

# **NURSING FOR CHILDREN WITH PARENTAL DEPRESSION**

**Chen You**

**Ollagnier Nadège**

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**JYVÄSKYLÄN AMMATTIKORKEAKOULU**  
JAMK UNIVERSITY OF APPLIED SCIENCES

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Abstract  <p>Depression is a significant mental illness treated in various health care settings in Finland, such as closed or open psychiatric wards, clinics but also in any other health institution. Nurses can meet depressive patients in any working environment.</p> <p>Depressive patients experience a various range of symptoms and those having children can encounter challenges in their parenting skills. Therefore children can be impacted by their parent's condition. Nevertheless, child-parent bonding and positive relationship is essential in child's development and general well-being. Based on this knowledge, it appeared relevant to explore how nurses working in psychiatric wards experienced the care of children with parental depression. More specifically, the aim of this research was to identify the main challenges nurses face when dealing with children of patients suffering from depression. The purposes were to have a better understanding on the obstacles working with children of depressive patients nurses can face, help to adapt the solution and support given to nursing staff in dealing with children of psychiatric patients and provide more information about communication between nurses and children with parental depression for other nursing students when it comes to mental health nursing.</p> <p>Qualitative video recorded interview provided three main results. Nurses expressed the challenge meeting depressive patients and their family can be. In fact, they can sometimes feel emotionally affected by the patients' and their relatives' situation. A wide-range of feelings is experienced by nurses who, nevertheless, have to remain professional and work in an appropriate manner. (1) Despite challenges and stigma on depression and its care, nurses described their role as essential in caring for children with parental depression, especially in ensuring connection and communication between family members. (2) Finally, nurses' experiences revealed that their practice could easily and efficiently be improved by using existing resources, alternative and creative methods to encounter children, and by the presence of a ward's culture and multi-professional way of working, focused on family nursing and child's inclusion in depressive patients' care. (3)</p> <p>These highlights helped in gaining a better understanding on nurses' experiences in dealing with children of depressive patients as well as provoking an encounter between nurses from different wards and enable them to share about their experiences and ideas on the topic. Finally, this paper can be a support for students or professionals interested in a more efficient inclusion of children in family care and depressive patients' care.</p>		
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# 1 Introduction

Mental health implies the ability of an individual to cope with every-life stresses, manage with various emotions, deal with social interactions, be active in a community and find potential in him or herself. (WHO, 2014) As stated in the WHO's Mental Health Action Plan (2013), there is "no health without mental health". In fact, being mentally healthy is seen as an important part of life and belonging to each individual. The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2014). Approaches to mental health vary from country to country, due to differences in human and financial resources, differences of cultures, economical status. (WHO, 2014)

Mental health problems still remain a challenge in Europe, according to the World Health Organization Regional Office for Europe (2013). Liimatainen (2000) defines them as "health conditions characterized by alterations of mood, thinking or behavior". In Finland, 4 to 9% of the population will experience mental disorder at some point of their lives (Ministry of Social Affairs and Health, 2005). 4 to 5% of the Finnish population experience depression, one of the most common mental disorders of the country (Isometsä, 2014). Depression can be long-lasting and recurrent or a brief episode of someone's life. The World Health Organization defines depression as a condition where an individual is prone to sadness, loss of interest or pleasure, feeling of guilt, a low self-esteem, sleep disturbances, loss of appetite, feeling of tiredness and poor concentration (WHO, 2015).

Nurses might come across patients with mental health problems in various settings (Pirkola & Sohlman, 2005). In fact, mental health disorder is affecting a person in many ways and can interfere with working abilities or social skills of the patient. Moreover, mental disorder increases one's physical illness risks. (Samele, Frew, Urquía, 2013)

The disorder may have effects on the whole family and can impact on the relationships and roles among the unit (Marshal, Bell, Moules, 2010). Among other mental health problems, depression might have effects on children who are still depending on their parent both emotionally and practically. Family orientated work is an essential aspect of mental health nursing. Family members need support and are important resources for the patient and the health care professionals.

Researches tend to highlight the negative impacts of parental illness on children (Aldridge, 2011). However nowadays, family nursing focuses more on working on strengths and favors early intervention in order to support the family and patient's offsprings (Feeley & Gottlieb, 2000).

Nonetheless, it seems that challenges still remain in nursing practice, when it comes to approaching children of mentally ill patients. Previous studies show that not denying the place of the child in the patient's care is essential. Some nurses might find it difficult to communicate with kids or to collaborate with other professionals from children's services. (Evans & Fowler, 2008)

In order to look further into the issues of mental health nursing, family nursing and children with parental depression, this research tended to identify the main challenges nurses face when dealing with children of patients suffering from depression from the point of view of mental health care providers in a psychiatric hospital of Finland. The purposes were to have a better understanding on the obstacles working with children of patients nurses can face. It aimed at helping to adapt the solution and support given to nursing staff in dealing with children of psychiatric patients. Finally, this thesis will provide more information about communication between nurses and children of parental depression for other nursing students when it comes to mental health nursing.

## 2 Depression

The World Health Organization (WHO) states that mental disorders include a range of problems with different types of symptoms. Mental illnesses or mental health disorders are a combination of abnormal thoughts, emotions, behaviors and relationships with others. (WHO, 2014) They are defined as a health condition that changes a person's thinking, behaviors, feelings and leads the person to distress and difficulties in functioning (Sullivan, 2009). Mental health issues can be various depending on the severity and frequency of the symptoms, based on individuals. (Sullivan, 2009, 12)

Mental disorders are classified under the Diagnostic and Statistical Manual of Mental Disorders (DSM). They also appear in the International Classification of Diseases (ICD). (WHO, 2014)

WHO (2014) defines depression as a mood disorder. It can affect individuals in various ways and cause different range of symptoms, such as long-lasting sadness associated with tearfulness, feeling of hopelessness and loss of interest in previously enjoyable activities. (NHS, 2014) Often patients complain of difficulties in concentrating, memorizing and being cognitively active (Isometsä, 2013). Physical symptoms can also be present: tiredness, sleeping problems, loss of appetite and sexual drive (NHS, 2014). Heredity but also personality characteristics might be underlying causes for depression. However, stressful or negative events in one's life can be trigger factors to depression. (Isometsä, 2013) Research also shows that women are more vulnerable towards developing depression than men (Lönqvist, 2009).

Patients can experience depression only once in their life, but over 50% of patients will have recurrent depressive episodes (Isometsä, 2014). People can have a persistent depressive disorder, also known as dysthymia, when the symptoms last at

least for two years (National Institute of Mental Health, 2011). Some other forms of depression might appear only in a short period of time after a stressful or life-changing event (example: post-partum depression, seasonal affective disorder) (National Institute of Mental Health, 2011).

Depression has been increasing during the past years and represents around 41% of the global mental disorders treated in hospital or outpatient clinics and makes it the most common mental disorder treated in Finland. (Kanerva, 2012)

The care of mentally ill patients in Central Finland costs about 32 700 euros every year and 34 120 patients were treated in hospital in 2012. 67 863 people used outpatient care the same year. (Kanerva, 2012) People suffering from mental disorders might be victim of stigma so we can assume that not all are diagnosed and treated because they do not seek for help (Byrne, 2000). The number of people affected by one or more mental disorder can be even bigger and reaching those undiagnosed patient is one of WHO's Mental Health Action Plan's objective. (WHO European Committee, 2013)

The Diagnostic and Statistical Manual of Mental Disorders-V divides depression under three different types depending on its severity: mild, moderate and severe. (American Psychiatric Association, 2013) According to Finnish Guidelines, professionals should also assess the severity of the depression as mild, moderate, severe or psychotic (Isometsä, 2013). In fact, the treatment and methods used to care for the patient will depend on the severity of his/her condition (NHS, 2014). Psychotherapy (cognitive, psychodynamic, interpersonal), pharmacotherapy (antidepressants, antipsychotics) and other somatic therapies (electroconvulsive therapy, bright light therapy) are the main treatments existing to treat depression. The most common one offered by nurses in Finland focuses mostly on psychosocial treatment including therapeutic methods. Even if those methods are most of the time combined, psychotherapy remains quite rarely used in the treatment of severe depression. (Isometsä, 2013)

In over 90% of suicides, it appears that the person has had a history of mood disorder or substance abuse (Henriksson, Kuoppasalmi, Isometsä, Heikkinen, Marttunen, Aro, Lönnqvist, 1993). In fact, as the severity of the depression increases, the risk of suicide becomes higher. Suicidal thoughts and attempt can be part of the symptoms experienced in severe depressive disorder. (Isometsä, 2013)

Depression affects patient's life in many aspects and causes him/her to suffer equal or worse disability than patients with physical/medical conditions (Isometsä, Katila, Aro, 2000). In fact, it impairs the person's physical and social capacities as well as its role functioning (Isometsä et al., 2000). In Finland, depressive patients can benefit from disability pension and/or rehabilitation pension when diagnosed by a specialist and undergoing treatment for at least three months (KELA, 2013).

### **3 Nursing for families experiencing mental disorder**

The concept of nursing can be simply understood as care for others (Ann Hemingway, 2013). Florence Nightingale changed nursing practice in the nursing history. She was the first acknowledged nurse who organized nursing training programs and her first training program for nurses was established in 1860 at St. Thomas Hospital in London (Klainberg, 2009).

The International Council of Nurses (ICN, 2014) defines that nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well, in all settings. In nursing profession, nurses perform independent or assisting care to patients. In other words, nurses may implement nursing care autonomously or assist physicians or other health care professionals. In addition, nurses have the responsibilities of public health promotion, prevention of illnesses, as well as providing care for the ill, disable and dying people. The roles of nurses include advocacy for patients, promotion of safe environment, research, participation in making health policy in patient and health system management as well as education. (International council of nurses, ICN, 2014)



### **3.1 Family nursing**

With the development of modern society and health care field, the evolution of nursing practice has also changed and developed significantly. Nowadays nurses can specialize in different fields and work in various wards in all settings including mental health nursing and other specialties. Nurses are taking care of their patients both physically and psychologically. In addition, nursing in health care field is strengthening worldwide, mainly improving nursing care into a more people centered care, and patient centered care. The World Health Organization (WHO, 2015) describes the concept of “people centered care” as the care of many individuals, families, communities and societies. Patient centered care can be understood as nursing care focusing on a more strictly individual care. (WHO, 2015)

Family oriented nursing or family partnership in nursing practice has been advocated and existing for many years (Craft-Rosenberg, Krajicek, 2006). Family nursing refers to nursing practices using a systematic approach and views or involving the family as a unit of care (Whyte, 1997). The concept of family strengths in nursing care has been studied for several decades, and it is believed that family involvement is essential for supporting individual members. In fact, family centered care is essential when providing nursing care for an individual patient. Nurses can use a family strengths approach to offer support to their patients and families during the care. (Sittner, Hudson, Defrain, 2007)

### **3.2 Mental health nursing**

Mental health nursing is a specialized nursing practice committed to promoting mental health through assessment, diagnosis, and treatment of individual responses to mental health disorders. Nurses who work in mental health units provide comprehensive, patient-centered care. The components of mental health nursing practices include health and wellness promotion by means of identifying mental

health problems, prevention of mental health problems and provision of care and treatment for people with psychological disorders. (American Nurses Association, 2007)

According to the American Nurses Association (ANA, 2007), mental health nursing started during the nineteenth century: the first training program for nurses in mental health was organized and established at the Johns Hopkins Hospital in 1913. This was used as the standard of nursing education programs in mental health nursing industry. Mental health disorders represent a major health problem internationally. However, identification, prevention and treatment of mental illness remain challenging for health care professionals. (American Nurses Association, 2007)

Mental health nurses play an essential role in mental health care. The World Health Organization (WHO, 2007) explains that nurses are direct lines of care between psychiatrists and patients. They understand patients' daily routines and their complex medical/psychiatric needs. In addition, they are tremendously important for shaping individualized treatment plan, as nurses are the main caregivers for patients who are suffering from mental disorders. It is more likely that patients feel more comfortable to express their psychological problems openly with nurses rather than with psychologists. (World Health Organization, 2007)

Furthermore, most primary mental health care is provided by mental health nurses. Primary mental health care refers to the provision of continuous mental health care services, the promotion and prevention of mental health problems, the maintenance, management, empowerment, and rehabilitation of patients. The responsibilities and scope of work for mental health nurses are different depending on their educational background and work placement. Nevertheless, in general, mental health nurses are concerned about a large range of factors when providing care for patients. (American Nurses Association, 2007)

Mental health nurses are mainly responsible for the promotion of optimal mental and physical health, well-being, and the prevention of mental illness. Impaired ability to function related to psychiatric, emotional and physiological distress need to be taken into consideration when providing mental health nursing care. In addition, patients may have alterations in thinking, perceiving and communicating due to psychiatric disorders or mental health problems. Mental health nursing is a holistic approach to the care of patients and their families and nurses need to consider the needs and strengths of the individual, family, group and community. (American Nurses Association, 2007)

## **4 Children with parental depression**

### **4.1 Children in Finland**

“Child” is described in the Oxford dictionary as a “human being, under the age of puberty or under the age of legal majority” or “a son or daughter of any age” (Oxford dictionary, 2015). A child is a physically and intellectually “immature” individual, a young and vulnerable human who needs support and protection in order to become an adult (Humanium, 2015).

Children are human beings with rights stated and protected by laws. The International Convention on the Rights of the Child has been adopted in 1989 by the United Nations. It consists of 54 articles defining children and their rights. It is based on the Universal Declaration of Human Rights, but stating the particular needs and rights of children. It specifically guarantees the status and need for protection children require. In fact, the Convention states that children are practically, financially and emotionally depending on adults. The Convention also protects children against trafficking, sexual abuse (prostitution, pornography), and participation in acts of war. (Convention on the Rights of the Child, 1989)

In Finland, the Constitution states rights and obligations of human being and those apply also to children. They should be treated equally and be allowed to influence the issues that concern them, depending on the child's stage of development (Ministry of Justice, 1999). Finland also signed the International Convention on the Rights of the Child and guarantees that children should be treated equally, that his/her best interests should be the primary focus in all decision-making, that all children have a right to a happy life and that their views have to be taken into consideration and do matter. (Infopankki, 2014)

Finland also insures that children's rights are respected, through the Ombudsman for Children. It acts as an essential lobby, in making sure children's rights are respected, decisions made from the children perspective and in their best interest, the UN Convention on the Rights of the Child applied. It acts as a spokesman and is essential in relaying information from the children and youth to decision-makers, child protection actors and public society. (Kurtilla, 2015) Finally, children's rights in Finland are specified in many different acts such as the Child Welfare Act, the Basic Education Act, the Child Maintenance Act, etc. (Ministry of Social Affairs and Health, 2015)

In Finland, legal majority being at the age of 18 years old, it was decided to include any child from 0 to 18 years old when talking about children in this research. However, it is important to mention that childhood is described in different stages and difference is made between an infant, a toddler, a preschooler, a school age child and a teenager (Center for Disease Control and Prevention, 2015).

Infancy relates to neonates, known as the phase right after birth and up to 28 days after it (WHO, 2015) and babies up to 18 months (Potter, Perry, 2007). They develop relatively quickly during this stage (Potter, Perry, 2007). Newborns are especially vulnerable since they are at higher risks of dying, need adapted and sufficient

nutrition, as well as effective care, in order for them to survive but also develop and start their life on a healthy basis. (WHO, 2015)

Toddler refers to kids of age 12 to 36 months/three years old (Potter, Perry, 2007). It is the phase during which the child develops mainly his/her motor skills and becomes more autonomous. Speech starts to appear as simple phrases and the child wants to act and function on his/her own ("I do by myself"). (Berk, 2003) Toddlers tend to have an egocentric moral but are starting to differentiate the "bad" from the "good" (Edelman, Mandel, 2002).

Preschooler is also referred to as early childhood and includes children from 3 to 5 years old (Behrman, 2004). At this age, children communicate and interact with others more efficiently. They can cooperate, express their thoughts and feelings more easily and are about to receive formal education. Physical growth is not as rapid as in previous age groups, but cognitive and psychosocial developments are extremely important. At this stage, children start to ask a lot of questions and possess a great imagination, which can originate feelings such as fear. (Hockenberry, 2003)

School-age child is from 6 to 12 years old. It is the time during which children go to school, receive education and evolve in a group, with peers and learn the fundamental values they will need as adults. (Edelman & Mandel, 2002) Children learn rules and how to live in a structured manner in the classroom. They become better at various things, develop constantly on cognitive, psychosocial and physical levels. (Berk, 2003)

From 13 to 18 years old, we talk about teenage hood or adolescence. It is the transitional stage from being a child to becoming an adult. (Edelman & Mandel, 2002) Adolescence suggests a psychological maturity throughout which the becoming adult can experience challenges, conflicts with adults, authority, and aims

to identify him/herself as a unique individual (Erikson, 1997). During this period, the children also go through physical changes known as puberty, which enables them to reproduce (Edelman & Mandel, 2002).

Interacting and caring for children can be variable and influenced by the age group of the child: the level of understanding, the relation to others, the ability to express own feelings and thoughts and other factors related to the child's age should be taken into account when providing care. (Potter, Perry, 2007)

## **4.2 The child as part of the family system**

When considering the child in a holistic manner, it is necessary to identify him/her as part of a family. This term has evolved through time and establishing a universal and unique definition remains challenging. In fact, "family" differs from country to country, culture to culture but also from one individual to another. (Schor, 2003) In fact, individuals might consider family as a more or less extensive level. Some might consider cousins, aunts or uncles as family, whereas for some others, family unit is very limited to the nucleus. (Hutchfield, 1999)

In Finland, family is protected by law and policies act in its favor. The Ministry of Social Affairs and Health as well as other ministries, national, regional and local actors are responsible for stating the rights and obligations of children and their families and make sure those are respected. The State has a responsibility in providing a safe environment for every child to grow in. Financial support to families, provision of a quality education and access to health are few examples of what Finnish state should guarantee to all children, regardless of their background. (Infopankki, 2014)

In Finland, the concept of family is limited to the nucleus, the immediate relatives, meaning the parents and their children. (Infopankki, 2014) Even though Finnish system provides every citizen with financial support if they are in need, every family

should be able to support their members, especially children, both materially and psychologically (Ministry of Social Affairs and Health, 2013). All children must have at least one guardian, usually being their mom and/or dad. The State supports families and children but the guardian(s) is/are legally the primary responsible for the child. (Infopankki, 2014)

From the various definitions available in literature, we adopted the one that defines family as a social group within the society. Family usually consists of one or more parents (The free dictionary, 2015). In fact, it is a group of two persons or more, being related by blood, marriage or adoption and living together (Schor, 2003). In the contemporary world, two persons of a same sex can be responsible for children, as well as a single parent (Schor, 2003). No matter the type of structure, family is often referred to as a system. In fact, family is a unit, composed of different members. Each member interacts with each other and the unit represents the primary and most essential basis for child's growth, education and development. (Hutchfield, 1999)

Morgaine (2001) introduces the main characteristics of family by stating that each family is unique, works as an interactional system, within which each member has a function. Almost every family goes through phases or changes that can cause stress and affect one or more members of the unit. Bowen's theory enhances the idea that a family is an interactional system. In fact, according to this theory, family is seen as a unit where the members are emotionally connected. It is defined as a system, since connections exist between the members and they interact with each other in a complex manner. (The Bowen Center for the Study of the Family, 2014) Within the system, members have rules and boundaries, expectations and needs. Each one has a role (child, parent, sister, brother, ...) and relations of power exist within the unit. Communication within the system is also given as an essential element that helps ensuring a viable functioning of the family. (Morgaine, 2001)

The concept of system is emphasized by the idea of interdependence of the members. This means that if one of the members' functioning is altered, it is most probable that other members will in a way or another be affected as well. (The Bowen Center for the Study of the Family, 2014) Also, WHO includes family as part of the determinants of health. When it comes to social support an individual might receive, family can be a support or on the contrary a limitation to a person's health and well-being. (WHO, 2015)

### **4.3 Children experiencing parental depression**

Children and adolescents can be exposed to mental illness of one or both of their parents at any given time of their life (Creswell, Brereton, 2000). Feelings like fear, anger or guilt can be experienced by the child, if he/she is not supported efficiently (Evans & Fowler, 2008). In fact, child-parent relationship is essential in child's growth and development (Vartiovaara, 2010). Schooling, socialization and child's well-being can be affected by parental mental illness (Fowler, Robinson, Scott, 2009). However, being cared for depression depends on factors such as geographical situation, financial status, language, sociocultural background, stigma on the illness (National Research Council and Institute of Medicine, 2009). Literature suggests that if the parent is efficiently treated for his/her condition, the impacts on the child are consequently lessened (Weissman, Pilowsky, Wickramaratne, Talati, Wisniewski, Fava, 2006). Researches show that mother's depression has a greater impact on the child than father's depression. If both parents are suffering from depressive disorder, the impacts on the child can as well be greater. (Goodmand, Gotlib, 1999) However, the impacts of maternal depression on the child are reduced if the father is healthy and positively involved in parenting (Chang, Halpern, Kaufman, 2007).

Nevertheless, parental depression affects the child and can cause him or her to feel guilt and shame linked to the parental illness (Evans, Fowler, 2008). Social isolation, feeling of being uncertain and unsecure related to the parent's unstable mood and



impairment in parenting, difficulties to understand the parent's behavior, and constant concern for the parent are outcomes of parental depression (Dam, 2014). As a consequence of parent's symptoms, some of the children might have to deal with tasks such as household cleaning, cooking, washing, might have to be emotionally supportive and present for their parents, or take care of younger siblings (Evans, Fowler, 2008). Some of them can even have to remind their parents about medication care and have to take over responsibilities (Dam, 2014).

As depression can affect the functional abilities of the patient, parenting can become challenging (Evans, Fowler, 2008). Especially in case of maternal depression, reduced emotional availability can impact the child and its development (Vartiovaara, 2010). Even though only a qualified professional is able to assess whether or not the parenting skills are impaired, some signs should be noticed in order to detect when intervention is necessary. In fact, insufficient parent-child relationship and interactions, withdrawn, depressed or neglected child, as well as a hostile parent's attitude towards the child, are examples of signs that should alert and raise one's attention. (Vartiovaara, 2010) Depression might increase the risks of violence among the family and of child neglect (Dam, 2014). Neglecting includes lack in providing basic needs, lack of close relationships, physical/psychological/sexual abuse, diseases or symptoms parents induce or construct to their child (Dam, 2014).

From the point of view of children, understanding parent's illness can be difficult (Stallard, 2004). Child's age, sex, temperament, intellectual skills and abilities to cope are examples of factors that affect child's resilience towards parental depression (Aldridge, Becker, 2003). The main needs usually expressed by children with parental mental illness are to be acknowledged about the parent's illness, get correct information, be secured, understand the illness, its symptoms and treatment, as well as reduce the feeling of guilt (Slatcher, 2011). Children feel they need to be able to ask questions, to have someone they trust and with whom they can talk, to get support in recognizing parent's illness' signs and symptoms, to have someone to

contact in case of an emergency but also someone close to support them in every-day life (Slatcher, 2011). Finally, children expect to be identified as part of the parent's care, by recognition and respect of their role in the family and get support and understanding from other institutions in their life such as school (Slatcher, 2011).

The Illness Belief Model (Wright, Bell, 2009) is an example of a theoretical basis that considers illness as an element affecting all members of the family, not only the patient. It highlights the need for advanced nursing practice to work with all the different individuals and systems included in the care of the illness. Wright and Bell (2009) suggest that nurses should support and work with families to alleviate the suffering caused by mental illness (physical, emotional, relational suffering). Family communication, therapeutic conversations between the nurse, the patient and family members are examples given to tend to this objective (Wright, Bell, 2009). In fact, mental health and family go hand-in-hand and they function reciprocally: the mental illness affects the family functioning, but the family also has an impact on the mental illness. In fact, the patient's ability to deal with the illness is affected by family support. The patient's condition can improve or get worse weather his/her family members understand and support him/her or not. (Marshall et al., 2010)

When it comes to practice, literature emphasizes some main challenges in dealing with children of depressive patients (Reupert, Maybery, 2007). To assess and acknowledge the patient/parent-child relationship appear to be important elements. Nurses and other health care professionals should recognize the experiences and contributions of the child in parent's care, in order to adopt helpful and adapted interventions. (Aldridge, 2006)

Working with the family and communication with different members appear to be another challenge (Marshall et al., 2010). Barnardo's (2007) suggests that nurses should be more aware of the importance of family contact and cooperation, benefiting to the patient and the child (or other family members). Nursing staff

should also improve their way to address family issues with the patient, insure confidence and be able to overcome the stigma surrounding depression. Finally, nurses are in need of developing their communication skills when it comes to children and young people. (Aldridge, Becker, 2003)

## **5 Aim, purposes and research questions**

The aim of this research was to identify the main challenges nurses face when dealing with children of patients suffering from depression. The purposes were to have a better understanding on the obstacles working with children of depressive patients nurses can face. It aimed at helping to adapt the solution and support given to nursing staff in dealing with children of psychiatric patients. Finally, this thesis will provide more information about communication between nurses and children of parental depression for other nursing students when it comes to mental health nursing. The research questions are:

1. What kind of experiences do nurses have when meeting children of depressive patients?
2. From those experiences, what do nurses feel they would need in order to improve their interventions towards children of depressive patients?

## **6 Qualitative video recorded group interview**

This research was conducted using a qualitative research method, also called interpretative research and qualitative inquiry. The terms are frequently used interchangeably in the literature. The main characteristics of this research method are to find explanation of a certain phenomenon by means of exploration, through human experiences, behaviors, perceptions, intentions, and motivations (Parahoo Kader, 2006). It is concerned with finding answers to questions beginning with

“why” and “how”, instead of focusing on “what”, “where” and “when” (Glenn, Jerome Clayton, 2010).

In addition, qualitative research method is exploratory, which means the study is hypothesis generating and researchers are aiming at analyzing words (Glenn, Clayton, 2010; Newell, Burnard, Philip, 2011). As one of the researchers had some experiences while doing a mental health clinical training in a psychiatric unit, through observations it was felt that there were some challenges between health care providers and children of depressive clients when it comes to explanation or communication. Qualitative study approach was adopted in this research as the aim of the research was mainly to concentrate on personal experiences of nurses, individual feelings and opinions. The researchers were interested in exploring and discovering the experiences of health care providers dealing with depressive patient’s children and how their attitudes and opinions were developed, without any biases and subjective perspectives. Marshall (1996) states that a research methodology design is contingent to the research questions, rather than depending on the preference of the researchers. The aim of this research and its research questions were therefore determining the study approach. A smaller group of participants was chosen in order to focus with depth on their feelings, gather adequate personal experiences, rich information and individual opinions in order to provide insight and understanding to the researchers. (Martin Marshall, 1996)

Qualitative data is usually collected through direct encounters with individuals, through one to one/face to face interviews, group facing interviews or by observation (Hancock, Beverley, 1998). This research was designed to perform a group interview with open-ended questions which allows participants to express themselves freely without any restrictions or manipulations. Interviewees’ subjective data are formed by participants’ expressing their opinions, personal experiences and individual feelings directly. Considering data analyzing, the process of research

implementation was video recorded so that the researchers could replay the interview as well as make transcriptions in a correct manner.

## **6.1 Setting**

The interview and data collection took place in a hospital setting that provides mental health care for both adults and children. It consists of six psychiatric departments providing adults' mental health treatment, outpatient care and child/youth psychiatric care.

In Finland all clients need a doctor's referral to be hospitalized in any psychiatric department of a hospital. Different settings welcome patients in need for mental health care. They can be treated in open-wards, closed wards or outpatient clinics. Depending on the severity of their condition, their willingness and cooperation to treatment, doctor will evaluate and decide on the type of ward suitable for a specific individual. Patients will often be guided for outpatient care after being hospitalized.

## **6.2 Recruitment of participants**

The targeted participants consisted of registered nurses and nursing personnel who are working as psychiatric nurses, from both outpatient as well as inpatient wards. The ideal number of participants was aimed to be between five to eight nurses.

According to Martin Marshall (1996), qualitative research is a study method which focuses on the experiences, opinions and feelings of the participants. As a result, qualitative sample size is usually small, and can differ from case to case. Stratified purposeful sampling approach with its subset of snowball sampling was used in this investigation ( Marshall, 1996). Stratified purposeful sampling is the most common

study approach in qualitative research, in which the researchers ensure that certain cases variations on preselected parameters are included. (Sandelowski, 2000).

The first criterion for this investigation was that participants had encountered and possessed experiences of dealing with psychiatric patients' children. Researchers mainly wanted to focus on experiences in relations, interactions, and communication between psychiatric health care providers and children of depressive patients. Considering the language barrier, participants who were not able to communicate in English were excluded from this study. In general, nurses working in hospital mental departments and who speak sufficient English as well as having previous experiences of dealing with psychiatric patients children were the targeted ideal group to take part in this research, regardless of their gender, age, race, culture, religion, nationality or other individual factors.

An informal meeting was organized before the official interview. After obtaining the research permission, the researchers started to contact psychiatric ward managers for gathering voluntary participants, through emails. Preliminary meeting was scheduled with one of the wards, which took place in November 2014. Researchers went to the ward and gave major information about the thesis topic including reasons for the choice of the topic, research aims and purposes, mentioning assurance of ethical principles such as confidentiality as well as voluntary and withdrawal rights of the possible participants. This gave the nurses a clue on what to expect, and increased the chance of honesty, and also was an essential aspect of the fundamental process of informed consent. The aim of informal meeting was to give participants general information about the research such as research aims, purposes, and information of the interview including location, duration of the interview and other things related to this study. In order to gather planned number of participants, researchers asked participants to suggest participation to other colleagues who would be interested or appropriate for the investigation. Other wards managers

indicated that a few nurses were eager to take part in the research. However they expressed that a preliminary meeting was not needed.

After having five participants eager to take part in the group interview, it appeared quite challenging and difficult to find a proper time and date to match all participants' schedules. We kept communicating and discussing with potential participants through email and finally agreed on a date for the interview. However, few of them had to come on their free time, whereas some other nurses participated in the interview as part of their working hours. Flexibility and compromises from the nurses was highly helpful in setting a date for the group interview.

In order to have a more natural and smooth interview, the interviewers gathered together for the planning of the interview. The preparation included review of research questions, rehearsal of the questions etc. In addition, for the avoidance of technical equipment malfunction, the researchers practiced the preparation of video recording over and over again. The interviewers arrived at the interview place one and a half hour in advance for setting up the area, such as setting up the chairs and material equipment.

All participants who took part in the research received and signed consent forms (appendix 1 and 2). Participation was voluntary and they could withdraw at any time without justification needed. All participants needed to agree to the terms of the consent form and signed it before conducting the interview. Consent forms were stored by the researchers. They were not used nor accessed by any other person external to the research. Anonymity of participants was stated and agreed via the forms and guaranteed by not disclosing any name or any detail that would compromise participant's identity before, during and after the research.

### **6.3 Data collection**

The method used for collecting data was face to face group interview, and five registered nurses from three different psychiatric wards were responding. Nurses were from either closed or open psychiatric wards. The interview was conducted on the 28th of January 2015 and took place in a neutral room available for teaching purposes. In fact, researchers did not wish to conduct the interview in one of the wards of origin of the participants but rather wanted a more neutral place for all of the respondents. To assure an organized interview, the researchers had their own tasks during the interview: one of the researchers was mainly responsible for guiding the interview discussion according to the interview questions format (appendix 3) while the other researcher was responsible for taking notes, video recording, and supported the other researcher whenever it was needed.

In order to gather an accurate original primary data, electronic device was used to video record the interview process. This was essential for the researchers to re-access the data later on and transcript it more accurately. As the primary resource was considered as original evidence, the researchers could distinguish the responses from certain participants when transcribing the data. Furthermore, taking notes was another data collection method which was performed in the process in order to avoid misinterpretations of the original resources from the respondents.

The interview was scheduled for approximately forty-five minutes. Before starting the interview participants were reminded about the topic of the thesis, aims, purposes, voluntary nature of the participation, assurance of confidentiality and finally the consent forms were signed by all the participants. In the end, the whole interview discussion took forty-seven minutes which was video recorded for the purpose of transcription.

The choice of organization of this research interview was a semi-structured interview format (appendix 3). According to Gill, Stewart et al. (2008), three fundamental types



of interviews are involved predominately in qualitative research interviews, including unstructured, semi-structured and structured interviews. Cohen and Crabtree (2006), explained that the characteristics of semi-structured interviews include: engaging both interviewers and responders in a formal interview and using semi-structured questions as an organized guidance for the discussion. Another advantage of semi-structured interview is that when comparing it to structured interview, the flexibility of this approach allows the interviewer to discover or elaborate information. This is significantly important to participants as it is not specifically strict, which allows them to express their perspectives freely. On top of that, semi-structured interview is used frequently in healthcare, as it has clear instructions for interviewers and it can provide reliable and comparable qualitative data. (Gill, Stewart, et al., 2008; Cohen, Crabtree, 2006)

English language was the main communication language during the interview. Considering English language was neither the first language of interviewers nor interviewees, miscommunication or misunderstanding could have occurred. Researchers asked participants to clarify their responses by asking: “what did you mean by that?”, “let me see if I understood you correctly”, “did you mean...or...?”, “could you give me an example?”, “what was your main point?”, ...

Also, a native Finnish speaker, and speaking fluent English, was present in the room in order to assist and support with translation if needed. The translator-like was however sitting back from the group, and was present just in case the need was felt from participants. If one of the participants wanted to share something but had difficulties expressing it in English, the presence of a translator was a way to guarantee all chances for participants to express themselves and overcome language difficulties. However, there has not been any need for translation, participants and interviewers understanding each other fluently and smoothly. The translator did not interfere and was also subject to confidentiality about the interview.


Finally, the two researchers were cooperating in a responsible and effective way during the process of conducting the interview. One of the researchers was concentrating on the interview and mainly on asking questions and communicating with the participants. The other researcher was mainly responsible for video recording as well as taking notes when there was a need for clarification. In this way, the researcher who was interviewing the informants could focus on the interview without any interruption, and informants could concentrate answering questions without distractions. Those two approaches combined could reduce errors occurring and give the researchers integrate original data and make it easier to carry out the data analysis process.

## **6.4 Data analysis**

All of the qualitative data represents the essences of objects, humans and situations. This is the general characteristic nature of the qualitative research data. (Miles, Huberman, 1994) In this research we concentrated on data in forms of words, experiences and opinions from the informants. Those words were directly from participants based on the video recorded interview and interviewers' notes. However, this primary collected data also referred to as "raw data" requires some process before being available for analysis. Raw data needed to be edited and all of the interview conversations transcribed into written form as Word program electronic documents.

The transcribed work was reconciled with the notes that were taken during the interview. Polit and Beck (2010) stated that qualitative analysis is an interactive and active process, whereby data scrutinizing is performed, by reading it several times to look for meaning and deeper understanding. Qualitative analysis involves a lot of work in order to organize the data. Making sense of the information collected from all the materials used in the research aims at reducing the data for reporting purposes. (Polit, Beck, 2010)

To analyze the data, researchers used inductive content analysis method, which was planned in three steps including data reduction, data display and conclusion drawing or data verification. The collected data was first transcribed into Microsoft Word document with a total page of thirteen, which was done by both of the researchers. The recorded video data was divided into two parts for transcription, part one consisting of the first twenty minutes and fifty seconds of the video data and part two, twenty seven minutes and ten seconds. After the data being transcribed on the Microsoft document, the data was printed out and the researchers read it repeatedly in order to be familiar with it and gain a deeper understanding of its content. Examination of the data was done by the researchers, by discussing it together and going through the unclear parts of the video in order to avoid mistranscription. The following step of analyzing the data was to highlight the points of participants' discussion, discard the same meaning sentences, and get rid of the irrelevant information. Researchers selected and highlighted the important and straight point words and sentences from transformed electronic documents and summarized the contents. As the data analysis progressed, further process included writing summaries, coding, summing up themes, making groups, and writing memos. (Miles, Huberman, 1994). The raw data, or subordinate, was grouped and analyzed in order to obtain categories, also defined as superordinates. Finally, those superordinates that emerged were also grouped in order to form main results. (See table 1)



<b>Analyzed data from original/raw data, coded into subordinate</b>	<b>Defined categories or themes as superordinate</b>	<b>Drawn conclusion</b>
1.1-Use of existing resources on the ward (for example booklets) 1.2-Nurses should read between the lines and observe the children 1.3-Use of art and playing 1.4. ... ...	1- Use of creativity	
2.1-Multi-professional cooperation and actions 2.2-Importance of “ward’s culture”/group effect 2.3-Self-training within the ward 2.4-Practice more needed over theory	2- Multi-professional working and peer support	III. Nurses resources in developing their practice
3.1-Existing focus on couple but more holistic approach needed 3.2-Group meetings for parents going through depression to be organized 3.3-Any family oriented action/project is perceived as needed ...	3- Beneficial family oriented actions	

Table 1. Sample of structured data analysis

## **7 Results**

The data collected from the group interview made various results emerge. Three main focuses have been highlighted according to the research questions: being professional when facing vulnerability of patients, nurses as an important key actor in insuring connection and communication in family care and nurses' resources in developing their practice. Each result is divided into sub-parts, illustrating the theme and giving more precisions and details on the results.

### **7.1 Being professional when facing vulnerable patients**

Nurses having to deal with depressed patients have to face human beings in vulnerable moments of their lives, deal with patient's care, families but also with their own emotions and feelings. Even if experiences vary depending on many elements, participants recognized the needs for boundaries in order to preserve their own well-being as professionals and human.

#### **Different experiences of nurses: working environment, cooperation and personal experience**

Nurses expressed different elements relative to their work in psychiatric wards. Even if experiences are individuals and affected by factors specific to each nurse, the need for professionalism and all the values and actions it includes is a common objective and way of working.

In fact, the organization of mental health care and the type of ward the nurse evolves in effect the experience the professional may face. Nurses reminded that patients with depression are mainly being treated in the open wards and, most of the time, voluntary admitted and willing to receive treatment. Nurses explained depressive patients represent the majority of patients they are dealing with in open wards. Therefore, providing care for this kind of patient is felt as being a daily task for nurses working in open wards. Participants highlighted the fact that patients in closed wards

often have depression as an underlying effect of, or associated with another mental disorder such as schizophrenia, bipolar disorder, etc. They also specified that those kinds of patients are usually forced to the treatment and the stay on the ward. Creating cooperation and building trust might be more challenging with patients forced to treatment and not initially accepting to be helped, compare to patients who are aware of their situation and willing to receive treatment. However, nurses meeting depressive patients regularly feel more performant in working with them.

Whatever ward nurses evolve in, the uniqueness of each patient effects on the level of challenge a nurse may face in working with depressive patients. In fact, the care is always patient-centered, thus individualized. Nurses expressed that the level of communication of the patient affects the nurse-patient relationship. The more a patient communicates, the easier it is for the nurse to understand his or her situation and to work with him/her.

Also, the reason that has led the patient to depression can affect the way nurses feel about the patient's state and facilitate or make harder the building of a therapeutic relationship.

“Maybe if there is some kind of life situation, something has happened behind and some changes in life situation is the basic thing, maybe the patient has some kind of tools to work out and has something to think about his or her problems then I think it is easier to face depression. But then there is this kind of patient who is lying in bed and she is thinking about nothing and she is very silent then I notice I will have very much emotions, some kind of frustration, how should, can I help this people to get out of this bed.”

The level of cooperation of the patient, his/her condition as well as the patient's attitude towards care and nurses affect the health care provider's emotions while caring for their patients. Cooperating relationship with the patient is easier to build if the client communicates and is eager to be treated. Protest from the patient towards care and cooperation is then experienced as difficult for nurses.

When it comes to interacting with children of depressive patients, nurses also suggested that experiences with children make it easier to face them on the ward and in a professional context. Nurses mentioned that having children of their own provided them with better skills to communicate with kids, while those with few or no experience in contact of children might experience the encounter as more difficult and challenging. However, this advantage nurses who have children might possess, has been balanced with the fact it might then be harder for them to keep the necessary distance from the child's situation and feelings.

“Sometimes the patient's children remind me of my children. But of course if you are not feeling anything that should be strange.”

Transference and distance can then become challenges for the care providers in their relationship to the client and/or their children, and they advised nurses to recognize their own feeling in order to remain professional.

### **Managing professional and personal boundaries**

Nurses highlighted how working with humans, patients and children, was affecting their feelings. Even if they expressed the essential need for empathy in their work, it can sometimes be difficult to keep the required professional distance. Interacting with children especially affects nurses, who expressed that they sometimes feel connected to their patient's kid. However, it can sometimes be an obstacle for them to work efficiently.

Nurses experience a various range of feelings such as sadness, helplessness, anger, frustration or tension. The frequency of meeting with depressive patients is proportional to the feelings nurses will experience. However, nurses notice the importance of being aware of their emotions and recognize the normal feelings and the harmful ones.

“Sometimes I feel if I treat many depressive patients all the time, then my energy starts to get low sometimes. Most of the time I feel not happy but well it’s just work. So I try to do it professionally.”

“And also the feeling of anger in me, it is something similar what the patient’s family has. To see and to realize it is to make it easier.”

Despite the challenges nurses might face in keeping distance and protecting boundaries, they believe the professionalism and therapeutic aspect of the work should overcome personal emotions in order to guarantee efficient and appropriate care. The management of boundaries is seen as important to insure beneficial outcomes to the patient, his/her family and the care provider.

### **Nurses’ duty in caring for their patient’s children**

Nurses explained and confirmed that they do involve patient’s child/children in the care. In fact, they are aware that the condition of the depressive parent may affect the child’s life in a way or another. Hence, they always try to get information about the patient's child. Nurses are conscious it is part of their responsibility and one of their duties.

“If the patient arrives on our ward, we always ask if he or she has children, what is their status at the moment so if they need help or... Usually it is the relatives or family members who take care of them but we have to make sure the children are okay.”

The consideration of the patient’s child is systematic and part of wards’ protocol. At least when the patient is admitted to the ward, health care providers explained they should be concerned about eventual kids within the patient’s family, their status and safety. Nurses said they have a role in protecting children from any abuse and have to contact or make a notification to the relevant department for child protection, if necessary. They also might have to seek for help from other professionals or



members of the patient and child's circle in order to guarantee the child's safety, protection and well-being.

Nurses expressed a high sense of ethics and responsibility in caring for their patients as well as their family members and especially children.

## **7.2 Nurses as an important key actor in insuring connection and communication in family care**

The care process sometimes brings up challenges. Nurses were able to reflect on their difficulties and experiences in working precisely with patients' families. The role of the nurse goes beyond medical assistance and consists, in some cases, of bringing back together members of a family. Participants highlighted specific challenges in dealing with children of patients. However, nursing for those children also turns out to be a very beneficial experience for the nurse, the children and the patient, when the encounter happens positively.

### **Nurses' identified challenges in working with families**

Nurses recognized the importance of family work in their practice. They try to apply family oriented nursing care by focusing on the whole family and its members. This includes spouse and children as well. However, nurses still highlighted challenges in applying efficient family nursing care.

When dealing with the families, the level of understanding of the members on depression plays a significant role in their involvement. In fact, stigma on the disorder and mental illness in general is perceived by the nurses, as a limitation in working with families. Some people might not understand nor accept their loved one to be in an extremely or constant low mood, needing psychiatric care and medication. Misconception about mental hospitals can remain and the family members can feel uncomfortable visiting the ward. Stigma about the ill person's own

responsibility for getting better and become more positive towards life consequently makes the family members to be distant and sceptic towards the care process.

“They (the family) think that this is not a real disease, not really notice that this is something really hard, this is not some kind of game or something. It makes the family angry. For example, the husband or wife is angry for the patient, why she or he does that.”

“Sometimes it is that the other parent who is home, they say that ‘no, I don’t want to bring my child in here, this is a terrible place, I don’t want’.”

Also, organizing meetings with families can be challenged by the distance between families’ home and the hospital. Some families might have to travel for quite a long time, therefore, finding a suitable moment for them to come and meet the nurses or visit in a regular manner can be difficult.

Managing the ward’s schedule and the families’ personal schedules and obligations represents also an important obstacle according to nurses. Many of the care meetings occur in the mornings, during week days. Patient’s partner might have professional obligation and having to deal with children’s care. The organization of the ward and its visiting hours are not necessarily suitable for working people.

“Usually families are available to come after 4pm or at week-ends and then there are only nurses working.”

“When ‘nurse \*’ said that the psychologist or social workers should be the other one when we meet families, most of the time we are 2 nurses. If it is in the evenings or in week-ends then they are only nurses. It’s difficult for families to arrange these visits on working times. Always.”

Nursing staff also expressed the lack of time and human resources. Even if they are conscious of the importance of family work and try to apply it, they feel they cannot do it as efficiently as they would like to or have been used to.

“Before we had more of these courses of learning family therapy, to get some tools to work with families. Now somehow I feel at least in our ward, during the last few weeks or months we don’t have very much time to sit and listen and to discuss.”

“The work differed then, the focus was on children, on the child, and we had time then, big time. (...) This work that I am doing now there is no time for them, if I need much or 2 times family meetings, and the children are there, there is nothing much I can do.”

### **Nurses as mediator when child-parent relationship is damaged**

Nurses thoroughly described the importance of parent-child relationship and bonding. As psychiatric nurses, they are aware of the significance of this link, are able to notice when parent-child interaction is damaged and think it is also their role to work on the parent-child relationship.

Nurses are convinced of the importance of a loving, positive and beneficial parent-child relationship on any child’s development. However, their experiences tend to show that communication problems between parent and their children can sometimes be the trigger for the patient’s depression. The relationship might be damaged before the arrival of the patient on the ward, and can be one of the leading causes to depression. In this case, nurses find it more difficult to open a gate to communication between the parent and the child. However, nurses feel it is their duty to connect them together again.

Nurses highlighted three main elements to include in order to facilitate parent-child communication: provide opportunities for them to meet, the importance of talk, and

the significance of common time spent together. Nurses feel they play a fundamental role in getting interaction and communication started between their depressive patients and their family members/children. They should be able to use their communication skills, their power and trust with the patient, in order to build opportunities for parent-child positive interaction to happen. They mentioned pre-meetings with the patient in order to prepare for the family meeting, encouragement and support as essentials in order to make the patient feel comfortable and ready for meeting the family. Also, setting a comfortable and secure environment plays a significant role.

“When you don’t have all the settings like in your home, maybe it is easier to talk in a hospital setting.”

However, nurses notice it is a long-term work and many meetings might be needed in order to restore parent-child relationship. Sometimes, family oriented actions can be hard to implement when children, especially teenagers, are not cooperating with health care providers. If a patient has a recurrent depression, teenagers or family members’ trust can be damaged.

“If you ask ‘do you want to meet?’ or ‘do you want to discuss?’ (acts to be a teenager) ‘ihan sama...’ they are saying. Do you understand what I mean? They just feel they are fed up, again. (...) You never know what will happen. It might be only a little thing and today she (the mother) is well, something happens, in 15 minutes... The mother is down and the children don’t know what to do. So they don’t feel like discussing or understanding their parent. The only thing they feel is this insecure feeling. And they are angry and they don’t want to talk.”

Nurses reported they also have to deal with the feeling of guilt of the parent and the child. Since depression might interfere with parenting skills, patients might reproach to themselves their temporary difficulties in taking care of their children. On the

other hand, children can have problems understanding the situation and interpret their parent's condition as a consequence of something they have done.

“At least two important things you can, you must say to the kids: they are not guilty for this situation, because almost always they are feeling guilty: ‘why does this happen?’, ‘is this my issue?’. And the other one, how can I do so they can trust me.”

Also, since many children might have difficulties understanding depression as a mental health problem, nurses observe that the depressed parent can become isolated and “put-aside”. It is hard for children to accept and support their parent who is going through depression. In this case, the condition may get worse. The distance taken by the patient's “significant other”, the child, can trigger the sad and desperate feelings, as well as guilt. Nurses notice that sometimes, when the children come to the ward, they do not necessarily interact with the hospitalized parent. Their instinct might lead them to refer more to the “healthy” adults or parent. Children use their senses to observe situations and can be afraid or feel threaten by their depressed parent unusual attitude. Nurses pointed out that, even small babies can observe and react differently between emotional and mechanical care.

“When the mother is taking care of the baby only mechanically, so the babies, they are not smiling or talking to the mother. But if somebody else goes and smiles, then the one who is doing it is getting these responses. And the mother is looking like ‘oh, my baby is doing that, but not to me, I'm bad.’”

“It is often harmful or almost dangerous when you have this after-birth depression with the mother. (...) It is almost much more dangerous than when you have a psychotic mother. Because maybe the psychotic mother she is talking and getting in touch in some way. A depressed mother is not doing it. “

“The goal is that the mother should be as much as possible with the baby, especially if the baby is the first one of the family. Being a mother or a father you can think of it as a skill or so. You develop it through being used or being with your children. And you don’t really learn if you are not with the baby.”

Nurses believe it is then their role to support and encourage their patient to engage in parenting skills. Empowering the patient is essential to favor emotional bonding to his/her child. Nurses think they should be trusted by their patient, use their power and expertise to motivate and empower as well as give support to the parent.

### **Two worlds meeting: adult’s and children’s world**

When the nurses’ work or intervention is directly focused on the child, participants agreed on the challenge communicating with them can be. In fact, they opposed the adults’ world to the children’s one.

The age of the child should make the nurse adapt his/her practice and ways to interact with the kid. Participants point out that dealing with teenagers is highly different from talking with a preschooler or having to deal with a baby’s needs, emotions and feelings. In fact, nurses feel they do have to adapt their practice and approach to the level of understanding of kids. Adaptation and empathy should be great qualities from nurses, in supporting children. Professionals should understand the child’s reality and view on things such as illness, hospital and other issues related to their family situation.

Nurses expressed that it feels more challenging to communicate with young children. In fact, they may have difficulties to understand the parent’s condition and/or language limitations to express their feelings and views on the events and the family situation. Nurses should possess efficient communication skills and adapt their speech or ways of communicating to the recipient.

“I think a tension is coming about this: to meet very small children.”

“The language problem, how I should meet this kid, what words I use about mother’s or father’s depression. Those children about 4 years old, there will be more tension than if they are older children.”

“You have to be some kind of aware, and plan when you are meeting those children, you have to know what kind of language you are using. You cannot speak to for example children age 4 in the same language as children age about 12 or 15 about depression. They don’t have the same way to look the words, they do not understand same words as the older children. That is a challenge!”

From their experiences, nurses agreed on the need of concreteness when talking about mental illness, hospital stay or more general issues with children. The nurses should understand the children perceive and interpret information differently than adults. They might not understand implied messages or may need extra precisions and explanations on some matters that are unfamiliar to them.

Being concrete and precise can avoid creating misunderstanding and extra-worries or stress to the kids. What is evident for the nurse and adults is not necessarily for the child. Finally, despite the challenges nurses experience, they reported that encountering children remains a rewarding experience and represents an outcome for the professional, the child and the patient. Nurses advised professionals should not be afraid of talking or interacting with children of all ages, and should apprehend encounter with patient’s child as a beneficial and rewarding experience.

### **The nurse as a safe marker for the child**

Nurses highlighted that they also have a role to play for the kids. In fact, they should be trustable and nurses have to create a relationship with the child based on reliance

and sureness. Just as in the relationship with the client, nurses should be able to apply those same principles with the children.

Also, participants notice that children do not identify nurses as health care professionals, providers or mental health experts, but rather regard them as adults, just like other significant grown-ups in their life. They do not necessarily expect good medical treatment or professionalism from the nurse, but see him/her as a human. Above all, children should perceive the nurse as a pleasant, friendly and nice person. They pay more attention and give more value to the personal qualities of a nurse rather than his/her professional skills.

### **7.3 Nurses' resources in developing their practice**

Despite some challenges nurses expressed, they also were able to identify the strengths and needs for development of their practice. They recognized useful ways to deal with children and clear areas of their work that could be improved in order to provide greater family and child oriented nursing care.

#### **Use of creativity**

In order to overcome experienced challenges, nurses suggested the importance of using existing resources on children and parent's mental illness. In fact, some wards provide booklets, books or other supports explaining depression. Nurses should use their expertise in the area and the resources provided by the working environment and relay them to the children or the parents. Participants reported that the use of books or stories thought and written especially for the purpose of describing mental illness to children should be known and used by the staff. They felt they can be useful supports and instruments to create interaction since they can find in those supports words and pictures to describe what feels difficult to explain. In fact, participants explained that, this way, depression can be introduced to kids in a playful and lighter



way. They can ask questions on the story, express their feelings and ideas on what has been presented to them.

Nurses suggested they can also use those supports and introduce them to help the other parent as well. This way, they felt patient's partner can also have a different approach on their spouse's illness, get informed and lessen some prejudices on depression. Participants notified that parents can use stories, pictures and booklets in order to discuss their family's situation with their kids in a more common and lighthearted manner.

Nurses find it useful to use other ways to observe kids' feelings and behaviors. If talking and using words is experienced as difficult by the nurse, participants suggested she/he can overcome the language issue by using games, drawing, or any other kind of alternative method that the professional finds suitable for the kid and more comfortable for him/her. Through painting, drawing, the nurse can already have an insight and view on the child's feelings. Nurses can interpret children's ways of playing and being active or very introvert for example.

“Do something another thing than talking. Maybe if there are some toys it's very challenging when small kids are playing we cannot play with them in family meetings but you can look the way how they are playing. What toys they are using, are they aggressive or are they playing very nicely or silent.”

When talking and using words is difficult, non-verbal communication was thought to be a useful and efficient way to notice child's behavior and have an idea on whether the child's attitude reflects well-being or unusual concerns. Nurses felt they should observe the kids and be able to read between the lines, find reassurance or signs that should alert.

### **Multi-professional working and peer support**

Nurses stressed the importance of multi-professional cooperation and actions.

In fact, nurses, doctors, psychologist, social workers, and other external professionals (school teachers or counsellors, outpatient clinics staff, etc.) should all work hand in hand, also when it comes to caring for depressed patients' children. Communication between the different occupations should be, in nurses' opinion, efficient, open and for the best interest of the family and its children. The different perspectives should benefit the care and help improve the work of one another. Workers on the ward should also use their own expertise and experience in order to support professionals who face difficulties in dealing with families and children.

Nurses also pointed out how group effect on the ward can make nurses improve their practice. In fact, they noticed that the more nurses do talk to kids and include them in the care, interact with them and implement actions in order to support them, the more motivated the nurses felt to act the same. Taking example on peers and seeing colleagues apply positive and beneficial actions pushes nurses to imitate and mimic. This way, the more the ward includes children in the process of caring for depressed parents, the more natural and easy encountering kids becomes. Nurses defined the need of a ward's culture which would be family and especially children oriented, in order to make the inclusion of children in the care more systematic.

When talking about peer support, nurses exposed their need for more training on the matter of children of depressed parents. Since nurses are conscious of the financial resources limitations they suggested the idea that self-training could be done within the ward, between the different members of the staff. More experienced and comfortable nurses in the area can train and support younger and more novice peers. Passing on skills and experiences between older and newer nurses can be a positive and low-budget way to reinforce training of nurses in family care, without having to pay for hiring external professional. The use of already existing resources, the experienced nurses, was seen as a realistic, easy and practical way to overcome financial issues.

Finally, nurses suggested those trainings should be as practical as possible. They feel practice is more needed over the theory. In fact, they all know the importance of family oriented nursing and are aware of the children's needs and emotions when a parent is hospitalized for depression, but the lack of experience and the fear of the unknown is rather the problem faced by nurses.

"If there are some kind of training arranged I think it should be very practical training. For example cases that the nurses should be dealing with, not that you are sitting in some great auditorium and just listen to the lesson."

### **Beneficial family oriented actions needed**

Participants recognized that mental health nursing practice surely does include family care, but highlighted that the focus is more on the couple. The spouse of the patient is central and highly included in the care. However, they regretted the lack of a more holistic approach of family. They expressed that a stronger focus on children is still needed in practice.

"In my opinion, I think we don't do enough and we won't meet enough children with parent."

"If the main reason for depression is like a life situation crisis or something which is not directly related to children then we don't talk about parenting so much."

Nurses suggested that any kind of initiative which would be family oriented is beneficial. Actions or projects in favor of families and children affected by depression are perceived as needed and helpful in caring for depressive patients and their relatives. Organizing group meetings of parents going through depression has been given as a possible example. This kind of support groups could focus on sharing experiences and tips on parenting.

Finally, nurses added that encountering children might not feel easy, however, it is a necessary and important aspect of nurse's role in caring for depressed patient and their family members. They suggested that practice is the best way to become better at it, and that nurses should not be afraid of facing children, despite challenges. They should not avoid those situations. Even though improvements can be made, learning by doing remains the best way to become better at interacting with children and families in general, in nurses' opinion.

“We also have to be aware that this is not a rocket science this thing to meet children with depressed parents. They are only humans and everyone can also talk and has his skill to talk with people.”

Nurses felt they should be informed and supported, in order to become more confident in this practice of including children in the care process for patients with depression. They advised that every professional should trust in themselves, the benefit of this kind of proceeding, and support one another to not neglect this aspect of the care.

## **8 Discussion**

### **8.1 Discussion on the results**

Nurses' experiences varied depending on the type of unit they are working in as well as their personal and professional experiences. As Johansson and Danielson's (2012) work mentions it, nurses evolving in closed psychiatric ward can experience their work differently than nurses working in open wards. In fact, this type of wards make nurses feel more stressed, in need of more safety in their workplace and the level of control they should have on their patients is higher than in open wards. Patients being admitted against their will can represent a bigger challenge and require a more

demanding work from the nurses. (Johansson, Danielson, 2012) The path of the patients and the way care is implemented can therefore have an impact on nurses' experience and feelings at work.

The early detection of depression's symptoms could help providing support to patients already before having to be hospitalized in a closed unit. This way, nursing care could be more efficient and the patient-nurse relationship built earlier and before an extreme distress of the client. This implies nurses should be trained not only if they intend to have a career in psychiatric care. In fact, depression could be recognized in primary health care settings and patients guided early enough to suitable supports, in order to provide early-intervention. (Lazarou, Kouta, Kapsou, Kaite, 2013)

The nurses' previous experiences in dealing with depressive patients and appropriate training in mental health nursing are essential for health care staffs to provide a professional care to depressive patients. Nurses should be able to give appropriate care to the clients but also have sufficient knowledge and awareness to not compromise and expose themselves to harmful feelings and experiences. (Kilkku, Vuokila-Oikkonen, 2011)

Nurses mentioned the importance of the patient-nurse relationship. They highlighted cooperation and communication as keys to a positive nurse-patient functioning. In fact, mental health nursing suggests that nurse and patient should build a relationship based on mutual trust and respect (Ross, Clarke, Kettles, 2013). Nurses need to create link with their client in order to provide efficient therapeutic care. In order to care for children of depressive patients, nurses should first create a positive relationship with their patient. In fact, nurses expressed their responsibility in making sure their patient's child/children is/are safe and that they should be included in the care. However, in a fragile nurse-patient relationship, the intrusion of the nurse into the patient's life and familial issues could be experienced negatively by the patient. What the nurse feels as essential in the care process can be experienced differently by the patient and therefore, conflict can emerge and impact on the nurse-patient

relationship. Patient and practitioner can have a different perspective on the relevance of including children within the care process. (Ross, Clarke, Kettles, 2013)

When asked about the inclusion of children of depressed patients, nurses estimated to be quite effective and aware about the care of children whose parents are going through psychiatric care for depression. In fact, Finnish law states that mental health professionals should acknowledge if their patient has children and evaluate the status of the child if any. Nurses reported that they usually ask about the presence of children within the patient's family. Korhonen, Pietilä and Vehviläinen-Julkunen's (2010) results on the gathering of information on mental health patients' children by mental health nurses raise similar observation: most of the nurses do ask and report information on their patients' children. However, variations exist between nurses when it comes to including the children in the parent's care process. More experienced nurses and those with more training on family care tend more to actively integrate the child in patient's care. (Korhonen, Pietilä, Vehviläinen-Julkunen, 2010) They also report that the personal characteristics of the nurses, gender, age, marital status and being a parent or not influence on the inclusion of children. In fact this idea was supported in this research, since nurses felt more comfortable in interacting with children if they were parents themselves or had previous experiences with children.

The research also confirmed the assumption suggested by the illness belief model (Wright, Bell, 2009) according to which illness would be a "family affair". In fact, nurses' experiences enabled them to recognize the impact of depression on a child and his/her relationship to the parent. They mentioned the importance of communication and connection between family members. Wright and Bell state that depression, as any other illness, impacts not only the diagnosed person but also his/her family. Stigma on depression has been stated as one obstacle encountered by nurses in working with families. Nurses mentioned that family cooperation and knowledge on the condition can also impact on the care and patient's healing. The

illness belief model supports this result. It implies the need for health professional to work on the family members' beliefs on depression as an illness. Through communication, cooperation, mutual trust and respect, as well as compassion, nurses should not neglect the importance of family members involvement on their patient's healing. (Wright, Bell, 2009)

Beardslee, Gladstone, Wright and Cooper (2003) confirm the effect mental health disorders can have on children. In fact in some cases, their safety can be compromised, emotional relationship can be damaged, thus impact on the child's development and lead to behavioral and emotional problems (Butler, Budman, Beardslee, 2000). Korhonen et al. (2010) reported that the knowledge of professionals on the risks children of depressed patients are exposed to increases the chances for nurses to care for the children of their patients as well.

However, the negative impact of depression on the children and, more generally the family, reported by nurses can be balanced. In fact, depression can impact parenting skills and cause conflict and misunderstanding between family members.

Nonetheless, if nursing interventions are done efficiently and appropriately, illness can represent an opportunity for people to come altogether, get to know each other from a different angle, share feelings and support one another. The resilience and capacity of a family to deal with an illness varies. Stigmatization of children of depressed parents and the risks they are exposed to should not influence nurses' intervention but rather encourage them to care for those children and see them as strengths and supports in patient's capacity to heal. (Beardslee, 2002)

Despite challenges in nursing for children with parental depression, potential of mental health care providers is a key resource to nursing practice development. Nursing for children with parental depression should not only be the responsibility of mental health nurses but rather extend to the nursing profession in general. Resources and supports, such as the manual "Lapset puheeksi, kun vanhemmalla on mielenterveyden ongelmia" exist and should be used to help nurses in understanding

depression and its effect on children. (Korhonen et al., 2010) This research highlighted the idea that nurses have ideas and possess resources to help improving nursing practice.

One of the resources available to nurses is the presence of other professionals and colleagues on the ward and outside of it. Walker, Barker and Pearson (2000) highlighted the importance of effective and positive relationships between different staff members. Communication, feedback and cooperation were revealed to be important elements of efficient and beneficial multi-professional care. Even though nurses raised difficulties such as scheduling of family meeting according to different professionals' agendas, lack of human and financial resources, results met similar conclusions on the relevance of multi-professional working. Working environment and team spirit are often reported in nursing practice, as factors improving professionals' motivation and practices (Koivula, Paunonen, Laippala, 1998)

The results suggested nurses would need more training on caring for families and children in particular. Despite ideas and alternative ways of working from nurses, the need for theoretical but mostly practical training has been brought up. Training is often mentioned in literature as an essential basis for nurses to develop their practice. (Koivula et al., 1998; Mc Knight, 2013) However, the request and demand for more training can impact mental health nurses' practice by providing technical education on matters that should, to some extent, fall under intuitive and more spontaneous and interpersonal skills. Mac Fayden and Farrington (1996) as well as Morall (1998) questioned the objective of nurses when it comes to extra training. In fact, they suggest it could reveal a need and wish from professionals to enhance their professional status rather than aiming at improving their practice and providing a better care to patients and their families. Also, the necessity of additional training in caring for families of depressed patients could lead to the belief that such skills and knowledge are neither accessible nor applicable by other nurses, who have not undergone special training. This could be a risk for nurses in other settings than psychiatric wards to ignore or neglect the detection and care of depressive patients



and their children, on the grounds that specialized nurses would be more competent in dealing with such clients. (Walker, Barker, Pearson, 2000)

## **8.2 Ethical considerations**

As in any research, researchers should work in an ethical manner. Ethics is a branch of philosophy that deals with morality. Conducting a nursing research requires expertise and diligence but also honesty and integrity. Researchers have an ethical responsibility to protect human rights of the participants, such as privacy, anonymity and confidentiality as well as self-determination. (Burns, Grove, 1993)

Participants were asked to read and sign a consent form, in order to guarantee that the prospective subject agrees to take part in the research. The permission of voice and image recording, taking notes and using the data for research purpose was asked from the participants and approved from all parts. (Royal College of Nursing, 2009) Data handling should be done in an appropriate and ethical way, in order to protect it, by storing, archiving, disposing it off during and after the research project in a secure manner. Since the research implied video recording, ethical considerations should be given to the use of individual's image (Banks, 2001). The recording purpose and the use of it are clear and have been set before collecting the data by the researchers. The video will not be published but has only been used by the researchers as a way to collect more accurate data and avoiding bias and diminish selectivity of information (Caldwell, Atwal, 2005). In order to guarantee the protection of participants' image, the video recording has been destroyed as soon as the transcription was done and valid.

According to the American Association of Critical Care Nursing (2013), research should also ensure integrity, meaning an active adherence to ethical principles and professional criteria. Research shall be honest and fair during the whole process. Researchers' judgment should be based on observable phenomena and uninfluenced by emotions or personal prejudices. The collected research data has been organized

right after the interview in order to avoid bias such as researchers' personal opinions in the data analysis. Moreover, two researchers working together has been a way to avoid personal interpretation but rather tend to a more objective analysis of data. In fact, discussing on the understanding and meaning of the data was often needed. When both researchers understood the data in a similar way, it can be said that the analysis is more trustable than if it emerged only from one analyzer's point of view. Discussing and finding a consensus on what the raw data was providing to the research was constantly discussed and avoidance of bias a continuous concern for researchers.

Finally, dilemma emerged about quoting within the results. The text being accessible by participants and sent to them when finished, questioning appeared concerning identification of own quote by participants. Even if quotes are anonymous, the participant who expressed an experience or feeling might be able to recognize him/herself while reading the text. After discussion and thought on the matter, researchers came to the conclusion that it was not fully avoidable for sure. However, it was decided that all quotes included to the text should be non-prejudicial, non-revealing personal or harmful issues. Quotes being neutral and stating an experience or emotion and being illustrative and explanative of a result were chosen to be included in the text. In fact, quotes had to be meaningful and beneficent for the results but non-harmful for participants in case they recognize themselves in saying that specific quote. Anonymity is anyway guaranteed and preserved since no name, no specific ward or special characteristics have been delivered through quoting. (Orb, Eisenhauer, Wynaden, 2001).

### **8.3 Reliability of the research**

Reliability refers to the dependability or consistency of a research. In order to ensure the reliability of this study, the interview was video recorded for the purpose of minimizing errors in the transcription of the original data. In addition, the

researchers examined the data individually first, and discussed it together afterwards in order to go through the unclear parts of the video and to avoid mistranscriptions and biases.

As in any research, critics and limitations can be raised. Even if researchers have applied ethics during the whole research process and have been as loyal as possible to the participants' original idea in the analysis of data, qualitative research is by definition more prone to bias. (Anderson, 2010)

In this research, group interview was an innovative and interesting way for nurses from different wards to meet and hear about one another's experience and ways of working. Video recorded interview and the use of English have not been reasons for participants to be uncomfortable or reserved in their participation. In fact, a lot of usable data has been collected thanks to an active conversation and relevant experiences of participants. Professionals were open to discuss about their experiences and were able to give the researchers answers to every question in an honest and straight forward way. Conversation was rich and composed of different themes and types of data.

However, participants' speech can be influenced by the presence of the researchers as well as other participants (Anderson, 2010). Moreover, English being the language of the research can be a limitation to the work. In fact, it was not the native language of any of the researchers. Researchers having a different mother-tongue, and the education received being in English, it was however evident that it would be the common language used in theoretical background, interview and research writing. Yet, misunderstanding or approximate analysis of theoretical articles can be higher in this case. (Wong, 2015)

When it comes to data gathering, English can also be a limitation to the work. It is possible that the results would have been more accurate and with a deeper understanding if the interview was conducted in Finnish, by native speakers.

Moreover, producing a mistake-free text and proper sentences in English can be more challenging for non-native English speakers. (Wong, 2015)

In the future, it could be interesting to conduct the same kind of research in Finnish, in order to confirm if the results are similar.

## **8.4 Conclusion and recommendations**

Results can be said to be rather positive despite existing challenges and difficulties identified by nurses in working with children. Participants expressed their wish to improve their practice and suggested ideas such as self-training, peer support, use of alternative communication methods as ways to be actively interacting with children of depressive patients. Further research could look deeper into concrete ways nurses can improve their practice and become more efficient in caring for children with parental depression. Nurses for example suggested alternative and creative ways, but it would be relevant to research more within this area. In fact, cooperative research could be made between students of different fields such as nursing, ergo-therapy, music therapy students, etc.

This research being mostly reflecting on the experiences of nurses, it would also be interesting to get knowledge on the experiences of families and on how they perceive the care received by nursing staff. This way, research could be extended to out-clinic care and their experience after being cared for in a psychiatric ward.

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# Appendices

## Appendix 1 – Information of Research

Dear Participants,

Please read this carefully and ask any questions you may have before agreeing to take part in this study.

The topic of this research thesis is “Nursing for children with parental depression”. The purpose of this investigation is to have a better understanding on the obstacles working with children of patients nurses can face. It would help identify the needs for development in nursing field when it comes to children with parental depression. In addition, it can help adapt the solution and support given to nursing staff in dealing with children of psychiatric patients and support teaching for other nursing students when it comes to mental health nursing. The aim of this study is to identify the main challenges nurses face when dealing with children of patients suffering from depression.

We will conduct a small group (2-4 participants) interview with you. With your permission, we will video record the interview for the purpose of this study only. The interview will include questions relating to your experiences when working with children with parental depression, and your opinion on what needs to be improved, based on your experiences. The interview will take approximately one to two hours to be completed.

There is no remuneration for taking part in this research. Your participation is completely voluntary and you are free to withdraw at any time. There is no specific risk in participating in this research. Participants can share their personal opinions freely and are not obliged to answer all questions during the interview. Collected data from participants will only be available for the researchers and only be used for the purpose of this research. You will receive a copy of this form and your confidentiality and anonymity is guaranteed.

If you have any questions, please feel free to contact the researchers :

Nadège Ollagnier at [g6594@student.jamk.fi](mailto:g6594@student.jamk.fi) or at 045 10 26 865.

You Chen at [g6609@student.jamk.fi](mailto:g6609@student.jamk.fi) or at 0407712568.

**Appendix 2- Consent form**

I have read the information above and have received answers to any questions I asked. I consent to take part in this research. In addition to agreeing participate, I also give the consent to video recording.

Your signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of researchers

\_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

### **Appendix 3 – Interview questions**

- **Working with people suffering from depression**
  - How often have you/are you working with depressive patients?
  - What kind of experience have you had/do you have when working with depressive patients ?
  
- **Children of depressive patients and nursing**
  - How often have you/are you dealing with the children of those patients?
  - What are your experiences in communicating or explaining what is going on to those children?
  - Could you share some of your stories or experiences to illustrate your statement ?
  - What do you do when the child is not able to understand the situation ?
  - When the child or children cannot understand their parents' situation, what kind of reaction do they have ? How do you feel about it ?
  - Do you include the child and parenting skills as part of the care you give to your patients ? If yes, how ? If not, why ?
  
- **Means existing in Central Finland/Finland**
  - Are you aware of means, programs and/or guidelines existing to support children with parental depression?
  
- **Challenges and strengths**
  - In your opinion, what are the main challenges when dealing with your patients' child/children ?
  - What are the tips you could share in order to help other nurses know better how to deal with those children?
  
- **Needs for development**
  - As nurses, what do you think should be improved in order to support children with parental depression?
  - What do you think is needed or should be done, nurses' approach to children of depressive patients ?