early encounter, then I can later on more easily build an alliance or relationship	Presence creates an alliance or relationship	Presence to establish relationships

The condensed text was then abstracted and labelled with a code. The codes were then compared for differences and similarities, and divided into groups. By this process of comparison, three categories with additional sub-categories were identified.

Table2. Examples of codes, sub-categories and categories.

Codes	Sub-category	Category
Presence as protection for the woman	Protecting the woman from self-destructive behavior	The use of presence to protect
Presence to establish relationships	Building a relationship	The use of presence to facilitate recovery

The descriptions of the discerned categories were explored until they captured the nurses' experience of their nursing presence. Attempts were

then made to include sufficient data to support these descriptions.

RESULTS

RPNs' descriptions of nursing presence in caring for women with PPP are presented in three categories with accompanying sub-categories (Table 3).

Table 3. Overview of main categories and sub-categories.

Main categories	Sub-categories
Use of presence to protect	Protecting the woman from self-destructive behavior Protecting the baby Protecting the woman from degrading herself
Use of presence to facilitate recover	Creating a calming environment Building a relationship Providing hope Managing daily life Normalizing reality Facilitating bonding
Use of presence for learning	Learning from being present Learning from the psychotic mind

Use of presence to protect

The RPNs stress the importance of being physically present and in close proximity to the women. The more time they spend with the women, the more they are protected. The nurses' presence also protects the newborns. As the RPNs talk with the women about what is happening in the here and

now, they try to help them to stay connected with reality. As the women recover the degree of physical presence from the RPNs are reduced and the relationship turns into something else, where trust and confidence is, and so the women increasingly are capable of being apart from the RPNs.

Protecting the woman from self-destructive behaviour

When the women use self-destructive behaviours, the nurses spend as much time as possible with them; at times it is necessary to follow them around everywhere, and to stick with them 'like glue'. Sometimes, when a woman has a desperate urge to hurt herself, the RPNs sit beside her and soothe her, sometimes even rocking her like a baby. When the RPNs are present, the women's desire to hurt themselves appears to decrease.

We sat with her and did not dare to leave her alone. We were afraid she would hurt herself. She broke glass into pieces and she wanted to cut herself with it. She was so sick and it was hard to sit with her. We were afraid that she would hurt herself, but we tried to be present with her to instill security in her.

If the women are very sick, anxious, violent, and worried, the RPNs stay with them, talking to them softly, trying to comfort them, and keeping them confined to bed.

Sometimes they have no strength left but are so worried, so anxious, and we have to stay with her and try to keep her down in her bed, calming her down, and we will have to deal with her like a baby herself.

Protecting the baby

When the baby stays with the mother and the mother takes care of her baby, the RPNs are present to protect the woman and the baby, in order to prevent a tragedy from occurring. If the woman is uncertain about how to treat and care for the baby, the RPNs help and become a role model for the mother.

The nurse is present with the patient to protect, well, in fact, to protect both the mother and her child. Of course, it would be a tragedy for the mother when she recovered, if something would have happened to her baby, if she had hurt her baby.

Protecting the woman from degradation

In the acute phase of the illness, when the women are psychotic, the RPNs are present, trying to protect them from embarrassing behaviour. This protection consists of being with the women in a secluded area of the ward and restricting them to their room when necessary. The RPNs stay with the women, talking, reading, and listening to the radio or music with them.

We tried to give her security as best we could throughout the whole time we took care of her. We were always at hand for her, but we also restricted her and kept her to her room. Only a few of the RPNs spent time with her and sat with her. We did this to save her from embarrassing behaviour and so that she wouldn't be ashamed afterwards.

Use of presence to facilitate recovery

The RPNs state that presence is a way of helping women recover from and cope with their illness. Presence facilitates a positive relationship with the

women, easing their need to remain hospitalized. The nurses care for the women by sharing positive experiences such as looking at a paper or magazine with baby clothes or toys. The RPNs emphasize the importance of spending time and relating with the mother in a way that is similar to friendship. Friendship does not require constant physical presence and as the women recover the constant physical presence turns into an intermittent presence of the RPNs.

Creating a calming environment

The RPNs state that their presence helps to maintain an environment that is calm and relaxed. A calming environment is particularly helpful when the women are in a manic state. The presence of the RPNs, music and speaking softly helps the women to calm down.

Well, mostly it was like this, that we had to sit with her all the time and soothe her. We gave her one-to-one care some days, and we were present there, just sitting and talking with her, just trying to be like a sister to her.

Building a relationship

As the women and the RPNs spend increasing amounts of time together, a trusting relationship is formed. This therapeutic relationship grows over time, supporting the women as they move from acute illness to recovery. The use of silence combined with the RPNs' presence communicates empathy, and the patient feels safe and well cared for.

If you stay with the woman, I've noticed that she becomes much safer in the encounter, and later on when she's getting better, you

notice that through this early presence you can build an alliance with her, without words. Calmness and security – that's what it gives.

Providing hope

To comfort the women, the RPNs give them their time, not always talking, but just being there, staying with them. The fact that the RPNs are present as fellow human beings gives the women security and confidence, and instill hope for the future, comforting them about an illness that will end, and reassuring them that there is a future.

We sat with her and tried to get her to have confidence in us, so that she understood that we stood for 'the good', and that we cared about her. We brought her food and care, and we thought of her family. And the acts of care that we contributed consisted of being present, providing continuity in that very moment. And we tried to create security so she could return home to her small children there – those she separated herself from.

Managing daily life

In the acute phase of the illness, when the women are not able to take care of themselves, the RPNs help them meet their basic physical needs, including taking showers, brushing their teeth, assisting them with dressing and accompanying them to meals.

The nurse is there and tries to keep the mother reality-based and bring her back to reality. And helping her with practical things like

taking a shower and brushing her teeth... and so on. But reality-based – here and now.

Normalizing reality

In the context of building a close relationship with the women through presence, the RPNs try to help the women stay connected to reality. Having conversations about normal and everyday life, such as talking about the baby, the woman's spouse and or family, the weather and the season, are particularly helpful. When the women have delusions, the RPNs confront them with reality in a gentle way, trying to reduce some of their suffering.

Well, in talking about what is real, and saying: "Maybe you experience these things, but I see it this way", trying to reduce her delusions to some extent, and not telling her that she is wrong, but toning it down a bit...

Facilitating bonding

One of the most important responsibilities of the RPNs is to promote and support maternal-infant bonding. By being with the woman as she tries to care for her baby, the RPNs decrease the woman's fear of hurting her baby. As a role model, the RPNs can show the mother how to hold and feed the baby, as well as change diapers and sing lullabies.

I always try to help the woman to get a good relationship...to bond with her baby...//...and I usually sit and talk a lot about the baby, and I make sure the woman gets to spend a lot of time with her baby, as much as possible.

The use of presence for learning

The RPNs recognize the importance of staying with and close to the women when they are admitted. This intervention keeps the women safe and communicates to them that they will not be abandoned. As a result of this vigilance, the RPNs learn more about PPP and women's reactions to their illness. According to the nurses, closeness demands professional competence. As their experience with psychiatric patients increases, they learn how to maintain this closeness in the midst of the women's suffering.

Learning from being present

The close and continuous contact that the RPNs have with women during the acute phase of their illness is maintained throughout the women's hospital stay. As a result of their relationship with the women, the RPNs learn that even in the midst of their psychosis, these women are vulnerable, sensitive, and can be easily offended and require a firm but kind approach. As they reflect on their practice, the RPNs develop a deep respect for these women and are humbled as they witness the women's emotional pain.

What I have learned from these patients is that these are vulnerable people, vulnerable and sensitive people, often very intellectual. They are often very gifted people, but at the same time very vulnerable. They are more sensitive, thoughtful, easily offended and insulted. But they are also very kind and very interesting people.

Learning from the psychotic mind

The RPNs caring for these women have to deal with their own anxiety resulting from witnessing the women reject their newborn and their spouses. Providing care for this acutely psychotic population is described as a great privilege by the RPNs; questions about the fragility of life are raised. They learn about delusions, rejection, aggression, suicidal and homicidal ideations and the suffering that occurs with psychosis.

These women are so interesting...//...to be able to sit down and talk to a person in a psychosis – and not try to get her to leave it, but try to walk with her in her own ‘world’ – I think that is a fantastic event that can only happen when you are very close to the patient.

DISCUSSION

The aim of this study was to explore RPNs' descriptions of presence when caring for women with postpartum psychosis. Three categories were described: *The use of presence to protect*, *The use of presence to facilitate recovery* and *The use of presence for learning*.

In this study, the RPNs stated that nursing presence is an important dimension of nursing practice. Their working hours mostly consisted of time together with their patients; in other words, RPNs talked about presence as physical presence. However, this is a unique time for the women and the RPNs, and can be a time of great quality which deepens the relationship on which the care is based. Thus physical presence can be seen as a prerequisite for the interpersonal process of presence (Finfgeld-Connett 2008a). When a patient with PPP is admitted, the nurse often spends long hours with her, and

may need to provide one-to-one care based on the doctor's orders. Every effort was made to have the same nurses assigned to the woman on all three shifts to maintain continuity. This is in accordance with an interview study by Rooney (2009), where RPNs who were on duty with one-to-one care were interviewed. It was found that staying close to the patient was perceived by the RPNs as worthwhile, but was not always appreciated by the patients.

When the woman recovers there might be no need for the nurse to be present in the same way as before, maybe the relationship gets closer and the woman feels secure with less physical presence.

The RPNs stated that being present with the women implied protection from self-destructive behaviour. The relationship between the RPNs and the mothers was enhanced, and their working alliance was developed over time. It provided the women with a safe and secure haven from their destructive wishes to harm themselves or their infants. RPNs' presence also helped avoid violent encounters and gave the women a feeling that the RPNs wished them well. This is consistent with Carlsson et al. (2004; 2006) study examining violent encounters in psychiatric care. These authors reported that when the nurse was not present, the result was a negative violent encounter in which the patient felt bad and abandoned. The reduction of nurses' presence in mental health wards and among patients has been found to increase aggression among patients. The importance of nurses being present while caring for patients has been verified in several studies. For example, Vanderslott (1998) performed a study of violence towards staff by patients in an NHS Trust hospital. It was found that at times when nurses

were not present, such as at handover periods and tea time, the occurrence of violence was at its peak. Handsley and Stocks (2009) found that psychiatric nurses, who were too busy performing their office duties, often distanced themselves. New nurses, novice nurses, could be immature in meeting the woman in their delusions and might be afraid of the patients' aggressive behaviour (Engqvist et al. 2009). This might cause anxiety and loneliness for the patients and evoke a desire for self-destructive behaviour. Therefore it is important to support novice nurses, giving opportunity to develop their competences in directions towards becoming an expert nurse (Benner 1984). The RPNs in this particular study were very experienced, they were expert nurses, and according to Handsley and Stocks (2009), they commented that bringing together experiential knowing and intuitive processes with knowledge and practice skills led to professional maturity.

An interpretation of the RPNs descriptions of nursing presence is that this has a direct effect on health, relationships, trust, hope, esteem, and sense of self. These results could be understood by DeLashmutt (2007), who found that nursing presence is both supportive and health-enhancing for the patient. Furthermore, nursing presence can empower mothers, because one of its fundamental elements is a spiritual connection and communion between the nurse and the patient. Within the context of a meaningful relationship, esteem and respect prospers and there is trust. Finfgeld-Connett (2006) states that the process of nursing presence is not possible if patients do not have the capacity for this process or are not open enough for a relationship. One could imagine that when a woman is psychotic she would not have this

capacity or it would be less possible to form a relationship. The findings from this study that presence is significant in caring for women suffering from PPP contradict Finfgeld-Connett's statement. Our findings indicate the importance of being present to protect the woman and facilitate recovery.

The RPNs stated that their presence gave the women stability and made them calm down when they were in turmoil. They also stated that their presence gave the women a sense of security and safety, and helping them cope better within their illness. It contributed to women's feelings of being well cared for, and increased their feelings of the RPNs' empathy, comfort and trust. If the RPNs sat down with the women and did everyday tasks with them, this decreased the women's psychosis and reality became more comprehensive for her. This is in accordance with what nursing presence consists of, as defined by Godkin (2001), where the author states that nurse-patient interaction promotes greater patient satisfaction and has a healing potential. In a literature review by Finfgeld-Connett (2006), it was found that presence is a helpful, beneficial and positive phenomenon, and is probably without any apparent negative consequences. The same study calls attention to the fact that presence cannot be established when willingness is absent. According to Finfgeld-Connett (2008b), patients reported improvement in mental wellbeing, as well as decreased stress, improved capacity to cope, increased sense of safety and security, greater self-esteem, personal growth and new understanding.

However, nursing presence also raises ethical questions. Being close to a woman all the time encroaches on her integrity. From the RPNs

descriptions, it could be interpreted that the protection of a woman's life comes before the ethical rules of defending the individual's integrity. Therefore the RPNs have to meet each woman with as much dignity as possible. The problem of being cared for one-to-one was investigated by Yonge and Stewin (1992). Constant care (one-to-one) implied negative aspects: being watched constantly, not having sufficient privacy, and the constant lack of continuity of nursing staff. These negative effects from the patients' perspective were not brought up at all by the RPNs in the interviews.

The RPNs stated that nursing presence enhanced and intensified bonding between the mother and her child. The RPNs could spend considerable time with them, and some of the RPNs found that singing lullabies together with the mother and her child was beneficial. This is in accordance with an interview study conducted by Mackinlay and Baker (2005), where mothers stated that singing lullabies enhanced their attachment to their baby, and promoted bonding and wellbeing for both the mother and her child.

The RPNs stated that through presence they learned how the psychotic mind worked, and they were excited about when it was possible to follow the woman's thoughts when she was psychotic. One would expect that the nurses would develop as human beings through these experiences in meeting the chaos in the women's minds.

They also learned about people and how they should be treated – with respect and dignity. Accordingly, the RPNs gained experience-based knowledge; i.e., they learned from experience in one situation and developed

new knowledge that was useful in future situations. According to Coles (2002), in order to develop wisdom from practical experience it is important that the occurrence and the experience are discussed, reconstructed and critically examined, as it is by reflecting over the result that experience-based learning can occur. In this study, the RPNs do not talk about supervision, but it is usual that RPNs working in mental health hospitals participate in supervision with colleagues (Engqvist et al. 2009).

For the RPNs, in this study, presence increased their knowledge and guided their nursing practice. Nursing presence is a central part of caring practice, and it is a cornerstone in nursing. It made the woman's hospital stay easier, and created a better relationship with the nurse. Presence was seen as an encounter between the nurse and the woman, in which the nurse meets her as a unique human being who is in a unique situation, and the nurse chooses to spend time with the woman. This is in accordance with Covington (2005), who conducted a literature review concerning caring presence, which was found to involve mutual trust and sharing, and human-to-human experience, providing physical and emotional healing.

This study's result has great implication in nursing practice in mental health care as the results point to the extreme importance of nursing presence in psychiatric nursing especially caring women with PPP. It can be used in different kinds of settings, but mainly in the inpatient care. This study also indicates implications in research and education as it is of importance to investigate whether or not there are effective strategies for teaching nurses to

acquire these skills and talents. If presence of nurses can comfort and heal our patients, we must design studies to document this outcome.

Strengths and limitations

The interview situation was open and friendly, which might explain the fact that the data were rich and provided vivid descriptions. However, one cannot disregard the risk of the interviewer's preconception of the study in question, as the interview situation can be influenced by the researcher's knowledge, values and frames of reference (Silverman 2001). The risk of interviewees expressing views that they think the interviewer wants to hear was prevented by the open and relaxed atmosphere during the interviews (Silverman 2001). To diminish this pitfall, the interviewer tried to be conscious of the preconditions from her experience of working as an RPN in this field. This pre-understanding was an advantage during the analysis, as the interpretation of the RPNs' statements facilitated the analysis. To decrease the risk of taking things for granted, the last author, who had no experience in the psychiatric field, functioned as a co-analyzer.

Credibility measures how sincere and faithful the description of the theme is and it was provided through quotations from the transcriptions. The convenience sample does limit the generalizability of the findings, but it should be possible to transfer the results to similar contexts, as the RPNs' descriptions can be understood from various perspectives. Conformability of this study was met by the fact that the interviews were tape-recorded and transcribed verbatim. Detailed descriptions of data collection and analysis

methods were provided and different perspectives were put in the analysis by the research team's different experiences.

CONCLUSION

The RPNs in this study recognized nursing presence as an important part of caring for women with PPP. The findings underscore the importance of recognizing nursing presence as a strategy to improve psychiatric nursing for this population, and emphasize that nursing presence benefits women with PPP and their newborn children. To fully understand the phenomenon of nursing presence in relation to caring for women with PPP, the women's own perspective needs to be investigated.

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CONTRIBUTIONS

IE: Study design, data collection, analysis, and manuscript preparation

GF: Examination of consistency in the analysis and manuscript preparation

KN: Study design, analysis and manuscript preparation

REFERENCES

Benner, P. (1984). *From novice to expert: excellence and power in clinical nursing practice*. Menlo Park, Calif: Addison-Wesley

- Berg, M. (2005). A midwifery model of care for the childbearing women at high risk: Genuine caring in caring for the genuine. *Journal of Perinatal Education, 14*(1), 9-21.
- Brockington, I. (2004). Postpartum psychiatric disorders. *Lancet, 363*(9405), 303-310.
- Carlsson, G., Dahlberg, K., Lützen, K & Nyström, M (2004). Violent encounters in psychiatric care: A phenomenological study of embodied caring knowledge. *Issues in Mental Health Nursing 25*, 191-208.
- Carlsson, G., Dahlberg, K., Ekeberg, M. & Dahlberg H. (2006). Patients' longing for authentic personal care: A phenomenological study of violent encounters in psychiatric settings. *Issues in Mental Health Nursing, 27*:287–305.
- Chase, SK. (2001). Response to “The concept of nursing presence: State of the science. *Research and Theory for Nursing Practice, 15*(4), 323-327.
- Coles, C. (2002). Developing professional judgment. *Journal of Continuing Educational Health Profession 22*, 3-10.
- Covington, H. (2003). Caring presence. Delineation of a concept for holistic nursing. *Journal of Holistic Nursing, 21*(3), 301-317.
- Covington, H. (2005). Caring presence. Providing a safe space for patients. *Holistic Nursing Practice 19*(4):169–172.
- DeLashmutt, M. (2007). Students' experience of nursing presence with poor mothers. *Journal of Obstetric, Gynecologic, & Neonatal Nursing 36*(2), 183-189.

- Engebretson, J. (2000). Caring presence: A case study. *International Journal for Human Caring*, 4(2), 33-39.
- Engqvist, I., Nilsson, A., Nilsson, K., & Sjoström, B. (2007). Strategies in caring for women with postpartum psychosis--an interview study with psychiatric nurses. *Journal of Clinical Nursing*, 16(7), 1333-1342.
- Engqvist, I., Ferszt, G., Ahlin, A. & Nilsson, K. (2009). Psychiatric nurses' descriptions of women with psychosis occurring postpartum and the nurses' responses – An exploratory Study in Sweden. *Issues in Mental Health Nursing* 30(1), 23-30.
- Finfgeld-Connett, D. (2006). Meta-synthesis of presence in nursing. *Journal of Advanced Nursing* 55(6), 708–714.
- Finfgeld-Connett, D. (2008a). Qualitative comparison and synthesis of nursing presence and caring. *International Journal of Nursing Terminology Classification*, 19(3), 111-119.
- Finfgeld-Connett, D. (2008b). Qualitative convergence of three nursing concepts: art of nursing, presence and caring. *Journal of Advanced Nursing*, 63(5), 527-534.
- Friedman, S., Horwitz, S., & Resnick, P. (2005). Child murder by mothers: A critical analysis of the current state of knowledge and a research agenda. *American Journal of Psychiatry*, 162:1578-1587.
- Godkin, J. (2001). Healing presence. *Journal of Holistic Nursing*, 19(1), 5-21.
- Graneheim U H & Lundman B (2004). Qualitative content analysis in nursing research: Concepts procedures and measures to achieve

- trustworthiness. *Nurse Education Today* 24, 105-112.
- Handsley, S. & Stocks, S. (2009). Sociology and nursing: Role performance in a psychiatric setting. *International Journal of Mental Health Nursing*, 18, 26-34.
- Hegedus, K. (1999). Providers and consumers perspective of nurses' caring behaviour. *Journal of Advanced Nursing*, 30(5), 1090-1095.
- Heron, J.; Robertson Blackmore, E.; McGuinness, M.; Craddock, N. & Jones, I. (2007). No 'latent period' in the onset of bipolar affective puerperal psychosis. *Archives of Women's Mental Health* 10(2), 79-81.
- Hornstein, C., Trautmann-Villalba, P., Hohm, E., Rave, E., Wortmann-Fleischer, S. & Schwarz, M. (2006). Maternal bond and mother-child interaction in severe postpartum psychiatric disorders: Is there a link? *Archives of Women's Mental Health* 9, 279-284.
- Knops G (1993). Postpartum mood disorders. *Postgraduate Medicine* 93, 103-116.
- Lindahl V, Pearson J & Colpe L (2005). Prevalence of suicidality during pregnancy and the postpartum. *Archives of Women's Mental Health*. 8:77-87.
- Mackinlay, E. & Baker, F. A. (2005). Nurturing herself, nurturing her baby: Creating positive experiences for first-time mothers through lullaby singing. *Women and Music: A Journal of Gender and Culture*, 9: 69-89.
- Okano, T., Nomura, J., Kumar, R. et al. (1998). An epidemiological and clinical investigation of postpartum psychiatric illness in Japanese mothers. *Journal of Affective Disorders*, 48(2-3), 233-240.

- Osterman, P., & Schwartz-Barcott, D. (1996). Presence: Four ways of being there. *Nursing Forum*, 31(2), 23-30.
- Osterman, P. (2002). A participant observation study of experienced nurses' presence in daily care. Dissertation, University of Rhode Island.
- Polit, D. F., & Beck, C. T. (2006). *Nursing research*. Generating and assessing evidence for nursing practice (8th ed.). Philadelphia: Lippincott Williams & Wilkins.
- Rooney, C. (2009). The meaning of mental health nurses experience of providing one-to-one observations: a phenomenological study. *Journal of Psychiatric and Mental Health Nursing*, 16, 76–86.
- Seeman, M.V. (2004). Relational ethics: when mothers suffer from psychosis. *Archives of Women's Mental Health* 7(3), 201-210.
- Semprevivo, D. (1996). The lived experience of postpartum mental illness. Dissertation, Rush University, USA.
- Silverman, D. (2001). *Interpreting Qualitative Data Method for Analyzing Talk, Text and Interaction*. Sage, London.
- Spinelli, M. (2009). Postpartum psychosis: Detection of risk and management. *American Journal of Psychiatry*, 166(4), 405-408.
- Valdimarsdottir, U, Hultman, C., Harlow, B., Cnattingius, S. & Sparen, P. (2009). Psychotic illness in first-time mothers with no previous psychiatric hospitalizations: A population-based study. *PLoS Med.*, 6(2),

- Vanderslott J. (1998). A study of incidents of violence towards staff by patients in an NHS Trust hospital. *Journal of Psychiatric and Mental Health Nursing* 5, 291–298.
- World Medical Association: Declaration of Helsinki. Ethical principles for medical research involving human subjects. *Nursing Ethics* 2002, 9(1):105-109.
- Yonge, O. & Stewin, L. (1992). What psychiatric nurses say about constant care. *Clinical Nursing Research* 1(1), 80-90.

Chapter Ten

Discussion

The overall aim of this dissertation was to increase our understanding of postpartum psychosis by providing fuller descriptions of the experience of this illness from the women's perspectives and the perspective of psychiatric nurses caring for these women during their inpatient psychiatric hospitalizations.

First, the findings will be summarized and discussed with reference to each paper which will be marked with the number I-IV. Next, the findings will be discussed in relation to three of Kim's (2000a) domains (client, client-nurse and practice) and the literature.

Summarizing The Study Findings

The findings indicated that the illness of PPP is disabling (Paper I) with potentially severe consequences for the women, their newborns and their families. The descriptions of the deep, dark and desperate fear that these women experienced was truly palpable in the narratives. The women described being afraid of killing their babies. Some kept silent for fear that their babies would be taken from them. Others were terrified that they would die or become forever "trapped in their insanity" and "locked up forever". Many were terrified by their delusions and hallucinations and didn't understand what was happening to them. The sense of being controlled, disorganized, confused and paranoid added additional layers of fear and anxiety.

The women's gripping descriptions of overwhelming and all encompassing fear revealed, to some extent, the degree of suffering that these women experienced which some women described as the "most traumatic experience of their lives." This is a very important contribution to the nursing literature; one that is not captured in the medical literature and minimally in the nursing literature.

The women's narratives also included descriptions of their psychosis, sleep deprivation, heightened anxiety, shame and guilt and unfulfilled dreams. Furthermore, some women described a sense of detachment from their babies, their families, and their surroundings. A number of women also described feeling abandoned and discontented with the nursing staff and the nursing care they received.

Insight of the women's experiences of PPP is provided by these descriptions, adding to our understanding of the suffering that accompanies this disorder. The women's own descriptions give a more substantial illustration than what is found in the medical literature where the words psychosis, delusions, paranoia, impairment in functioning and personality change are used to describe PPP (Brockington 2004b, 2006; Chandra et al., 2002; Currid; 2004a; Seyfried & Marcus, 2003; Sharma et al., 2004; Sit et al., 2006; Spinelli, 2009). When remembering these narratives one must keep in mind that they represent what the women remember. Recall bias is possible (Azorin et al., 2010; Jaspers, de Meer, Verhulst, Ormel, Reijneveld, 2010) as is the possibility of false memories or biased processing of memories.

The psychiatric nurses described (Paper II) the women whom they cared for as having delusions, disconnection, aggression, changed personalities, self-absorption, insomnia, quietness, suicidal ideation, chaos, and strange eyes. Some of these descriptions are also found in the medical literature (Brockington, 2004b, 2006; Chandra et al., 2002; Currid, 2004a; Seyfried & Marcus, 2003; Sharma et al., 2004; Sit et al., 2006; Spinelli, 2009). The word “chaos” was used by the nurses to describe women who had intense fear, anxiety, and were disorientated. A number of nurses used the term “strange eyes” when describing some women during the acute phase of their illness. Since the nurses who described “strange eyes” had more than 10 years of clinical experience with psychiatric patients, it is possible that the nurses observed this subtle symptom based on their clinical experience (Benner, 1984). The nurses primarily associated suicidality with self destructive behaviors. Several nurses described some of the women as being quiet or calm. They did not associate this presentation as being potentially related to suicidal ideation. In fact one of the women who was described as being quiet drowned her baby during a hospital pass. This is a very important finding suggesting the need to educate nurses about the potential meaning of different signs and symptoms that women have when diagnosed with PPP.

In order to deliver safe and comprehensive nursing care to this population, nurses need to be competent in their clinical assessment of their patients and correlate clinical findings with a knowledge base of the disorder. Given the shortened length of inpatient hospitalizations, it is also essential

for nurses who provide care for these women in other settings to have a sound knowledge base of this disorder. In Sweden, midwives provide care for women and their newborns on the postnatal unit, and child care nurses from the child care center make home visits to women who are usually discharged from the postnatal unit 1-4 days postpartum (Eberhard-Gran, Garthus-Niegel, Garthus-Niegel & Eskild, 2010; Hagberg et al., 2008). Therefore, it is also crucial for these nurses to be familiar with the signs and symptoms of PPP.

The nurses in this study described strong positive and negative emotional responses towards the women with PPP (Paper II). When providing care, the nurses responded with sadness, sympathy, empathy and compassion, discomfort, anger, anxiety, and happiness. Descriptions of nurses' feelings of sadness and anxiety in relation to patients has been found in other contexts (Lundström et al., 2007). Nurses need to be prepared to recognize when they have negative responses towards patients and have systems in place to assist them when this occurs. This finding supports the value of developing structured mentoring programs to promote critical reflection of nurses' clinical practice in psychiatric facilities. Through this process, nurses can continue to increase their knowledge, deepen their understanding of their reactions to their patients, and expand their knowledge of therapeutic nursing strategies to provide comprehensive care for women with PPP.

The psychiatric nurses in this study employed a number of strategies (Paper III) when they provided nursing care to these women. One of the

primary strategies described in great detail was the importance of being continuously present. Descriptions of physical presence were graphic and profound. For example, nurses talked about putting their arms around a patient or sitting next to her just being quiet. Since presence is often described as an interpersonal presence in the nursing literature, this emphasis on physical presence needs to be further explored.

Other nursing therapeutic interventions included satisfying the women's basic needs, creating a safe environment, providing a sense of security, fostering hope, and helping the women reconnect with reality. Ongoing education and support for the patient and her relatives was also described.

Providing safe and competent care for this population requires the nurse to recognize and understand the potential meaning of the symptoms of PPP as well as have knowledge related to caring for patients with acute psychosis. According to McCabe (2004), Dearing (2004), Shattell (2004), as well as Hewitt and Coffey (2005) creating a patient-nurse relationship is valuable and consistent with Peplau's (1988) discussion of the therapeutic relationship acting as a therapeutic force. The nurses in the study described the importance of creating a partnership with the women they cared for in order to include them in decision-making related to their treatment plan. They recognized the importance of using therapeutic communication in meeting the women's basic self care needs, reconnecting the women with reality, informing the patient and their families about PPP, and connecting the patient to the health care team. These nursing strategies are consistent with Peplau (1988) and Falk and Allebeck (2002), who discuss the need to build

an interpersonal relationship with psychiatric patients in conjunction with the educating process.

Logically, in psychiatric care, nurses use special strategies developed and tailored for women with disorders including PPP in order to promote positive outcomes. Although the nurses in this study did recognize the importance of caring for the woman and her baby in order to support mother infant bonding, their nursing strategies lacked specificity in their care for patients with PPP. They used strategies consistent with general psychiatric care provided to all psychiatric patients.

Presence (Paper IV) is a component of several nursing frameworks, and is recognized as extremely significant in nursing practice (Chase, 2001; Engebretson, 2000; Fingfeld-Connett, 2008a, 2008b; Osterman & Schwartz-Barcott, 1996). Moreover, presence has been described in the nursing literature as increasing patients' feelings of safety and security (Osterman, 2002), facilitating positive coping (Fingfeld-Connett, 2006) and contributing to the patients' recovery (Covington, 2003). Patients have also described feeling "cared for" when nurses use presence (Fingfeld-Connett, 2008a). In the last paper, nursing presence was used as a strategy by the nurses to: facilitate the women's recovery; protect them from degrading themselves; protect them from self-destructive behavior and from hurting their babies. It is possible that the use of presence by the nurses in this study had a direct effect on the women's health, their relationships, building trust, promoting hope, and promoting the women's positive sense of self. DeLashmutt (2007) found nursing presence to be supportive and health-enhancing for the patient.

The results have implications for psychiatric mental health nursing practice and point to the importance of nursing presence in psychiatric nursing. Being physically close to the patient can raise ethical questions about the right to be close and stay with the patient for a long time. Nursing presence could have a negative impact on the patients' integrity. Although this was not mentioned by the nurses in this study, it has been discussed in the literature. Potential negative outcomes of constant care (one to one) have been discussed by Yonge and Stewin (1992); in particular this author discussed the potential impact of being watched constantly, not having sufficient privacy, and the lack of continuity of nurses assigned to the woman.

The main findings of the four papers have also been analyzed in relation to Kim's (2000a) domains and are presented below.

Study Results in Relation to the Domain of the Client

According to Kim (2000a) the client domain includes a range of human phenomena. Kim's typology of concepts in the client domain includes essentialistic, problematic, and health care experiential concepts. A number of concepts were identified in papers I-IV. Several of these were highlighted in Kim's discussion and others were not included. This work adds a number of concepts to the client domain. Those concepts that were particularly important are outlined in table 4 and discussed in more detail.

Table 4. Concepts in the Client Domain

Paper	Concepts
I	Disappointment (unfulfilled dreams)
I	Dissatisfaction (with nursing care)
I and II	Caretaking ability (inability to take care of the baby)
I	Shame and guilt (pervasive)
I	Anxiety
I	Fear (deep, dark, overwhelming, unbearable)
I	Being in an unreal world
I	Loneliness
I	Concentration (decreased)
I and II	Paranoia
I	Elation
I	Confusion
I	Restlessness
I	Self destructive behaviors
I and II	Distrust (lack of trust in the nurses)
I and II	Delusions
I and II	Disconnection (from the baby)
II	Aggression
II	Personality change
II	Self-absorption
I and II	Insomnia
II	Chaos
II	Quietness
I and II	Suicidal ideation
II	Strange eyes
I and II	Thoughts of infanticide

The descriptions of the women's experiences of the illness and how the illness was presented by the nurses relates directly to the client domain. As

mentioned in chapter three, it is the problematic concepts that are of most interest as it can be expected to be the women's focus when they express their experiences of being stricken by PPP.

The women's dreams and their expectations concerning their delivery were not met. As a result, they were distressed and disappointed by this. Many of them had unrealistic expectations regarding the delivery i.e. the delivery would go easy and with little complications, and subsequently were very distressed when their expectations were not met. When the women were not able to care for their child, their despair was even greater. Feelings of guilt and shame were overwhelming for them.

The nurses described (Paper II) the women's disappointment, their distress, feelings of guilt and shame, as well as the women's inability to care for their baby. The nurses also described the connection with the baby as absent or very weak. One nurse mentioned the relationship between the mother and the baby was not as strong as the connection mothers usually have with their newborn infant. These findings are similar to Robertson and Lyon's (2003) and Semprevivo's (1996) studies. The disconnection that women with PPP have with their infants and how this impacts their relationships with their partners and other family members have also been reported by Bågedahl-Stridlund and Ruppert (1998), Brockington (2004b), Currid (2004a), Hornstein et al. (2006), Moehler et al. (2006).

Most of the nurses described the women as having fear of the baby, aggression and confusion. The nurses described the women as disorientated, worried and anxious. This is consistent with studies from Brockington

(2004b) and Sit et al. (2006). The descriptions from the women and the nurses mutually reinforced each other, which also is in accordance with the study conducted by Semprevivo (1996) who interviewed ten women with PPP.

The nurses' descriptions of the women illustrate essential knowledge about women with PPP. This knowledge is important for nurses engaged in "body work" that involves caring for and treating parts of the body or the body as a whole, as well as helping the women with their emotional, existential, and spiritual aspects of life (Kim 2000a). The conceptualization of knowledge in the client domain related to patients' descriptions of their experiences of PPP is an important nursing contribution to the literature. Additionally Kim argues that orientation toward clients in nursing needs to be centered around the client as a human living being (Kim, 2000b).

Being human (Kim, 2000b) encompasses all dimensions of an individual, that is, the biological, spiritual, psychological and social. Given all the signs and symptoms described by the women and the nurses, and the risk of self-destructive behaviors, it is easy to understand how difficult it is to be diagnosed with this disorder. The women have difficulties living with themselves, with others and in the context of the inpatient psychiatric setting.

The women were described by the nurses as aggressive towards themselves with self-destructive behaviors. They had destructive thoughts about their baby and few of them even had thoughts about killing their baby. Some of them had negative thoughts towards staff in the hospital. A few were involved in fights with the staff and needed to be restrained. There are

points of correspondence between the nurses' descriptions and the women's narratives in their descriptions of the same behaviors. This is all in accordance with the medical literature, described by Brockington (2004b), Kaliski (2002) and Torrey (1994). The consequences of the illness that the women face might be difficult for the nurses to understand. When the nurses try to explain and describe the patient's signs and symptoms from their own perspective, a comprehensive description may therefore be lacking.

Most of the women described a feeling not being like themselves or having a changed personality. They described being different for a long time; some of them for as long as their treatment continued. Some of the women were self-absorbed and out of touch with reality. They had little ability to care for their babies or devote much attention to their babies and their surroundings; rather they were totally focused on their illness and their psychotic delusions. In the matter of changed personality, the nurses gave somewhat different descriptions as they did not know the women before they were ill, but the relatives of the women told the nurses about their change in personality. These findings, point to the importance of involving relatives, when caring for the woman with PPP. Knowing about these experiences contributes to the understanding of how the women experience living with the illness (Kim 2000a). This is in accordance with Semprevivo's (1996) study with ten women with PPP.

The majority of the women in this study had difficulty sleeping in the early phase of the illness. This is one of the most distinctive symptoms of the illness and described by many researchers (Brockington et al., 2006; Chandra

et al., 2002; Seyfried & Marcus, 2003; Sharma, 2003; Sharma et al., 2004; Sit et al., 2006). The nurses worked only on the inpatient unit and did not meet the women until they were admitted to the psychiatric units, which explains why only four of the interviewed nurses mentioned sleeplessness as a symptom. Therefore, it is most important for all care providers and family members to be aware of the significance of the lack of sleep. Early diagnosis and prompt treatment can influence the women's recovery (Sharma, 2003; Sharma & Mazmanian, 2003; Sharma et.al, 2004; Sit et.al, 2006).

Some of the women were described as chaotic. In Sweden this term is used when women are "out of control". The word "chaos" is not described in the medical or nursing literature, and needs to be further investigated. When the nurses described the women being in a chaotic condition, it is the nurses own words that are being used to describe how they experienced the women's condition. In Sweden it is not unusual to describe a psychiatric patient's inner turmoil in this way.

To obtain a better understanding of the women's experiences more investigations need to be done as the word chaos does not exist in the women's descriptions. This concept is an additional concept that can be added to the client domain in relation to PPP. This is an important finding and may have relevance for other nurses caring for this population. It may also reflect the nurses' clinical experience versus what was learned in their formal education (White, 1995). What nurses learn during their education and in clinical practice could be understood as expressions for the 'voice of medicine', used by Mishler (1984) as a metaphor for the medical discourse in

which the nurses are socialized. Therefore it is important to emphasize the women's own descriptions, i.e. their lived experiences in order to facilitate the nurses' comprehensive understanding of the women's situation.

Another symptom the nurses mentioned was 'strange eyes'. This symptom is not found in the literature, nor in the medical or nursing literature, and needs further investigation. This symptom is not found in the women's narratives but could be understood from the nurses' point of view. In Sweden, the saying is that the eyes are the mirror of the body. When the woman's inner world is in turmoil this chaos will be reflected in her body. Since having eye contact is important in the western culture, it is not surprising that the nurses did observe changes in the woman's eyes.

The women's descriptions (Paper I) are in accordance with Edward and Timmons' (2005) study of stigma in postpartum mental illness. Edward and Timmons talk about feelings of being a bad mother; the women in this study talked about the inability to care for the baby. Furthermore the risk for disclosure is described as a stigma (Edward & Timmons, 2005); expressing shame and guilt could also be stigmatizing. In Paper I, the majority of the women expressed dissatisfaction with the staff and the care they received. They were of the opinion that the staff were unknowledgeable about their illness, and consequently ignored many of their needs. Since psychosis prevents the patient from being able to distinguish between the real world and the imaginary world, it is possible that their opinion could be colored by their psychosis, paranoia and confusion (Chandra et al., 2006; Hodelet, 2001).

Patients' dissatisfaction with nursing staff and nursing care has been reported in the general psychiatric literature. A correlation has been found between dissatisfaction and individuals who are psychotic and hospitalized. In a study by Gigantesco, Picardi, Chiaia, Balbi and Morosini (2002) inpatients were more dissatisfied than outpatients. The primary reasons for dissatisfaction included drug side effects, lack of information, lack of involvement in treatment planning or decision-making and lack of involvement of family members in the care plan. These findings are reinforced by Bowskill, Clatworthy, Parham, Rank & Horne (2007).

Länge et al. (2003) reports the relationship between the patient and the therapeutic staff is crucial as well as relationships with the multiprofessional team inside the hospital; this is more important than receiving information. More specifically, younger patients are more dissatisfied with the efficacy of treatment, professionals' skills, behavior of staff, and the information given (Kessing, Hansen, Ruggeri & Bech, 2006).

One wonders if the dissatisfaction of the women (Paper I) originated from a sense of guilt. Not being able to care for her newborn baby can be considered shameful; it is possible that blame was placed on the nurses and thus dissatisfaction with care. In order to counteract this discontent, when the woman is improved from her illness, the nurse could discuss with the woman the first phase of her illness, what was being done and what was said. One can compare this information with postpartum counseling (Gamble et al., 2005; Lavender & Walkinshaw, 1998; Olin & Faxelid, 2003; Rowan, Bick & da Silva Bastos, 2007), which is usually provided by the midwife and

implemented while the woman is on the postnatal unit after childbirth. Perhaps counseling after the psychosis clears, could correct misunderstandings that may have arisen. The counseling is the nurses' responsibility and requires skills and sensitivity of what the woman can accommodate in her continuing fragile situation (Stewart & Henshaw, 2002).

Study Findings in Relation to the Client-Nurse Domain

According to Kim (2000a) the key concepts in the client-nurse domain are contact, communication and interaction, and consist of various types of processes such as interpersonal presence, touch, therapeutic communication, role modeling, teaching and exchange of information. It is important to note that client-nurse encounters are the medium through which the nurse provides nursing care. In a caring situation, there are constant encounters between the caring nurse and the patient (Kim, 2000a).

Although nurse-patient interactions were not observed in either of the two studies that were conducted, information describing nurse-client interactions and the outcomes of therapeutic interactions were described by the nurses who were interviewed for Paper III.

Table 5. Concepts in the client-nurse domain

Paper	Concepts
III	Presence (physical presence) Partnership (forming a partnership with the patient) Information giving (informing the patient and relatives about PPP) Interaction Communication
III	Role Modeling
IV	Relationship building
III	Therapeutic communication
IV	The nurse patient relationship

The nurses highlighted the importance of being physically present and close to the women (Paper III and IV). They described the importance of sitting beside the women, physically touching them and putting their arms around them so they could see and feel the presence of the nurse. In Kim's (2000a) client-nurse domain these examples of comforting touch can be categorized as the contact concepts. According to Finfgeld-Connett (2008b) nursing presence gives a sense of security and empowers the patient. In their study, Osterman, Schwartz-Barcott and Asselin (2010) described nursing presence on an oncology; presence varied due to the patients' condition and was imbedded in the care provided throughout the day.

When the women had delusions (Paper III and IV) the nurses caring for them tried to normalize reality. They talked with the women about everyday things such as talking about the baby, the woman's family or the weather for the day. According to the nurses who were interviewed, these communication strategies, or what Kim calls nurse-client talk were particularly helpful for the women.

According to Kim (2000a) all client-nurse encounters are guided by how the philosophy of care is integrated by the nurse. If a patient is confused the communication between the nurse and the patient will be impaired (Andersson, Knutsson, Hallberg & Norberg, 1993). In light of the psychotic symptoms experienced by women with PPP, one can question if communication between the patients with PPP and the nurses providing care could have been impaired. Therefore it is important for nurses to be aware of the possibility that psychosis could interfere with therapeutic communication thus affecting the patient's responses to care that is provided.

For the nurses (Papers III and IV) it was important to create a good and stable relationship with the woman with PPP, which is considered important in psychiatric care as well as in somatic care (Eriksson & Nilsson, 2007; Forchuk et.al, 1998a; 1998b; 1998c; 2000; Salzman-Erikson et al., 2008; Shattell, McAllister, Hogan, & Thomas, 2006). In the context of this relationship, the nurse uses different strategies including being continuously present with the woman.

The nurses also described (Paper III) the importance of forming a partnership as well as building a relationship with their patients. They were

role models for the women when they changed the baby's diapers and held them with the goal of helping the women become more secure in taking care of their babies. Through their interactions and communication with the women, the nurses provided hope, normalized reality, and facilitated bonding between mother and child.

The delicacy of the encounter between the patient and the nurse can be understood in Kim's description of the interaction phenomena which include mutuality, presence, transaction, and a therapeutic alliance (Kim, 2000a). These holistic concepts are likely to require maturity and experience of the nurse. This in turn demands that the management (employer) of a psychiatric unit recognizes that these types of encounters, which also include the counseling role of the nurse, require time. Nurses responsible for counseling will need special training, in order for them to have enough knowledge and maturity for this kind of special work. The employer will have to educate and pay for this training which in the long run could improve patient satisfaction (Sit et al., 2006). According to Hätönen, Suhonen, Warro, Pitkänen & Välimäki (2010) patient education is appreciated among patients. In addition to patient education, the nurse-patient interaction and relationship are also essential components in the care.

The importance of encounters, mutual interaction and relationship, as mentioned above, is in correspondence with Längle et al. (2003), Forchuk et al. (1998a, 2000), and Salzmänn-Erikson et al. (2008). These concepts include mutuality, empathetic relationships, transactions and the therapeutic alliance. According to Kim (2000a) respect, understanding and empathy

provide the base for the encounters between the client and the nurse.

According to Peplau (1988) quality nursing care demands a safe and supportive relationship with the patient. It is necessary for both parties to be able to communicate and to understand each other's thoughts and feelings. For Peplau (1988), nursing is a mature force and an instrument for education as well as a therapeutic process in the interpersonal relationship between patient and nurse.

The nurses also assumed responsibility for informing and teaching the patient and her relatives about PPP (Paper III) which can be categorized under Kim's (2000a) communication concept. The authors state it is important how the nurse informs the patient and the nurse need to be clinically competent which requires continued professional development. In the management of women with PPP the nurses are responsible for exchanging information with the patient, the husband and other relatives. This includes information about the progress, the consequences and the future care for the woman (Höye & Severinsson, 2010). Of course, two way communication between the nurse and the patient is important to maintain. However in the busyness of the day, this type of communication may be minimized. Therefore, it is important for nurses to receive education containing theories and training related to dialogism (theories concerning dialogue) including approaches to avoid one-way communication (Höye & Severinsson, 2010).

Marmion (2000) indicates that the nurse can give the woman and her partner information about the illness to reduce shame, guilt and isolation that

typically accompany the knowledge of having this illness. A large part of the nurses' communication also includes teaching the families (Jarret & Payne, 2000; Nilsson et al., 2009). The Swedish National Board's of description of a nurse, (2005-105-12005) includes the responsibility for providing information to the woman and her husband and other relatives about the illness, as well as the progress and consequences and care after the woman's discharge from the hospital (Höye & Severinson, 2010).

The Swedish Health and Medical Services Act (1982:763/2010:662) indicates that patients as much as possible should be informed about and involved in decisions affecting their care. Many of the women suffering from PPP may need to receive care under compulsion (1991:1128/2008:415) and consequently do not have the opportunity to participate in decisions concerning their treatment. These women are not able to express and talk about their experiences but the nurses and doctors have to rely on their own knowledge of PPP and interpretations of what they observe. If the relatives are involved and receive information in the early stage of the illness, they will be better prepared to understand the patient's situation, participate in the care, and make good decisions regarding treatment. The Health and Medical Services Act (1982:763) also states that the patients have to be involved in her/his own care and treatment. There are several studies that point to the lack of involvement of the nurse from the patients' point of view (Borg, Karlsson & Kim, 2009; Efraimsson, Sandman, Hydén & Rasmussen, 2004; Howard et al., 2001; Howard, El-Mallakh, Rayens & Clark, 2003; Latvala, Janhonen, & Moring, 2000).

In order to reach a favorable outcome, the nurses discussed the importance of forming a partnership with the women, including them in the care planning and discharge planning. This finding was supported by Gigantesco et al., (2002), who reported patients' dissatisfaction with their psychiatric inpatient care when they were not involved in treatment planning or decision-making. It is possible that patient satisfaction could be increased if nurses involve their patients in their treatment planning as well as provide them with education.

Study Findings in Relation to the Domain of Practice

According to Kim (2000a), the practice domain includes a number of concepts that can be classified as holistic or particularistic and are related to the cognitive, behavioral, social and ethical aspects of professional actions and activities performed by the nurse and/or experiences by the nurse in relation to nursing care. A number of concepts from the practice domain were identified in Papers III and IV and are displayed in Table 6. Those concepts that were highlighted are discussed in more detail.

Table 6. Concepts in the Practice Domain

Paper	Concept
III	Creating a caring safe environment
III	Nursing assessment
III	Nursing care planning
III	Prioritizing
III and IV	Compassionate care
III	Connecting the patient to the care team
III and IV	Providing hope
IV	Facilitating bonding
IV	Protecting the mother and baby

According to Kim et al. (2008) the nurse selects strategies that will meet the needs of the specific patient at a specific time i.e. she/he will tailor the care for the patient. Based on their assessment and prioritizing care, in the early phases of the illness, the nurses stayed with the women in their rooms or in a quiet space on the ward, talked to them, but also remained silent when this was indicated. The nurses were also aware of creating and maintaining a safe, secure environment and protected the mother and the baby.

The nurses described the importance of facilitating and supporting bonding between the women and their babies. This finding is also reported, in the studies by Semprevivo and McGrath (1990) as well as Jones and Venis (2001) indicating that mother-child bonding and reducing time of forced mother-child separation is crucial for the child's development. In delivering

patient care to the psychiatric population, nurses need to have empathy and compassion (Schröder, Ahlström & Larsson, 2006). In Paper II, the nurses described having empathy and compassion for the women who were ill and not able to care for themselves or their newborns. Most of the nurses also described feelings of sadness, frustration, anger and anxiety. They were sad when they observed the lack of connection between the women, their new baby, and their partner.

The nurses felt discomfort (Paper II) when the women needed involuntary treatments, such as being restrained due to aggressive behavior towards themselves or others and when they needed to give forced injections. Although this is a necessary component of the care that needs to be provided to some women with PPP, nurses still had a feeling of uneasiness. In a Swedish study (Haglund, von Knorring & von Essen, 2003) of 15 patients and 15 nurses concerning involuntary treatments like injections, the patients as well as the nurses stated that involuntary treatments is a violation of the integrity and of psychological discomfort.

The nurses gave the impression that they infused hope and promoted confidence (Paper IV) in the women by reassuring them that there was a future and that the illness would not last forever. The patient who carries hope of improvement should be allowed to maintain that hope. In Kim's (2000a) practice domain this phenomena can be understood as part of the enactment dimension. Nursing takes into account the woman as an individual with her history, her experiences and personality (Glavin et al., 2010; Harlow et al., 2007) and is categorized under the philosophy of care

(Kim, 1994). As mentioned in chapter three, Kim (2000a) and Kim et al. (2008) assert that a nurse should have a holistic approach and have the ability to care for the physical, emotional, existential, and spiritual needs of the patient.

It is important for the nurse to create a caring culture in which the patient feels welcome, respected and seen (Erickson, 1994). Not to see a patient and give her sight is a violation of her dignity, which gives rise to unnecessary sufferings. The nurse cares for the patient when the patient is acknowledged, and their grief, sorrow or joy is validated or confirmed. Confirming a patient's dignity is expressed in care activities such as responsibility, listening, understanding and recognition (Eriksson, 1994). Nevertheless, it is each nurse's responsibility to validate each patient, individualize care solutions and specify care-giving alternatives that are independent of the eventual length of hospital stay (Råholm & Lindholm, 1999; Randers, Olson & Mattiasson, 2002). The ability to acknowledge or confirm patients' differences, and see them all as equally important, reduces the risk that they will receive only structured or compartmentalized care. Confirmation has the power to touch the patient and represents a significant health action in psychiatric care. In psychiatric care, frequently the nurses encounter patients who have had no confirmation in their lives and therefore have difficulty trusting other people. These findings are supported by several researchers (Hansson, 1989; Lindström, 1994; Lovell, 1995; Svensson & Hansson, 1994). According to Lützén and Nordin (1993) an effort to preserve dignity means patients are allowed to take responsibility for themselves and for their

ability to participate in decisions affecting them and their care. Even when the nurse assumes responsibility for the woman when she is not able to, the nurse must maintain the woman's dignity (Lützén & Nordin, 1993; Ewertzon, Lützén, Svensson & Andershed, 2010; Salzmänn-Erikson et al., 2008).

The nurses participated in conferences with the multiprofessional team including doctors, patients, and relatives. The nurses' work also consisted of connecting the patient to the care team and making sure that there were adequate social supports for childrearing women. An important task for the nurses was connecting the patient with the different members of the care teams (Paper III), to prepare for the woman's discharge from the hospital to her home (Engqvist et al., 2010, 2011; Forchuk et al., 1998a, 1998b, 1998c). The nurses collaborated with the midwives in the early phase of the illness and with the outpatient clinic staff and pediatric nurse at the child care center, prior to discharge to maintain continuity of care (Brockington, 2004a; 2004b; Chaudron, 2006; Currid, 2004b; Ebeid et al., 2010; Engqvist et al., 2010). In order to make these arrangements the nurse requires skills in collaboration which is included in the deliberation dimension (Engqvist et al., 2010; Kim, 2000a). This phenomenon can also be understood in Kim's (2000a) domain as part of the enacting dimension, knowing the actions will follow the deliberation phase.

In the delivery of nursing care, the nurses described many positive and negative emotional responses towards the women with PPP. These findings emphasize the need to develop structured systems approaches, such as

clinical supervision, to promote critical reflection of nurses' clinical practice in psychiatric facilities. The findings in a study conducted in Sweden by Berggren and Severinsson (2000), indicate that nurses who participate in clinical supervision added to their knowledge base, clinical competence and enhanced their ability to provide better and more compassionate care. As a result, the nurses may have more job satisfaction and a reduction in their stress and burnout. Clinical supervision enhances the nurses' ability to plan, reflect on and evaluate their clinical practice. These findings are substantiated by Buus, Angel, Traynor and Gonge (2010) in their empirical study of 22 psychiatric nurses concerning clinical supervision where it is stated that supervision adds positively to the nurses' professional identity. Clinical supervision is also seen as a valuable pedagogical intervention helping the nurses when they are stuck or trapped in their clinical work. According to Coles (2002), in order to develop wisdom from practical experience, it is important that the occurrence and the experiences are discussed, reconstructed and critically examined, as it is by reflecting the result that experience-based learning can occur.

One can wonder how the nurses' negative feelings affected the relationship between the nurse and the woman and the delivery of nursing care. Certainly, the women must have had a sense of these nurses' feelings, and maybe these in turn led to the women feeling shame, guilt, anger, and frustration at not being accepted by their nurses. Björkdahl, Palmstjärna and Hansebo (2010) conducted an empirical study in Sweden examining different nursing approaches concerning caring and uncaring encounters. In this

study, some of the nurses believed their main task was to always keep the ward orderly and safe, and therefore demonstrated an uncaring attitude. As a result some patients distrusted the staff and believed that they did not really care about their welfare. The authors suggest that nurses must be made aware of the possible implications of this behavior and encouraged to use a more caring approach.

As a result of caring for women with PPP, (Paper IV) the nurses learned from being present to the women; they learned that even in the midst of the psychosis, these women were vulnerable, sensitive, and could easily be offended, requiring a firm but kind approach. They learned about delusions, rejection, aggression, suicidal and homicidal ideations and the suffering that occurs with psychosis. In providing care to women during their psychosis, the nurses recognized that they needed to identify and deal with their own anxiety resulting from witnessing the women rejecting their newborns and their partners. Providing care for this acutely psychotic population was described as a great privilege by the nurses. Questions about the fragility of life were raised. This will increase the nurses' knowledgebase and in time could contribute to their increased competence (Benner, 1984).

Methodological Considerations

For this dissertation a number of different approaches were used to establish trustworthiness. In the four papers, the pre-understandings of the researchers, based on their different professional backgrounds were included.

The methodology for each study including sampling, approaches to data collection, data analysis have been carefully discussed.

The trustworthiness of the studies using a qualitative approach is concerned with being able to describe the different steps in which data have been collected and processed, in a systematic manner (Lincoln & Guba, 1985). Therefore the data collection and analysis have been described as carefully as possible. It is important for researchers to explain their own pre-understandings of the phenomenon studied, their own background, education, and experiences (Silverman, 2001; Streubert & Carpenter, 1999). Three of the authors have a background in psychiatric care, whereas the fourth author has a different background, which lends credibility, in that a different viewpoint and different questions were expressed; this strengthened the papers. The dissertation also describes the conditions for the studies and how the results have emerged during the research process.

Since this dissertation, has been composed in a foreign language, extra language review was a requirement. However, even if this has been carefully done it is always the reader who finally interprets and understands the text. But when talking about communication, the most important question is whether the results can be transferred to other contexts. The samples in the two studies included in this dissertation are limited, which makes it difficult to talk about transferability to a wider context, but it may be possible to transfer the results to similar contexts, or women with PPP. It may therefore be possible to transfer the findings to mental health nursing provided in general psychiatric units anywhere in the world.

The description of the data collection needs to be detailed. If the data has been collected over a long period of time, this might increase the trustworthiness of the study (Lincoln & Guba, 1985; Polit & Beck, 2004). The sampling also needs to be described in detail, as does the analytic process. Therefore every effort was made to fulfill these obligations. Credibility refers to the extent that the descriptions are faithful to the data, and can be provided through quotations from the transcriptions (Lincoln & Guba, 1985; Polit & Beck, 2004; Streubert & Carpenter, 1999).

A number of limitations are noted. The number of nurses interviewed was not large, they were similar in age and education, and they lived in a small area of Sweden. Furthermore, only one man was included in the study. One can assume that the nurses thought and acted in similar ways. If the study had been larger and if the informants had been from diverse regions in Sweden, the results might have been different. There was no diversity in race or religion. All except one of the nurses in these studies were married and had children. If the researchers had tried to engage psychiatric nurses from other countries, working in Sweden, the answers and the results might have been more varied.

The Internet narratives were different in many ways; the women who narrated appeared to be from different countries, which could be seen by the way they wrote and what they referred to. A limitation of this study is that the researcher did not meet the women face-to-face in interviews that did not allow for probing. On the other hand, the strength of this Internet study is that the women were not known to the researcher. They could pour out their

hearts and narrate their narratives as they wished. As mentioned before, Internet narratives tend to be more detailed in contrast to verbal narratives, and the secure feeling of being anonymous makes the person reveal their inner thoughts and encourages a rich flow of text relating to different events (Robinson, 2001).

Chapter Eleven

Conclusions

The overall aim of this dissertation was to contribute to the knowledge base of post partum psychosis; specifically the experience of women diagnosed with this disorder; the experience of nurses providing care for women diagnosed with PPP on inpatient psychiatric units; and nursing strategies used when delivering care. The findings have implications for contributing to nursing knowledge development, practice, education, administration and research.

The first research study examined women's descriptions of their experiences with PPP. Study results add further support to the disabling nature of this illness and provided a fuller and richer understanding of the individual experience not fully captured in the medical or nursing literature. Descriptions of the depth of the women's fear add to our understanding of the degree of suffering these women experience. Some of the narratives in this study are old, but the experience of the illness is the same today as before and the findings are relevant also today. Health care professionals often observe only a small part of the course of the illness. It is particularly in the acute phase or in early recovery they meet these women. Medical treatment and nursing strategies generally address the signs and symptoms of the disorder. The additional knowledge gained from this study underscores the need for compassionate care that takes into account all the dimensions of the women's experience.

The second research study explored nurses' descriptions of women with PPP whom they had cared for on inpatient psychiatric units. The descriptions of the women included "chaos" and "strange eyes" which have not been used in the medical or nursing literature. These descriptions may be culturally specific and need to be explored further. Study findings add support to the need for clinical supervision of psychiatric nurses discussed in the literature. The nurses in this study had negative as well as positive feelings towards the women which could have interfered with their nursing care. In the process of clinical supervision, nurses have the opportunity to critically examine their responses to their patients as well as develop a greater understanding of the patient's experience. Through reflective inquiry, nurses can develop more effective nursing strategies to provide comprehensive care for women with PPP. This study also revealed the need for educating nurses about the potential meaning of different signs and symptoms that women with PPP described. For example, women who are "quiet" may not necessarily be calm. The quietness that is observed could also occur when the women are having thoughts of harming themselves or their baby.

The analysis of the data from Study II used for Paper III added support to the literature describing the importance of the nurse patient relationship. The nurses in this study described a number of nursing strategies indicated in the care of psychiatric patients that have been discussed in the nursing literature. A secondary analysis of the data from Study II that was used for Paper IV added to the knowledge base describing nursing presence as an

important therapeutic strategy. The nurses in this study described in great detail the use of physical presence. Since nursing presence is often described as interpersonal presence in the nursing literature, physical presence warrants further exploration.

Descriptions of PPP in the medical and nursing literature, from Studies I and II and the public domain were compared. Descriptions in the medical and nursing literature were categorized under psychosis, postpartum onset; the Internet narratives and other literature in the public domain were found under postpartum psychosis. Information about PPP in the nursing textbooks used in nursing education is very limited and focuses on the signs and symptoms. Nursing care is discussed under “psychosis” and lacks strategies specific to women with PPP. As can be seen in Table 7 there are some similarities and some important differences.

Table 7. An overview of comparing medical, nursing, interviews, Internet narratives, and general information on the Internet.

Medical Literature	Nursing Literature	Nursing Interviews N = 10	Internet Narratives N = 10	General information on the Internet
			Disappointment with delivery and inability to care for baby	
Psychosis	Psychosis	Psychosis (delusions)	Psychosis	Hallucinations or delusions
Paranoid		Paranoid	Paranoid	
Insomnia		Insomnia	Insomnia	Insomnia
Suicidal Ideation	Suicidal Ideation	Suicidal Ideation	Suicidal (self destructive behaviors)	Suicidal thoughts
Infanticidal	Infanticidal	Infanticidal	Infanticidal	Homicidal

Thoughts	Thoughts	thoughts	thoughts	thoughts
	Disconnection from baby	Disconnection with baby	Disconnection from baby (detachment)	
			Detachment from world and surroundings	
Irritability and restlessness	Irritability, agitation		Restless and pacing	Extreme agitation and anxiety
			Lonely	
		Changed personality	Changed personality	
		Aggression		
		Self absorption		
	Shame and Guilt	Shame and Guilt	Shame and Guilt	
Disorientation or confusion			Confused, forgetful, lack of differentiation between past and present events; fear of staying insane	Illogical thoughts
		Quiet (did not correlate with possible suicidality)		
Disorganized behavior	Disorganized behavior	Chaos (due to intense fear, disorientation and anxiety)		
Depressed or elated mood	Manic or Depressed Mood	Only one noted mania	Elation or depression	Delirium or mania
		Strange Eyes		
			Fear and terror	
	Distrust of Staff and dissatisfaction		Distrust of Staff and dissatisfaction	

n with care	n with care	
	Feeling abandoned	
		Refusing to eat
Safety a priority	Safety a priority	
	Physical Presence	

The ill woman's disconnection from the baby is discussed in the literature. This is also described by the women in the Internet Narratives as well as being one of the prominent symptoms mentioned by the nurses in Study II. This finding is not described in the general information on the Internet.

The women in the narratives described themselves as being detached from the world and their surroundings. These findings are not found in the medical, nursing literature or in the general information on the Internet. Nor was it described by the nurses in the Study II.

Shame and guilt were described by the women's narratives as well as in the nursing literature and also described by the nurses in Study II. However shame and guilt were not discussed in the general information on the Internet.

The nurses in Study II used the word quiet to describe some of the women. To be quiet does not necessarily mean that the women with PPP are calm and quiet, but may be pondering about harming herself or her baby. In fact one woman who had been described as quiet in Study II later committed suicide. This finding was only described by the nurses, but not in the medical or the nursing literature nor in the general information on the

Internet. In Study I, five of the women (50 % of the women) described having a desire to kill her baby. This incidence is higher than what is reported in the professional literature (4 %). One could question if the women who's identity is unknown on the Internet were able to share these distressing thoughts due to their anonymity. Given the small number of narratives it is not possible to make any general conclusions, but this finding does raise this important question.

Fear and terror were common descriptions in the women's narratives. All the narratives contain descriptions of a terrifying fear that seem to envelope them. These descriptions were not found in the medical, nursing or in the general information found on the Internet, nor in the nurses' descriptions of the illness. Given the pervasive nature of this fear and the acute distress that follows, it is important for nurses to be aware of this finding so that they can be proactive in their assessment of women with PPP.

Seven of the women's narratives contain descriptions of discontentment with staff and nursing care. This finding raises a number of questions that have already been discussed. Since this finding has also been reported in the nursing literature, patients' satisfaction with nursing care warrants further investigation. There was no discussion of patients' dissatisfaction with nursing care in the medical literature, nor in the general information on the Internet.

A major description in the women's narratives was the feeling of being abandoned. In the reading of the narratives, it is easy to see how this leads to loneliness and isolation. This is another experience that cannot easily be

understood by anyone else. However it raises important questions for nurses to consider when providing care to this group of women. This finding was not found in the medical or nursing literature, and was not described in the descriptions by the nurses.

Implications for Research

A number of areas that need further research were identified in this dissertation. In order to capture the interaction between nurses and women with PPP, research observing interactions and interviews following interactions, i.e. an ethnography study, could add to our knowledge base. To fully understand the phenomenon of nursing presence in relation to caring for women with PPP, the women's own perspective needs to be investigated. Therefore another area of research is the use and impact of physical nursing presence. The nurses' descriptions of the women in Study II included "chaos" and "strange eyes" which has not been used in the medical or nursing literature and needs to be explored further. This dissertation focused on the experiences of the women with PPP. Given the impact of this illness on the family there is still a need to investigate the partners' experiences. To our knowledge there has been no research in other cultures concerning the nursing care for women with PPP or the women's own experiences. Therefore further research in other cultures may add to our knowledge base.

Implications for Knowledge Development

This empirically based dissertation contributes to Kim's (2000a, 2000b, 1994; Kim et al., 2008; Kim & Kollak, 1999) extensive work in knowledge development regarding nursing practice. Several additional concepts in the domain of client were identified in this research including disappointment with the delivery and dissatisfaction with care; shame and guilt, fear and terror, inability to care for the baby, as well as anxiety, loneliness, lack of concentration, confusion, restlessness, and disconnection from the baby and the world. A deeper understanding of the nursing strategies in the domain of practice related to this group of women, suffering from PPP was gained. The nursing strategies including nursing presence, partnership, interaction, communication, and role modeling are important knowledge to further expand nurses' domain of practice.

Knowledge of the domain of client – nurse relationship highlights the importance of presence; at least in the view of nurses' experiences. But the women's experience of their relationships with the nursing staff does raise some important questions. The concept of normalizing reality for the ill women is an important concept, as well building a stable relationship, communication and information. The concept of mutual interaction to involve the patients in their own care and treatment are important concepts. Accordingly the findings can be useful to other professionals who provide care for or interact with women with PPP.

Implications for Clinical Practice and Nursing Education

As a practice profession, it is essential that nurses develop their knowledge of postpartum psychosis in order to implement more comprehensive client interventions to improve the quality of nursing care and positive outcomes for the women and their babies. Nursing textbooks have very limited information about PPP and solely identifies the signs and symptoms. Nursing strategies no longer discuss specific nursing strategies indicated when caring for women with PPP and are now described under the care of patients with psychosis. This change has implications for nursing education and nursing practice. Therefore, there is an essential need for nurses to receive knowledge related to the illness of PPP and specific strategies that need to be used when caring for a woman with PPP. In Sweden, this is particularly important in the specialized nursing education, i.e. for district nurses, midwives, and primarily for psychiatric nurses. Assessment skills must incorporate an understanding of the potential meaning of specific signs and symptoms that these women display in order to recognize the severity of the illness and develop a plan of care that maintains safety. Recognizing the degree of suffering women with PPP experience will hopefully enhance nurses' ability to be compassionate.

Many of the women in the first study were discontent with the care they received. They felt misunderstood, neglected, and not well taken care of. These findings point to the need for further education of nurses as well as doctors concerning postpartum psychosis. The women and their babies need

more support and understanding from the staff; this can be improved by further education and supervision in the clinical setting.

The nurses described negative emotions towards the women with postpartum psychosis which could interfere with the delivery of compassionate care. The importance of recognizing negatively charged emotions was highlighted in the second study. This identified the need for developing a structured system's approach, such as clinical supervision, to promote critical reflection of nurses' clinical practice in psychiatric facilities.

Limitations and strengths

This dissertation has some strengths and limitations. Since the narratives were drawn from the Internet, there was no opportunity to probe for more detailed descriptions or to clarify information. However, telling one's story on the Internet can provide more privacy for the women and allow them to share information that they may not choose to share in face to face interviews. Also the women can pace themselves if the telling of their stories becomes too painful.

The limitations concerning the interviews with the nurses were, as mentioned before, the small sample size, the homogenous group of nurses from a small area, small age differences and only one man. On the other hand, it may be possible to transfer the results to contexts similar to the one studied. One strength of this dissertation was the researcher's familiarity with psychiatric nursing in Sweden. Given her clinical experience, it was easy for the researcher to promote a calm and supportive environment

conducive to face to face interviews in Study II. There are also potential limitations to conducting two secondary analyses from the same data collected from Study II, i.e. paper II and IV. On the other hand a secondary analysis does allow the researchers use of existing data to explore different research questions.

Finally, multiple contributions were made to Kim's conceptual framework. As a result of the theoretical analysis of the study findings, a number of concepts were added to the client, client-nurse and practice domains.

Bibliography

- Agar, M. (1985). "Institutional discourse." *Text*(5). 147-168.
- Ahern, N. (2005). Using the Internet to conduct research. *Nurse Researcher*, 13(2), 55-69.
- Allwood, C.W, Berk, M., & Bodemer, W. (2000). An investigation into puerperal psychoses in black women admitted to Baragwanath Hospital. *South African Medical Journal*, 90(5), 518-520.
- American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (text revision). Washington, DC.
- American Psychiatric Association. (2002). *Diagnostic and statistical manual of mental disorders* (4th ed. Text revision). Pilgrim Press, Danderyd, Sweden.
- Anderson, A., & Klemm, P. (2008). The Internet: friend or foe when providing patient education. *Clinical Journal of Oncology Nursing*, 12(1), 55-63.
- Andersson, E.M., Knutsson, I.K., Hallberg, I.R., & Norberg, A. (1993). The experience of being confused: A case study. A breakdown in communication between a confused patient and a nurse may have everything to do with the nurses' point of view. *Geriatric Nursing*, 14(5),242-247.

- Anis-Ur-Rehman, St Clair, D., & Platz, C. (1990). Puerperal insanity in the 19th and 20th centuries. *British Journal of Psychiatry*, *156*, 861-865.
- Appleby, L., Mortensen, P., & Faragher, E. (1998). Suicide and other causes of mortality after post-partum psychiatric admission. *British Journal of Psychiatry*, *173*, 209-211.
- Areskog, B., Kjessler, B., & Uddenberg, N. (1981). Fear of childbirth in late pregnancy. *Gynecological and Obstetric Investigation*, *12*, 262-266.
- Arvidsson, B., & Skärsäter, I. (2006). *Psykiatrisk omvårdnad (Psychiatric nursing)*. Studentlitteratur, Narayana Press, Denmark.
- Austin, M.P., Kildea, S., & Sullivan, E. (2007). Maternal mortality and psychiatric morbidity in the perinatal period: challenges and opportunities for prevention in the Australian setting. *The Medical Journal of Australia*, *186*(7), 364-367.
- Ayers, S., & Pickering, A.D. (2005). Women's expectations and experiences of birth. *Psychology and Health*, *20*(1), 79-92.
- Azorin, J.M., Kaladjian, A., Besnier, N., Adida, M., Hantouche, E., Lancrenon, S., & Akiskal, H. (2010). Suicidal behaviour in a French cohort of major depressive patients: Characteristics of attempters and nonattempters. *Journal of Affective Disorders*, *123*, 87-94.
- Babu, G., Subbakrishna, D., & Chandra, P. (2008). Prevalence and correlates of suicidality among Indian women with post-partum psychosis in an inpatient setting. *Australian and New Zealand Journal of Psychiatry*, *42*, 976-980.

- Bågedahl-Stridlund, M. (1987). Parapartum mentally ill mothers and their children. Doctoral thesis, Karolinska Institutet, the Institute for Psychiatry, Stockholm Sweden.
- Bågedahl-Stridlund, M., & Ruppert, S. (1998). Parapartum mental illness: A long-term follow-up study. *Psychopathology* 31, 250-259.
- Beck, C., & Driscoll, J. (2006). *Postpartum mood and anxiety disorders*. Jones and Bartlett Publishers, USA.
- Benner, P. (1984). *From novice to expert: excellence and power in clinical nursing practice*. Menlo Park, Calif: Addison-Wesley.
- Benner, P., Tanner, C.A., & Chesla, CA. (2009). *Expertise in nursing practice: caring, clinical judgment & ethics*. New York: Springer Publications.
- Beauchamp, T. L., & Childress, J.F. (1994). *Principles of biomedical ethics*. (4th ed.) New York and Oxford: Oxford University Press.
- Berg, G.V., Hedelin, B., & Sarvimäki, A. (2005). A holistic approach to the promotion of older hospital patients' health. *International Nursing Review*, 52(1), 73-80.
- Berggren, I., & Severinsson, E. (2000). The influence of clinical supervision on nurses' moral decision making. *Nursing Ethics*, 7, 124-135.
- Björkdahl, A., Palmstjärna, T., & Hansebo, G. (2010). The bulldozer and the ballet dancer: aspects of nurses' caring approaches in acute psychiatric intensive care. *Journal of Psychiatric and Mental Health Nursing*, 17, 510-518.

- Bondas, T., & Eriksson, K. (2001). Women's lived experiences of pregnancy: A tapestry of joy and suffering. *Qualitative Health Research, 11*(6), 824-840.
- Borg, M., Karlsson, B., & Kim, H.S. (2009). User involvement in community mental health services - principles and practices. *Journal of Psychiatric & Mental Health Nursing, 16*(3), 285-292.
- Boritz Wintz, C. (1999). Difficult decisions: Women of childbearing age, mental illness, and psychopharmacologic therapy. *Journal of the American Psychiatric Nurses Association, 5*, 5-14.
- Bowskill, R., Clatworthy, J., Parham, R., Rank, T., & Horne, R. (2007). Patients' perceptions of information received about medication prescribed for bipolar disorder: Implications for informed choice. *Journal of Affective Disorders, 100*(1-3), 253-257.
- Brockington, I. (1996). *Motherhood and mental health*. Oxford University Press, Great Britain.
- Brockington, I. (2004a). Postpartum psychiatric disorders. *Lancet, 363*(9405), 303-310.
- Brockington, I. (2004b). Diagnosis and management of postpartum disorders. *World Psychiatry, 3*(2), 89-95.
- Brockington, I. (2006). Early postpartum syncope, delirium and stupor. *Archives of Women's Mental Health, 9*, 347-348
- Brockington, I., Macdonald, E., & Wainscott, G. (2006). Anxiety, obsessions and morbid preoccupations in pregnancy and the puerperium. *Archives of Women's Mental Health, 9*, 253-263.

- Brockington, I., Margison, F., Schofield, E., & Knight, R. (1988). The clinical picture of the depressed form of puerperal psychosis. *Journal of Affective Disorders, 15*, 29-37.
- Buist, A. (1997). Postpartum psychiatric disorders: Guidelines for management. *CNS Drugs 8*, 113-123.
- Buus, N., Angel, S., Traynor, M., & Gonge, H. (2010). Psychiatric hospital nursing staff's experiences of participating in group-based clinical supervision: An interview study. *Issues in Mental Health Nursing, 31*, 654–661.
- Cantwell, R., & Cox, J.L. (2006). Psychiatric disorders in pregnancy and the puerperium. *Current Obstetrics & Gynaecology, 16*(1), 14-20.
- Carlsson, C., Nilbert M., & Nilsson, K. (2005). Supporter or obstructer; experiences from contact person activities among Swedish women with breast cancer. *BMC Health Services Research, 5*(9) 5:9.
- Chandra, P., Bhargavaraman, R., Raghundandan, V. & Shaligram, D. (2006). Delusions related to infant and their association with mother-infant interactions in postpartum psychotic disorders. *Archives of Women's Mental Health, 9*, 285-288.
- Chandra, P., Venkatasubramanian, G., & Thomas, T. (2002). Infanticidal ideas and infanticidal behavior in Indian women with severe postpartum psychiatric disorders. *The Journal of Nervous and Mental Disease, 190*(7), 457-461.
- Chase, S.K. (2001). Response to “The concept of nursing presence: State of the science. *Research and Theory for Nursing Practice, 15*(4), 323-327.

- Chaudron, L. (2006). Critical issues in perinatal psychiatric emergency care. *Psychiatric Times*, 23(6), 1-3.
- Cleary, M., Edwards, C., & Meehan, T. (1999). Factors influencing nurse–patient interaction in the acute psychiatric setting: An exploratory investigation. *Australian and New Zealand Journal of Mental Health Nursing*, 8, 109–116.
- Coastworth-Puspoky, R., Forchuk, C., & Ward-Griffin, C. (2006). Nurse–patient process in mental health: recipients' perspectives. *Journal of Psychiatric and Mental Health Nursing*, 13, 347-355.
- Coles, C. (2002). Developing professional judgment. *Journal of Continuing Educational Health Profession* 22, 3-10.
- Comitz, S., Comitz, G., & Semprevivo, D. (1990). Postpartum psychosis: A family's perspective. *NAACOG's clinical issues in perinatal and women's health nursing*, 1(3), 410-418.
- Comtois, K.A., Schiff, MA., & Grossman, D.C. (2008). Psychiatric risk factors associated with postpartum suicide attempt in Washington State, 1992-2001. *American Journal of Obstetrics and Gynecology*, 199, 120.e1-120.e5.
- Cotton, A. (2003). The discursive field of web-based health research: implications for nursing research in cyberspace. *Advanced in Nursing Science*, 26(4), 307-310.
- Covington, H. (2003). Caring presence. Delineation of a concept for holistic nursing. *Journal of Holistic Nursing*, 21(3), 301-317.

- Crabtree, B.F., & Miller, W. L. (1992). *Doing qualitative research*. London, England: Sage.
- Currid, T.J. (2004a). Issues relating to puerperal psychosis and its management. *Nursing Standard*, 100(17), 40-47.
- Currid, T.J. (2004b). Improving perinatal mental health care. *Nursing Standard*, 19(3), 40-43.
- Darj, E., & Stålnacke, B. (2000). Very early discharge from hospital after normal deliveries. *Upsala Journal of Medical Science*, 105(1), 57-66.
- Dearing, K. (2004). Getting it, together: How the nurse patient relationship influences treatment compliance for patients with Schizophrenia. *Archives of Psychiatric Nursing*, 18(5), 155-163.
- DeLashmutt, M. (2007). Students' experience of nursing presence with poor mothers. *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 36(2), 183-189.
- Doucet, S., Dennis, C., Letourneau, N., & Robertson Blackmore, E. (2009). Differentiation and clinical implications of postpartum depression and postpartum psychosis. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 38, 269-279.
- Doucet, S., Jones, I., Letourneau, N., Dennis, C., & Robertson Blackmore, E. (2010). Interventions for the prevention and treatment of postpartum psychosis: a systematic review. *Archives of Women's Mental Health*, DOI 10.1007/s00737-010-0199-6.
- Drife, J. (2001). Maternal mortality. *Current Obstetrics & Gynaecology*, 12, 314-321.

- Dyson, M. (1999). Intensive care unit psychosis, the therapeutic nurse-patient relationship and the influence of the intensive care setting: analyses of interrelating factors. *Journal of Clinical Nursing*, 8(3), 284-290.
- Ebeid, E., Nassif, N., & Sinha, P. (2010). Prenatal depression leading to postpartum psychosis. *Journal of Obstetrics & Gynaecology*, 30(5), 435-438.
- Eberhard-Gran, M., Garthus-Niegel, S., Garthus-Niegel, K., & Eskild, A. (2010). Postnatal care: a cross-cultural and historical perspective. *Archives of Women's Mental Health*, 13, 459-466.
- Edwards, D. (1997). *Discourse and cognition*. London, Thousands Oaks, New Delhi, Sage.
- Edwards, E., & Timmons, S. (2005). A qualitative study of stigma among women suffering postnatal illness. *Journal of Mental Health*, 14(5), 471-481.
- Efrainsson, E., Sandman, P-O., Hydén, L-C., & Rasmussen, BH. (2004). Discharge planning: 'fooling ourselves?' – patients' participation in conferences. *Journal of Clinical Nursing*, 13, 562-570.
- Engbretson, J. (2000). Caring presence: A case study. *International Journal for Human Caring*, 4(2), 33-39.
- England, S., Richardson, B., & Brockington, I. (1998). Postpartum psychosis after short gestation. *Archives of Women's Mental Health*, 1, 143-146.
- Engqvist, I., Åhlin, A., Ferszt, G., & Nilsson, K. (2010). Nurses – psychiatrists' main collaborators when treating women with postpartum

psychosis. *Journal of Psychiatric and Mental Health Nursing*, 17(6), 494-502.

- Engqvist, I., Åhlin, A., Ferszt, G., & Nilsson, K. (2011). Comprehensive treatment of women with postpartum psychosis across health care systems from Swedish psychiatrists' perspectives. *The Qualitative Report*, 16(1), 66-83.
- Eriksson, I., & Nilsson, K. (2007). Preconditions needed establishing a trusting relationship during health counseling - an interview study. *Journal of Clinical Nursing*, 17(17), 2352-9.
- Eriksson, K. (1994). *Den lidande människan*. (In Swedish. The suffering man). Arlöv: Liber, Stockholm.
- Ewertzon, M., Lützén, K., Svensson E., & Andershed, B. (2010). Family members' involvement in psychiatric care: experiences of the healthcare professionals' approach and feeling of alienation. *Journal of Psychiatric and Mental Health Nursing*, 17, 422-432.
- Falk, K., & Allebeck, P. (2002). Implementing assertive community care for patients with schizophrenia. *Scandinavian Journal of Caring Sciences*, 16, 280-286.
- Filippi, V., Ronsmans, C., Campbell, O.M.R., Graham, WJ., Mills, A., Borghi, J.,... Osrin D. (2006). Maternal health in poor countries: the broader context and a call for action. *Lancet*, 368, 1535-1541.
- Finfgeld-Connett, D. (2006). Meta-synthesis of presence in nursing. *Journal of Advanced Nursing* 55(6), 708-714

- Finfgeld-Connett, D. (2008a). Qualitative comparison and synthesis of nursing presence and caring. *International Journal of Nursing Terminology Classification, 19*(3), 111-119.
- Finfgeld-Connett, D. (2008b). Qualitative convergence of three nursing concepts: art of nursing, presence and caring. *Journal of Advanced Nursing, 63*(5), 527-534.
- Forchuk, C., Westwell, J., Martin, M., Azzopardi, W.B., Kosterewa-Tolman, D., & Hux, M. (1998a). Factors influencing movement of chronic psychiatric patients from the orientation to the working phase of the nurse-client relationship on an inpatient unit. *Perspectives in Psychiatric Care, 34*(1), 36-44.
- Forchuk, C., Chan, L., Schofield, R., Martin, M., Sircelj, M., Woodcox, V.,...Overby, B. (1998b). Bridging the discharge process. *Canadian Nurse, 9* (3), 22–26.
- Forchuk, C., Jewell, J., Schofield, R., Sircelj, M., & Valledor, T. (1998c). From hospital to community: Bridging therapeutic relationships. *Journal of Psychiatric and Mental Health Nursing, 5*(3), 197–202.
- Forchuk, C., Westwell, J., Martin, M., Bamber-Azzopardi, W., Kosterewa-Tolman, D., & Hux, M. (2000). The developing nurse-client relationship: Nurses' perspectives. *Journal of the American Psychiatric Nurses Association, 6*(1), 3–10.
- Forray, A., & Ostroff, R. (2007). The use of electroconvulsive therapy in postpartum affective disorders. *Journal of ECT, 23*, 188-193.

- Friedman, S.H., Horwitz, S.M., & Resnick, P.J. (2005). Child murder by mothers: a critical analysis of the current state of knowledge and a research agenda. *The American Journal of Psychiatry*, 162(9), 1578-1587.
- Friedman, S., Resnick, P., & Rosenthal, M. (2009). Postpartum psychosis: Strategies to protect infant and mother from harm. *The Journal of Family Practice*, 8(2), 40-46.
- Gaiser, T.J., & Schreiner, A.E. (2009). *A guide to conducting online research*. London: Sage.
- Gamble, J., Creedy, D., Moyle, W., Webster, J., McAllister, M., & Dickson, P. (2005). Effectiveness of a counseling intervention after a traumatic childbirth: A randomized controlled trial. *Birth*, 32(1), 11-19.
- Gaskell, C. (1999). A review of puerperal psychosis. *British Journal of Midwifery*, 7, 172-175.
- Gigantesco, A., Picardi, A., Chiaia, E., Balbi, A., & Morosini, P. (2002). Patients' and relatives' satisfaction with psychiatric services in a large catchment area in Rome. *European Psychiatry*, 17, 139-147.
- Glavin, K., Smith, L., Sörum, R., & Ellefsen, B. (2010). Supportive counseling by public health nurses for women with postpartum depression. *Journal of Advanced Nursing* 66(6), 1317-1327.
- Godkin, J. (2001). Healing presence. *Journal of Holistic Nursing*, 19(1), 5-21.

- Graneheim, U.H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts procedures and measures to achieve trustworthiness. *Nurse Education Today*, 24, 105-112.
- Green, L., Elliott, S., Anwar L., Best, E., Tero, M., Sarkar A.,... Boocock, A. (2008). An audit of pregnant women with severe mental illness referred during the first 2 years of a new perinatal mental health service. *Archives of Women's Mental Health*, 11, 149-158.
- Grigoriadis, S., & Romans, S. (2006). Postpartum psychiatric disorders: What do we know and where do we go? *Current Psychiatric Reviews*, 2(1), 151-158.
- Grube, M. (2005). Inpatient treatment of women with postpartum psychiatric disorders – the role of the male partners. *Archives of Women's Mental Health*, 8, 163-170.
- Hagberg, H., Marsal, K., & Westgren, M. (2008). *Obstetrik* (In Swedish: Obstetrics). Studentlitteratur, Elanders Hungary Kft, Hungary.
- Haglund, K., von Knorring, L., & von Essen, L. (2003). Forced medication in psychiatric care: patient experiences and nurse perceptions. *Journal of Psychiatric and Mental Health Nursing*, 10, 65-72.
- Halbreich, U. (2005). Postpartum disorders: multiple interacting underlying mechanisms and risk factors. *Journal of Affective Disorders*, 88(1), 1-7.
- Handsley, S., & Stocks, S. (2009). Sociology and nursing: Role performance in a psychiatric setting. *International Journal of Mental Health Nursing*, 18, 26-34.

- Handy, J., & Ross, K. (2005). Using written accounts in qualitative research. *South Pacific Journal of Psychology, 16*(1), 40-47.
- Hansson, L. (1989). Patient satisfaction with in-hospital psychiatric care. A study of a 1-year population of patients hospitalized in a sectorized care organization. *European Archives of Psychiatry and Neurological Sciences, 239*, 93–100.
- Harlow, B., Vitonis, A., Sparen, P., Cnattingius, S., Hadine J., & Hultman, C. (2007). Incidence of hospitalization for postpartum psychotic and bipolar episodes in women with and without prior prepregnancy or prenatal psychiatric hospitalizations. *Archives of General Psychiatry, 64*, 42-48.
- Harwood, K., McLean, N., & Durkin, K. (2007). First-time mothers' expectations of parenthood: What happens when optimistic expectations are not matched by later experiences? *Developmental Psychology, 43*(1), 1-12.
- Hätönen, H., Suhonen, R., Warro, A., Pitkänen, A., & Välimäki, M. (2010). Patients' perceptions of patient education on psychiatric inpatient wards: a qualitative study. *Journal of Psychiatric and Mental Health Nursing, 17*, 335–341
- Hellzen, O., Asplund, K., Gilje, F., Sandman, P-O., & Norberg, A. (1998). From optimism to pessimism. A case study of a psychiatric patient. *Journal of Clinical Nursing 7*(4), 360-370.
- Heron, J., Haque, S., Oyebode, F., Craddock, N., & Jones, I. (2009). A longitudinal study of hypomania and depression symptoms in

- pregnancy and the postpartum period. *Bipolar Disorders*, 11(4), 410–417.
- Heron, J., McGuinness, M., Robertson Blackmore, E., Craddock, N., & Jones, I. (2008). Early postpartum symptoms in puerperal psychosis. *British Journal of Obstetrics and Gynaecology*, 115, 348-353.
- Heron, J., Robertson Blackmore, E., McGuinness, M., Craddock, N., & Jones, I. (2007). No 'latent period' in the onset of bipolar affective puerperal psychosis. *Archives of Women's Mental Health*, 10(2), 79-81.
- Hewitt, J., & Coffey, M. (2005). Therapeutic working relationships with people with schizophrenia: literature review. *Journal of Advanced Nursing* 52(5), 561-570.
- Hodelet, N. (2001). Psychosis and offending in British Columbia: characteristics of a secure hospital population. *Criminal Behavior and Mental Health*, 11(3), 163-172.
- Holma, J., & Aaltonen, J. (1998). Narrative understanding in acute psychosis. *Contemporary Family Therapy*, 20(3), 253-263.
- Hornstein, C., Trautmann-Villalba, P., Hohm, E., Rave, E., Wortmann-Fleischer, S., & Schwarz, M. (2006). Maternal bond and mother-child interaction in severe postpartum psychiatric disorders: is there a link? *Archives of Women's Mental Health*, 9(5), 279-284.
- Howard, L.M., Goss, C., Leese, M., Appleby, L., & Thornicroft, G. (2004). The psychosocial outcome of pregnancy in women with psychotic disorders. *Schizophrenia Research*, 71(1), 49-60.

- Howard, P.B., Clark, J.J., Rayens, M.K., Hines-Martin, V., Weaver, P., & Littrell, R. (2001). Consumer satisfaction with services in a regional psychiatric hospital: a collaborative research project in Kentucky. *Archives of Psychiatric Nursing, 15*, 10–23.
- Howard, P.B., El-Mallakh, P., Rayens, M.K., & Clark, J. (2003). Consumer perspectives on quality of in consumer mental health services. *Archives of Psychiatric Nursing, 17*, 205–217.
- Höye, S., & Severinsson, E. (2010). Professional and cultural conflicts for intensive care nurses. *Journal of Advanced Nursing 66*(4), 858–867.
- Hsieh, H-F & Shannon, S. (2005). Three Approaches to Qualitative Content Analysis. *Qualitative Health Research, 15*(9), 1277-1288.
- Hydén, L-C. (2008). Narrative in illness. *Qualitative Sociology Review, (4)*3, 49-58.
- Hydén, L.-C., & Hydén, M. (1997). *Att studera berättelser*. In Swedish. (To study narratives). Stockholm, Liber.
- ICD. (1974). ICD-9-CM. *International statistical classification of diseases clinical modification - mental disorders and glossary* (9th revision) WHO.
- ICD. (1992). ICD 10. *International statistical classification of diseases and health related problems* (10th revision) WHO.
- Jarrett, N.J., & Payne, SA. (2000). Creating and maintaining optimism in cancer care. *International Journal of Nursing Studies, 31*, 81-90.
- Jaspers, M., de Meer, G., Verhulst, F.C., Ormel, J., & Reijneveld, S.A. (2010). Limited validity of parental recall on pregnancy, birth, and

- early childhood at child age 10 years. *Journal of Clinical Epidemiology*, 63, 185-191.
- Johansson, B. (1989). *Omvårdnaden och dess villkor. En studie av kunskapsanvändning i förhållande till determinerande faktorer*. Göteborg: Institutionen för vårdlärarutbildning, Göteborgs universitet. (Nursing care and its conditions. A study of knowledge use in relation to determined factors. Gothenburg: School of Health Teacher Education, University of Gothenburg.)
- Johansson, H., & Eklund, M. (2003). Patients' opinion on what constitutes good psychiatric care. *Scandinavian Journal of Caring Sciences*, 17, 339-346.
- Jones, H., & Venis, J. (2001). Postpartum psychiatric disorders. *Journal of Psychosocial Nursing*, 39, 23-30.
- Jones, I., & Cantwell, R. (2010). The classification of perinatal mood disorders – suggestions for DSM V and ICD 11. *Archives of Women's Mental Health*, 13, 33-36.
- Jones, I., & Craddock, N. (2001). Familiality of the puerperal trigger in bipolar disorder: Results of a family study. *American Journal of Psychiatry*, 158, 913-917.
- Jones, I., & Craddock, N. (2005). Bipolar disorder and childbirth: the importance of recognizing risk. *The British Journal of Psychiatry: The Journal of Mental Science*, 186, 453-454.
- Kaliski, S.Z. (2002). A comparison of risk factors for habitual violence in pre-trial subjects. *Acta Psychiatrica Scandinavica*, 106(s 412), 58-61.

- Kendall-Tackett, A. (1993). *Postpartum depression – a comprehensive approach for nurses*. Newbury Park: SAGE publications.
- Kendell, R.E., Chalmers, J.C., & Platz, C. (1987). Epidemiology of puerperal psychoses. *British Journal of Psychiatry*, *150*, 662-673.
- Kessing, L.V., Hansen, H.V., Ruggeri, M., & Bech, P. (2006). Satisfaction with treatment among patients with depressive and bipolar disorders. *Social Psychiatry and Psychiatric Epidemiology*, *41*(2), 148-155.
- Kihlgren, A.L., Nilsson, M., & Sörlie, V. (2005). Caring for older patients at an emergency department -- emergency nurses' reasoning. *Journal of Clinical Nursing* *14*(5), 601-608.
- Kim, H.S. (1994). Practice theories in nursing and a science of nursing practice. *Scholarly Inquiry for Nursing Practice*, *8*(2), 145-158.
- Kim, H.S. (2000a). *The nature of theoretical thinking in nursing*. (2nd ed.). Springer Publishing Company, NY.
- Kim, H.S. (2000b). An integrative framework for conceptualizing clients: A proposal for a nursing perspective in the new century. *Nursing Science Quarterly*, *13*(1), 37-44.
- Kim, H.S., Ellefsen, B., Han K.J., & Alves, S.L. (2008). Clinical constructions by nurses in Korea, Norway, and the United States. *Western Journal of Nursing Research*, *30*(1), 54-72.
- Kim, H. S., & Kollak, I. (1999). *Nursing theories. Conceptual and philosophical foundations*. Springer Publishing Company, NY.

- Klompshouwer, J., van Hulst, A., Tulen, J., Jacobs, M., Jacobs, B., & Segers, F. (1995). The clinical features of postpartum psychoses. *European Psychiatry, 10*, 355-367.
- Knops, G. (1993). Postpartum mood disorders. *Postgraduate Medicine, 93*, 103-116.
- Koenen, M., & Thompson, J. (2008). Filicide: Historical review and prevention of child death by parent. *Infant Mental Health Journal, 29*(1), 61-75.
- Kondracki, N. (2002). Content analysis: Review of methods and their applications in nutrition education. *Journal of Nutrition Education Behaviours, 34*, 224-230.
- Koslander, T., Barbosa da Silva, A., & Roxberg, Å. (2009). Existential and spiritual needs in mental health care: An ethical and holistic perspective. *Journal of Holistic Nursing, 27*(1), 34-35.
- Krippendorff, K. (1980). *Content analysis. An introduction to its methodology*. The Sage Commtext Series, Sage Publications, Ltd, London.
- Krippendorff, K. (2004). *Content analysis. An introduction to its methodology*. Sage Publications, USA.
- Kumar, R. (1994). Postnatal mental illness: a transcultural perspective. *Social Psychiatry and Psychiatric Epidemiology, 29*, 250-264.
- Kvale, S., & Brinkmann, S. (2009). *Den kvalitativa forskningsintervjun (The qualitative research interview)*. 2nd ed. Studentlitteratur, Lund, Sweden.

- Lagan, M., Knights, K., Barton, J., & Boyce, P. (2009). Advocacy for mothers with psychiatric illness: A clinical perspective. *International Journal of Mental Health Nursing, 18*, 53-61.
- Lanczik, M., Bergant, A., & Klier, C. (2006). Are severe psychiatric disorders in childhood of endogenous or organic nature? German contributions to the biological, nosological and psychopathological research in postpartum psychosis in the 18(th) and 19(th) century. *Archives of Womens Mental Health, 9*(5), 293-299.
- Längle, G., Baum, W., Wollinger, A., Renner, G., U'ren, R., Schwärzler, F., & Eschweiler, G. (2003). Indicators of quality of in-patient psychiatric treatment: the patients' view. *International Journal for Quality in Health Care, 15*, 213-221.
- Langley, G.C., & Klooper, H. (2005). Trust as a foundation for the therapeutic intervention for patients with borderline personality disorders. *Journal of Psychiatric and Mental Health Nursing, 12*, 23-32.
- Larsson, S. (1986). *Kvalitativ analys – exemplet fenomenografi. (In Swedish. Qualitative analysis – the example of phenomenography)*. Studentlitteratur, Lund, Sweden.
- Latvala, E., Janhonen, S., & Moring, J. (2000). Passive patients: a challenge to psychiatric nurses. *Perspectives in Psychiatric Care, 36*, 24–32.
- Lavender, T., & Walkingshaw, S. (1998). Can midwives reduce postpartum psychological morbidity? A randomized trial. *Birth, 25*(4) 215-219.

- Levy, M., Sanders, D., & Sabrow, S. (2002). Moms who kill – when depression turns deadly. *Psychology Today*, Nov. 02, 60-66.
- Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry*, SAGE Publications, Newbury Park.
- Lindahl, V., Pearson, J., & Colpe, L. (2005). Prevalence of suicidality during pregnancy and the postpartum. *Archives of Women's Mental Health*, 8, 77-87.
- Lindström, U. (1994). *Psykiatrisk vårdlära*. (In Swedish. Psychiatric nursing). Liber, Stockholm.
- Linell, P. (1994). *Transkription av tal och samtal: teori och praktik*. (In Swedish. Transcription of speech, theory and practice). Linköping, Linköpings universitet, Sweden.
- Littlewood, R., Jadhav, S., & Ryder, A. (2007). A cross-national study of the stigmatization of severe psychiatric illness. Historical review, methodological considerations and development of the questionnaire. *Transcultural Psychiatry*, 44(2), 171-202.
- Liu, Y., & Tien, Y. (2009). Internet research methods: advantages and challenges. *Journal of Nursing*, 56(6), 71-75.
- Lovell, K. (1995). User satisfaction with in-patient mental health services. *Journal of Psychiatric and Mental Health Nursing*, 2, 143-50.
- Lovestone, S., & Kumar, R. (1993). Postnatal psychiatric illness: the impact on partners. *The British Journal of Psychiatry*, 163, 210-216.

- Lundström, M., Åström, S., & Graneheim, U. (2007). Caregivers' experiences of exposure to violence in services for people with learning disabilities. *Journal of Psychiatric and Mental Health Nursing, 14*(4), 338-345.
- Lützén, K., & Nordin, C. (1993). Benevolence, a central moral concept derived from a grounded theory study of nursing decision making in psychiatric settings. *Journal of Advanced Nursing, 18*, 1106-1111.
- Määttä, S. (2006). Closeness and distance in the nurse-patient relation. The relevance of Edith Stein's concept of empathy. *Nursing Philosophy, 7*(1), 3-10.
- Marmion, S. (2000). Reflections on emotional disturbances after childbirth. *British Journal of Midwifery, 8*(9), 539 - 543.
- McCabe, C. (2004). Nurse-patient communication: an exploration of patients' experiences. *Journal of Clinical Nursing, 13*, 41-49.
- McGillis Hall, L., & Kiesners, D. (2005). "A narrative approach to understanding the nursing work environment in Canada". *Social Science & Medicine 61*(12), 2482-2491.
- Melender, H.L. (2002). Experiences of fear associated with pregnancy and childbirth: A study of 329 pregnant women. *Birth, 29*(2), 101-111.
- Menon, S. (2008). Psychotropic medication during pregnancy and lactation. *Archives of Gynaecology and Obstetrics, 277*, 1-13.
- Midtgaard, J., Stelter, R., Rört, M., & Adamsen, L. (2007). Regaining a sense of agency and shared self-reliance: the experience of advanced disease cancer patients participating in a multidimensional exercise

- intervention while undergoing chemotherapy--analysis of patient diaries. *Scandinavian Journal of Psychology*, 48(2), 181-190.
- Miles, A. (2009). Of butterflies and wolves: enacting lupus transformations on the Internet. *Anthropology and Medicine*, 16(1), 1-12.
- Miles, M., & Huberman, M. (1994). *An expanded sourcebook. Qualitative data analysis*(2nd. ed.). Sage Publications, USA.
- Miller, W.L., & Crabtree, B.F. (1994). *Clinical research*. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 607-632). London, England: Sage.
- Mishler, E.G. (1984). *The discourse of medicine. Dialectics of medical interviews*. Norwood, NJ: Ablex.
- Mishler, E.G. (1986). *Research interviewing. Context and narrative*. Cambridge, Ma, Harvard University Press.
- Moehler, E., Brunner, R., Wiebel, A., Reck, C., & Resch, F. (2006). Maternal depressive symptoms in the postnatal period are associated with long-term impairment of mother-child bonding. *Archives of Women's Mental Health*, 9,273-278.
- Morrissey, M.V. (2007). Suffer no more in silence: challenging the myths of women's mental health in childbearing. *International Journal of Psychiatric Nursing Research*, 12(2), 1429-1438.
- Morse, J., & Field, P. (1995). *Qualitative research methods health professionals*. (2nd ed.).Sage Publications, USA.
- Morse, J.M., & Field, P.A. (1998). *Nursing research, the application of qualitative approaches*. WestKey Limited, Falmouth, Cornwall.

- Mowbray, C.T., Oyserman, D., Zemencuk, J.K., & Ross, S.R. (1995).
Motherhood for women with serious mental illness: pregnancy,
childbirth, and the postpartum period. *American Journal of
Orthopsychiatry*, 65(1),21-38.
- Munk-Olsen, T., Munk-Laursen, T., Mendelson, T., Pedersen, C., Mors, O.,
& Mortensen, P.B. (2009). Risks and predictors of readmission for a
mental disorder during the postpartum period. *Archives of General
Psychiatry*, 66(2), 189-195.
- Murray, L., Cooper, P., & Hipwell, A. (2003). Mental health of parents
caring for infants. *Archives of Womens Mental Health*, 6 Suppl 2, S71-
77.
- Nager, A. (2009). Postpartum psychosis and the association with
sociodemographic and obstetric factors. Thesis for doctoral degree.
Karolinska Institutet, Sweden.
- Nager, A., Johansson, L-M., & Sundqvist, K. (2005). Are sociodemographic
factors and year of delivery associated with hospital admission for
postpartum psychosis? A study of 500 000 first-time mothers. *Acta
Psychiatrica Scandinavica*, 112,47-53.
- Nager, A., Sundqvist, K., Ramírez-León, V., & Johansson, LM. (2008).
Obstetric complications and postpartum psychosis: a follow-up study of
1.1 million first-time mothers between 1975 and 2003 in Sweden. *Acta
Psychiatrica Scandinavica*, 117(1), 12-19.

- Nielsen Dana, S., & Wambach, K. (2003). Patient satisfaction with an early discharge home visit program. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 32(2), 190-198.
- Nilsson, K. (2003). *Mandate - power - management: a study of nursing managers' experience of leadership in the health care sector* [In Swedish] (Diss). Göteborg, Acta Universitatis Gothoburgensis.
- Nilsson, K., Campbell, A.M., & Pilhammar Andersson, E. (2008). Night Nursing - a study of the working conditions and duties of the night staff. *BMC Nursing*, 7:13.
- Nilsson, K., & Warrén Stomberg, M. (2008). Nursing students motivation towards their studies - a survey study. *BMC Nursing*, 7:6.
- Nilsson, K., Lundgren, S., & Furåker, C. (2009). Everyday activities of registered nurses in municipal health care - a study of diaries. *International Journal of Nursing Practice*, 15(6), 543-552.
- Noorlander Y., Bergink, V., & van den Berg, M. (2008). Perceived and observed mother-child interaction at time of hospitalization and release in postpartum depression and psychosis. *Archives of Women's Mental Health*, 11, 49-56.
- Nylander, H. (2005). *Jag fick barn – och hamnade på psyket (I had a baby and ended up in the psychiatric clinic)*. (2nd ed.). Pappersverkstan, Visby, Sweden.
- Nystedt, A., Högberg, U., & Lundman, B. (2005). The negative birth experience of prolonged labour: a case-referent study. *Journal of Clinical Nursing*, 14(5), 579-586.

- Oates, M. (2003). Perinatal psychiatric disorders: a leading cause of maternal morbidity and mortality. *British Medical Bulletin*, *67*, 219-229.
- Okano, T., Nomura, J., Kumar, R., Kaneka, E., Tamaki, R., Hanafusa, I.,... Matsuyama, A. (1998). An epidemiological and clinical investigation of postpartum psychiatric illness in Japanese mothers. *Journal of Affective Disorders*, *48*, 233-240.
- Olin, R-M., & Faxelid, E. (2003). Parents' needs to talk about their experiences of childbirth. *Scandinavian Journal of Caring Sciences*, *17*(2), 153-159.
- Olofsson, B., & Norberg, A. (2001). Experiences of coercion in psychiatric care as narrated by patients, nurses and physicians. *Journal of Advanced Nursing*, *33*(1), 89-97.
- Osterman, P. (2002). *A participant observation study of experienced nurses' presence in daily care*. Doctoral Dissertation, University of Rhode Island.
- Osterman, P., & Schwartz-Barcott, D. (1996). Presence: Four ways of being there. *Nursing Forum*, *31*(2), 23-30.
- Osterman, P., Schwartz-Barcott, D. & Asselin, M. (2010). An exploratory study of nurses' presence in daily care on an oncology unit. *Nursing Forum*, *45*(3), 197-205.
- Paffenbarger, R., Steinmetz, C., Pooler, B., & Hyde, R. (1961). The picture puzzle of the postpartum psychosis. *Journal of Chronic Diseases*, *13*(2), 161-173.

- Patel, R., & Davidsson, B. (2003). *Forskningsmetodikens grunder. Att planera, genomföra och rapportera en undersökning*. (In Swedish. The foundation of research methods. To plan, implement and report a study). Studentlitteratur, Lund, Sweden.
- Peplau, H. (1952). *Interpersonal relation in nursing. A conceptual frame of reference for psychodynamic nursing*. MacMillian Education, London.
- Peplau, H. (1988). The art and science of nursing: similarities, differences and relations. *Nursing Science Quartely*, 1, 8-15.
- Peplau, H. (1997). Peplau's theory of interpersonal relations. *Nursing Science Quartely* 10(4):162-167.
- Philipp, D., Fivaz-Depeursinge, E., Corboz-Warnery, A., & Favez, N. (2009). Young infants' triangular communication with their parents in the context of maternal postpartum psychosis: four case studies. *Infants Mental Health Journal*, 30 (4), 341-365.
- Pfuhmann, B., Franzek, E., Beckmann, H., & Stöber, G. (1999). Long-term course and outcome of severe postpartum psychiatric disorders. *Psychopathology*, 32, 192-202.
- Pfuhmann, B., Stöber, G., & Beckmann, H. (2002). Postpartum psychoses: Prognosis, risk factors, and treatment. *Current Psychiatry Reports*, 4, 185-190.
- Pillitteri, A. (2009). *Maternal and child health nursing: Care of the childbearing and childrearing family*. (6th ed.) Philadelphia: Lippincott Williams & Wilkins.

- Polit, D.F., & Beck, C.T. (2004). *Nursing research. Principles and methods* (7th ed.). Philadelphia: Lippincott Williams & Wilkins.
- Polit, D.F., & Beck, C.T. (2008). *Nursing research: Generating and Assessing Evidence for Nursing Practice* (8th ed.). Philadelphia: Lippincott.
- Posmontier, B. (2010). The role of midwives in facilitating recovery in postpartum psychosis. *Journal of Midwifery & Women's Health, 55*(5), 430-437.
- Putkonen, H., Weizmann-Henelius, G., Collander, J., Santtila, P., & Eronen, M. (2007). Neonaticides may be more preventable and heterogeneous than previously thought - neonaticides in Finland 1980-2000. *Archives of Womens Mental Health, 10*(1), 15-23.
- Råholm, M-B., & Lindholm, L. (1999). Being in the world of the suffering patient: a challenge to nursing ethics. *Nursing Ethics, 6*(6), 528-539.
- Randers, I., Olson, T., & Mattiasson, A-C. (2002). Confirming older adult patients' views of who they are and would like to be. *Nursing Ethics, 9*(4), 416-431.
- Reed P., Sermin, N., Appleby, L., & Faragher, B. (1999). A comparison of clinical response to electroconvulsive therapy in puerperal and non-puerperal psychoses. *Journal of Affective Disorders, 54*(3), 255-260.
- Robertson, E., & Lyons, A. (2003). Living with puerperal psychosis: A qualitative analysis. *Psychology and psychotherapy: Theory, Research and Practice, 76*, 411-431.

- Robinson, K. (2001). Unsolicited narratives from the Internet: A rich source of qualitative data. *Qualitative Health Research, 11* (5), 706-714.
- Roca, E. (2007). Intuitive practical wisdom in organizational life. *Social Epistemology, 21*(2), 195 - 207.
- Rowan, C., Bick, S., & da Silva Bastos, M. (2007). Postnatal debriefing interventions to prevent maternal mental health problems after birth: Exploring the gap between the evidence and UK policy and practice. *Worldviews on Evidence-Based Nursing, 4*(2), 97-105.
- Rubin, H., & Rubin, I. (1995). *Qualitative interviewing: The art of hearing data*. Thousand Oaks, CA: Sage
- Ruppert, S., & Bågedahl-Stridlund, M. (2001). Children of parapatum mentally ill mothers: A follow-up study. *Psychopathology, 34*(4), 174–178.
- Saisto, T., & Halmesmälis, E. (2003). Fear of childbirth: a neglected dilemma. *Acta Obstetrica et Gynecologica Scandinavica, 82*, 201-208.
- Salzmann-Erikson, M., Lützén, K., Ivarsson, A-B., & Eriksson, H. (2008). The core characteristics and nursing care activities in psychiatric intensive care units in Sweden. *International Journal of Mental Health Nursing, 17*, 98–107.
- Sandelowski, M. (2000). Focus on research methods. Whatever happened to qualitative description? *Research in Nursing & Health, 23*, 334-340.
- Schopf, J., & Rust, B. (1994). Follow-up and family study of postpartum psychoses. Part I: overview. *European Archives of Psychiatry and Clinical Neuroscience, 244*, 101-111.

- Schout, G., Dee Jong, G., & Zeelen, J. (2010). Establishing contact and gaining trust: an exploratory study of care avoidance. *Journal of Advanced Nursing*, 66(2), 324–333.
- Schröder, A., Ahlström, G., & Larsson, BW. (2006). Patients' perceptions of the concept of the quality of care in the psychiatric setting: a phenomenographic study. *Journal of Clinical Nursing*, 15(1), 93-102.
- Seale, C. (2004). *Researching society and culture*. SAGE Publications London Thousand Oaks New Delhi, India.
- Seidman, I. (1998). *Interviewing as qualitative research. A guide for researchers in education and the social sciences*. (2nd ed.). New York: Teachers College, Columbia University, USA.
- Semprevivo, D.M. (1996). *The lived experience of postpartum mental illness*. Doctoral Dissertation, Rush University, Chicago
- Semprevivo, D.M., & McGrath, J. (1990). A select psychiatric mother and baby unit in Britain: Implications for care in the United States. *NAACOG's clinical issues in perinatal and women's health nursing* 1, 402-409.
- Seyfried, L.S., & Marcus, SM. (2003). Postpartum mood disorders. *International Review of Psychiatry*, 15(3), 231-242.
- Sharma, V. (2003). Role of sleep loss in the causation of puerperal psychosis. *Medical Hypotheses*, 61, 477-481.
- Sharma, V. (2008). Treatment of postpartum psychosis: Challenges and opportunities. *Current Drug Safety*, 3, 76-81.

- Sharma V., & Mazmanian, D. (2003). Sleep loss and postpartum psychosis. *Bipolar Disorders, 5*, 98-105.
- Sharma, V., Smith, A., & Khan, M. (2004). Brief report. The relationship between duration of labour, time of delivery, and puerperal psychosis. *Journal of Affective Disorders, 83*, 215-220.
- Sharma, V., Smith, A., & Mazmanian, D. (2006). Olanzapine in the prevention of postpartum psychosis and mood episodes in bipolar disorder. *Bipolar Disorders, 8*, 400–404.
- Shattell, M. (2004). Nurse-patient interaction: a review of the literature. *Journal of Clinical Nursing, 13*, 714-722.
- Shattell, M., McAllister, S., Hogan, B., & Thomas, S. (2006). “She took the time to make sure she understood”: Mental health patients’ experiences of being understood. *Archives of Psychiatric Nursing, 20*(5), 234–241.
- Silverman, D. (1993). *Interpreting qualitative data: methods for analyzing talk, text and interaction*. Sage Publications, London.
- Silverman, D. (2001). *Interpreting qualitative data: Method for analysing talk, text and interaction*. Sage Publications, London.
- Sit, D., Rothschild, A.J., & Wisner, K. L. (2006). A review of postpartum psychosis. *Journal of Women's Health, 15*(4), 352-368.
- Sjögren, B. (1997). Reasons for anxiety about childbirth in 100 pregnant women. *Journal of Psychosomatic Obstetrics and Gynecology, 18*, 266-272.
- Spinelli, M.G. (2001). A systematic investigation of 16 cases of neonaticide. *American Journal of Psychiatry, 158*, 811–813.

- Spinelli, M.G. (2004). Maternal infanticide associated with mental illness: Prevention and the promise of saved lives. *American Journal of Psychiatry*, 16(9), 1548-1557.
- Spinelli, M.G. (2009). Postpartum psychosis: Detection of risk and management. *American Journal of Psychiatry*, 166(4), 405-408.
- Stern, D., Bruschweiler-Stern, N., & Freeland, A. (1999). *The birth of a mother: How the motherhood experience changes you forever*. Basic Books, New York, USA.
- Stewart, C., & Henshaw, C. (2002). Midwives and perinatal mental health. *British Journal of Midwifery*, 10(2), 117-121.
- Stone, S.D. (2007). Patient concerns posthaemorrhagic stroke: a study of the internet narratives of patients with ruptured arteriovenous malformation. *Journal of Clinical Nursing*, 16(2), 289-297.
- Streubert, H., & Carpenter, D. (1999). *Qualitative Research in Nursing*. (2nd ed.). Lippincott, NY.
- Suhonen, R., Gustafsson, M-L., Katajisto, J., Välimäki, M., & Leino-Kilpi, H. (2010). Nurses' perceptions of individualized care. *Journal of Advanced Nursing*, 66(5), 1035–1046.
- Sullivan, CF. (2008). Cybersupport: empowering asthma caregivers. *Pediatric Nursing*, 34(3), 217-224.
- Svensson, B., & Hansson, L. (1994). Patients' satisfaction with inpatient psychiatric care. The influence of personality traits, diagnosis, and perceived coercion. *Acta Psychiatrica Scandinavica*, 90, 379–84.

- Terp, I.M., & Mortensen, P.B. (1998). Postpartum psychoses. Clinical diagnoses and relative risk of admission after parturition. *The British Journal of Psychiatry*, 172, 521-526.
- The Health and Medical Services Act. (1982:763). Stockholm, Sweden: Ministry of Health and Social Affairs.
- The Health and Medical Services Act. (1982:763/2010:662). Stockholm, Sweden: Ministry of Health and Social Affairs.
- The act of psychiatric compulsory institutional care. (1991:1128/2008:415). Stockholm, Sweden: Ministry of Health and Social Affairs.
- The National Board of Welfare. (2005-105-12005). Socialstyrelsen. Socialstyrelsens kompetensbeskrivning för legitimerad sjuksköterska. (In Swedish. The National Board of competence description of a nurse).
- The National Board of Welfare. (2009). Graviditeter, förlossningar och nyfödda barn – Medicinska födelseregistret 1973–2008, Assisterad befruktning 1991–2007. (In Swedish. Pregnancy, childbirth and neonates. Medical Birth Register 1973-2008. Assisted reproduction 1991-2007). Stockholm: The National Board of Welfare.
- Thorne, S. (1994). *Secondary analysis in qualitative research*. In J. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 263-279). Thousand Oaks, CA: Sage.
- Torrey, E.F. (1994). Violent behavior by individuals with serious mental illness. *Hospital & Community Psychiatry*, 45(7), 653-662.

- Ugarriza, D.N. (1992). Postpartum affective disorders: Incidence and treatment. *Journal of Psychosocial Nursing*, 30, 29-32.
- Valdimarsdottir, U., Hultman, C., Harlow, B., Cnattingius, S., & Sparen, P. (2009). Psychotic illness in first-time mothers with no previous psychiatric hospitalizations: A population-based study. *PLoS Med.*, 6(2), 13.
- Vamos, M. (2008). "The cognitive side effects of modern ECT: patient experience or objective measurement?" *Journal of ECT* 24(1), 18-24.
- Videbech, P., & Gouliaev, G. (1995). First admission with puerperal psychosis: 7-14 years of follow-up. *Acta Psychiatrica Scandinavica*, 91, 167-173.
- Wesemann, D., & Grunwald, M. (2008). Online discussion group for bulimia nervosa: An introductory approach to Internet-based communication between patients. *International Journal of Eating Disorders*, 41, 527-534.
- Wilson, L., Reid, A.J., Midmer, D.K., Biringer, A., Carroll, J.C., & Stewart, D.E. (1996). Antenatal psychosocial risk factors associated with adverse postpartum family outcomes. *Canadian Medical Association Journal*, 154(6), 785-799.
- White, J. (1995). Patterns of knowing: review, critique, and update. *Advances in Nursing Science* 17(4), 73-86.
- Whitmore, J., Heron, J., & Wainscott, G. (2010). Predictors of parenting concern in a mother and baby unit over a 10-year period. *International Journal of Social Psychiatry*, doi: 1177/0020764010365412.

- World Medical Association: Declaration of Helsinki. (2002). Ethical principles for medical research involving human subjects. *Nursing Ethics*, 9(1), 105-109.
- Yin, R. K. (1984). *Case study research: Design and methods*. Newbury Park, CA: Sage.
- Yonge, O. & Stewin, L. (1992). What psychiatric nurses say about constant care. *Clinical Nursing Research* 1(1), 80-90.
- Yonkers, K., Wisner, K., Stowe, Z., Leibensluft, E., Cohen, L., Manber, R., ... Altshuler, L. (2004). Management of bipolar disorder during pregnancy and the postpartum period. *American Journal of Psychiatry*, 161(4), 608-620.
- Ziebland, S., Chapple, A., Dunelow, C., Evans, J., Prinijha, S., & Rozmovits, L. (2004). How the internet affects patients exploration of cancer. *British Medical Journal*, 328 (7439), 564-567.