


Examining the Synergy of Practice: The Irish Public Health Nurse's Potential From the First Postnatal Visit and Beyond

Global Pediatric Health
January-December 2014: 1-8
© The Author(s) 2014
DOI: 10.1177/2333794X14553623
gph.sagepub.com


Amanda Phelan, BNS, MSc, PhD¹

Abstract

Public health nurses in Ireland are charged with conducting a home visit to every postnatal mother within 48 hours of hospital discharge. This represents the beginning of a long-term relationship, not only with the mother and newborn child but also with the family. This article fundamentally demonstrates the essential work of the public health nurse in promoting the health of the baby within a family. In this article, the expertise the public health nurse uses in the first visit is examined in the context of 3 competencies: communication, partnerships with the family, and partnerships with individual family members. This expertise provides the foundation for a long-term therapeutic relationship with the family to the essential benefit of the baby's early childhood growth and developmental milestones. Consequently, the first postnatal visit by public health nursing in Ireland represents a synergy of practice, which provides the foundation for enduring family relationships focused on potentializing both individual family members' health and the family as a dynamic unit.

Keywords

general pediatrics, public health nursing, competencies, postnatal visiting, family relationships

Background

The role of the public health nurse (PHN) in Ireland is based on a generalist geographic caseload and is underpinned by the principle of universal equality in nursing care delivery in the community.¹ Research has shown that families require support following a new birth from not only their immediate social support system but also from health care professionals.² Such support provides an important context and foundation for positive pediatric health and well-being. Most births in Ireland occur in the hospital environment,³ and Ireland has the highest natural rate of increase in population in the 28 European states.⁴ In the early stages of a newborn's life, mothers and families can require varying levels of support, particularly as hospital stays have decreased in recent years.⁵ Within this context, the initial postnatal visit by the PHN is imperative as this functions to meet a variety of care objectives that transcend a simple review of mother and child to the potential to engage in health promoting family partnerships. The competencies to meet these care objectives are embedded in a synergy of public health nursing practice. This article focuses on an exploration of this synergy through 3 practice competencies: effective

communication, assessment of the family as a unit, and individual family members.

The Irish Public Health Nurse

Public health nurses in Ireland are general nurses, with 2 years nursing experience, who complete a 1-year post-graduate diploma.⁶ Public health nurses practice within an ecological, social model of care,^{1,7,8} which differs from other nursing settings.^{9,10} Although the PHN provides a free generalist and universal community service, there have been some debates regarding role definition. Such commentaries have been critical of the generalist nature of PHN's practice and argue that alternative and more flexible roles should be pursued.^{1,8} Indeed, with the establishment of the new Child and Family Support Agency and calls for PHN specializations, the role of the

¹University College Dublin, Dublin, Ireland

Corresponding Author:

Amanda Phelan, University College Dublin, Health Sciences' Building, Belfield, Dublin D4, Ireland.
Email: amanda.phelan@ucd.ie



PHN may become population group focused.^{11,12} However, current PHN responsibilities predominantly consist of geographical caseloads wherein care is directed toward individuals, families, communities, and population caseloads vary between 650 and 6500.¹³ The complex delivery of care requires careful, reflective practice that transcends direct interactions with client groups to areas such as interdisciplinary collaboration, entrepreneurial skills, community mobilization and participation, leadership, innovative care planning, and the promotion of social capital. Fundamentally, public health nursing is about enhancing and optimizing health through effective partnerships.

Although PHNs have a remit in primary, secondary, and tertiary care for all age groups within a defined geographical caseload area, the predominant clinical interactions are within older person care and child health.¹³ PHN responsibilities outlined by the Department of Health & Children¹⁴ include the provision of professional advice, child protection, and the support of families. Specifically, the PHN is mandated to visit the home, within 48 hours of hospital discharge, when a new birth has occurred and to facilitate family health and well-being as well as monitoring the baby's developmental progress.¹⁵ Although the PHN may engage in antenatal and postnatal care, in many areas antenatal care is delivered through the maternity setting and domino schemes with general medical practitioners. The postnatal visit often provides the catalyst for the PHN's entrance into the family home where his/her scope of practice focuses on the family as client rather than a reductionist focus on the mother and newborn. Thus, the first postnatal visit can represent the initiation of a partnership with the family that lasts at least until school-going age.

The First Postnatal Visit: An Opportunity for Family Practice

The postnatal visit represents a synergy of PHN competencies rooted in Carper's¹⁶ ways of knowing in nursing, which can facilitate evidence-based practice and sound clinical decision making. A synergy may be defined as producing "a combined effect greater than the sum of their separate parts."^{17(p1452)} In combining knowledge bases from ways of knowing (personal ways of knowing, ethical ways of knowing, aesthetics, and empirics), the postnatal visit transcends particular activities and skills to produce a reflective, therapeutic engagement with the family. This approach is of paramount importance as the promotion of family well-being by health care professionals has been identified as more important than a simple child health focus.^{18,19}

The birth of a newborn baby facilitates the opportunity to potentialize family partnerships. An important

component of true facilitative partnership is placing the family within an egalitarian, reciprocal framework of care relationships. This means practice focuses on the family being in control of their own health, where power is delegated to the family and informed choices are enabled through discussion, consultation, and information giving. The PHN therefore recognizes that the family is essentially a resource for its members and an important element in postnatal support systems.^{2,20} Figure 1 delineates a model of the PHN's practice related to the first postnatal visit, where the family is the central concern and areas of communication, assessment of the family unit, and individual family members are essential elements of the PHN's focus. Promoting health partnerships with families is the ultimate objective and is underpinned by the PHN's competencies, technical skills, evidence-based practice, and tacit knowledge bases.

The family has collective realities and health requirements but also fractured realities as each individual member generates his/her own health needs. Thus, the family is assessed as a whole unit but family members are acknowledged as having the potential to have individual and alternative realities.

Communication: Preparing for the Visit

Reflectively reviewing the initial referral allows the PHN to familiarize himself/herself with important details regarding the discharge. A fundamental difference in home visiting is that the PHN is a guest in the family's home and should always respect the fact that families have their own internal commitments and self-determination. Consequently, a phone call to arrange a time demonstrates the belief that the family requires respect in terms of negotiating a visit time, but also raises the probability of successful access to the home. From a time management perspective, scheduling visits enables the PHN to arrange his/her visits through effective planning, organization, and prioritizing of care. Although the PHN must offer a first postnatal visit and ongoing support, a minority of families decline the service and it is important that local protocols are followed to record the family's wishes. However, in the case of child protection concerns, legislation²¹ takes precedence and the family may be legally mandated to provide access to the child(ren).

Communication Skills: Family Engagement

The initial family encounter with a health care professional can be a difficult experience.²² Therefore, meeting families for the first time requires well-developed, careful communication strategies to continue access and

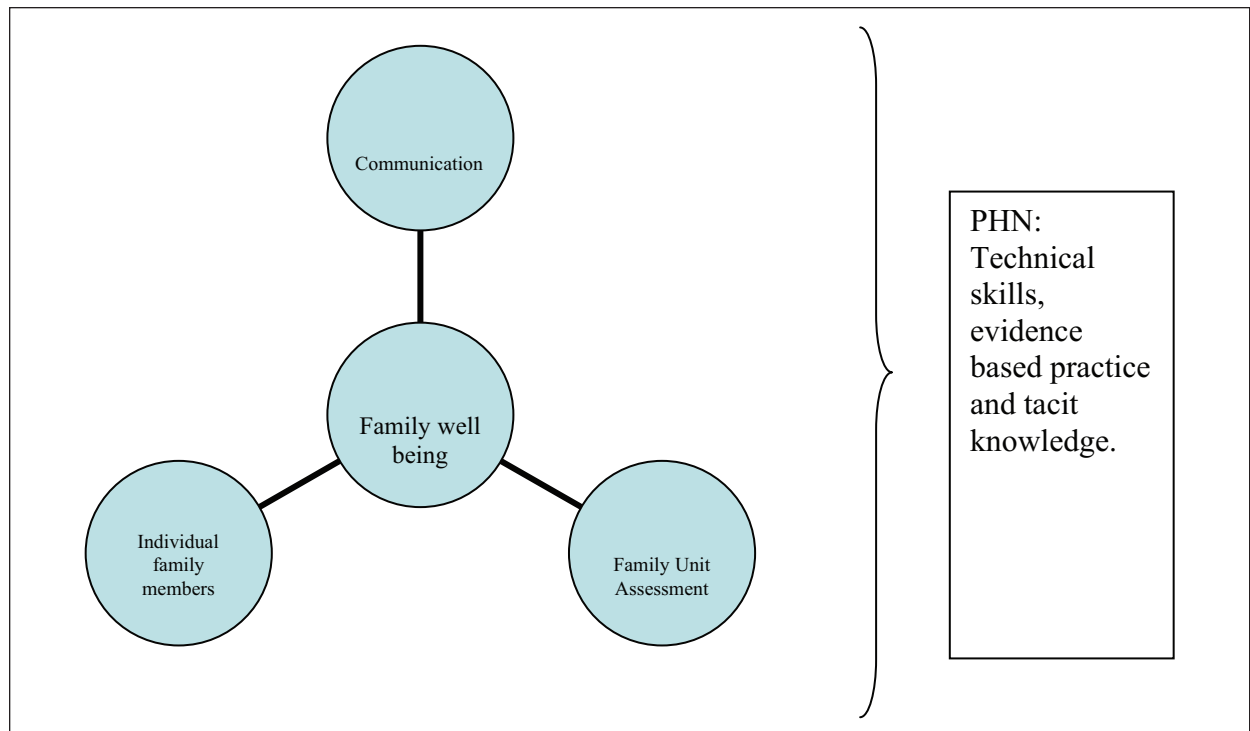


Figure 1. Model for PHN practice in postnatal visit.

promote positive, therapeutic partnerships. Often, the first postnatal visit can reveal how families struggle with a first or subsequent baby. Communication is tailored to facilitate age and understanding; thus, conversational styles and nontechnical terms potentialize clarity. A particularly useful skill is that of motivational interviewing. Miller and Rollnick^{23(p137)} describe this as a “collaborative, person centred form of guiding to elicit and strengthen motivation for change.” Thus, health challenges can be explored openly and the PHN employs a cooperative partnership that evokes the family’s ideas about health and emphasizes autonomy. As a result, either the family as a unit or individual family members can develop self-efficacy to initiate change.

An important element of communication is the ability of the PHN to reassure the family and to be responsive to the presenting realities. Central to this process is a nonjudgmental attitude that demonstrates unconditional positive regard and empathy.²⁴ Rather than being constructed as the “expert,” the PHN’s interactions focus on building up family members’ confidence, giving support, making suggestions, and discussing possibilities for partnership with family members. Another important element of communication is self-awareness, which has been identified as a key component in understanding why some interactions are challenging.²⁵ Consequently, reflection before, in, and on practice

provides a critical insight into why problems may occur and how these may be addressed in further interactions. Crucially, the PHN must build up communication pathways with each family member and appreciate barriers to communication, such as only focusing on the mother and child or taking particular perspectives for granted as agreeable to all family members. From an ethical point of view, communication with family members is confidential; however, the PHN may provide an important independent link in negotiating family issues.²⁶

Sensitive communication is also essential in transcultural interactions. This is particularly important due to the recent increase in diverse cultural populations in Ireland. Central to transcultural communication is disciplinary cultural competence—the ability to provide PHN interactions that transcend cultural differences.²⁷ Korbin²⁸ considers the unpacking of culture as necessary for care delivery by professionals, as even within cultural groups, diversity is common. Essentially, a balance between ethnocentrism and cultural relativism is required so that acceptable, negotiated perspectives are agreed with the family.²⁸

Family Unit Assessment

The concept of the family is a socially constructed phenomenon. Allender et al²⁹ propose that a family is a

small social unity that consists of 2 or more individuals who have an emotional bond and who have particular roles, responsibilities, and recognized social positions. Families are often referred to as providing functions such as kinship, security, emotional attachment, primary socialization, and security for its members. Families can also be imbued with positive and idealized notions, although these perspectives have been challenged in recent years.³⁰

Ireland has gradually refocused its understandings of the family due to influences such as the economy, the state and judiciary, civil society organizations, as well as changing cultures and values.³¹ The interpretation of “family” within the Irish Constitution (*Bunreacht na hEireann*)³² was heavily influenced by the Catholic church. Consequently, changes to the sacrosanct position of the family in the Irish Constitution have occurred through national referenda (eg, divorce 1995, children’s rights 2012). Although 74.4% of Irish school-aged children live with both parents,³³ multiple family forms are now more societally acceptable.

A PHN assessment of family functioning encompasses an appraisal of the historico-social, medical, and cultural context of both the family and individuals within the family. Moreover, discussions also focus on the relationships between individuals in the family and the family’s relationship to their community and extended family. As such, the geneogram and the ecogram can assist in assessment at the postnatal visit. The geneogram provides a visual representation of the family and may include information on significant life events. In contrast, the ecogram demonstrates a visual representation of the social connectedness of the family within their community. Both diagrams can stimulate important discussions and point to areas that may be a PHN care focus. For example, linking families to community support groups has a positive impact on adjustment to new roles and can also extend social contacts.²²

Family theories have been used to examine the complexity of families and understand family dynamics. Each theory is underpinned by particular views regarding the definition of the family¹⁹ and how families interact and develop. However, family theories, such as those based on symbolic interactionism,³⁴ structural functionalism,³⁵ or family development,³⁶ should be considered a prismatic lens into family functioning. Similar to a prism, each family theory can generate innovative insights, and consequently, a PHN consideration of more than one theory can provide a more comprehensive understanding into individual family dynamics and generate targeted discussions in areas such as anticipatory guidance, fundamental family values, and how the family adapts to stress and conflict.

Political functioning refers to how the family is governed internally and examines areas such as parenting styles and family decision-making processes. For example, in authoritarian families, children are not encouraged to be creative and may become rebellious, whereas in children in a *laissez-faire* family may find difficulty adjusting to the external boundaries of the family and experience insecurity.³⁷ Within a true partnership, these values are given credence in the PHN’s assessment and are integrated into care planning.

PHNs also assess the physical environment of the family habitat. The physical environment may have an important influence on family functioning. For example, overcrowding, poor state of repairs, a lack of facilities may all have an impact on both individual and family health³⁸ and may be a factor in child protection concerns.³⁹ In working in partnership with the family to improve the physical environment, the PHN may mobilize assistance from multidisciplinary and voluntary agencies. In addition, simple safety advice can improve environments for the family.⁴⁰

Family Members’ Assessment

All members of the family should be invited to discuss their perspective. Although the catalyst of visiting the home is the new birth, the opportunity should not be lost to explore health opportunities with each member of the family. The birth of a new baby can bring financial strain, anxiety, and displacement of members. The gendered nature of health issues is important.⁴¹ For example, family intervention work has noted that there is little literature that focuses on fathers’ engagement in relation to the child and family⁴² and this neglects the importance of fathering and supportive partnering in the family context.⁴³ This lack of engagement is considered a lost opportunity to promote and foster fathers’ capabilities in terms of contributing to areas of child welfare^{43,44} and could impede further interactions with the PHN.² Taken-for-granted assumptions about gendered caregiving may prevent the establishment of effective relationship with fathers, who may even self-fulfil this by avoiding contacts with health care professionals.^{43,45} Although postnatal depression is frequently associated with mothers,^{2,20,46} fathers can also experience this. Paternal postnatal depression has a moderate correlation to maternal postnatal depression, with a prevalence of approximately 10%, representing a significant public health issue.⁴⁷ Thus, careful screening and discussion of the father’s perspective is warranted to elucidate anxieties, fears, concerns, and health issues.

Partnerships with other children in the family are also important. Issues of concern for other members may

include sibling rivalry.^{48,49} Certain challenges may also arise in relation to the health and development of young children and may include toilet training, tantrum management, and appropriate nutritional intake. For older children, health education in the areas of bullying, smoking, and alcohol are relevant. For example, bullying in Ireland is a public health issue with 10 722 calls to a helpline in 2011.⁵⁰ In addition, the Health Behavior in School Children in Ireland research³³ reported that 11.8% of Irish school children engaged in smoking, while 28.1% are reported to have experienced being “really drunk.” Other issues of relevance to children relate to dieting, sexual behavior, emotional well-being, exercise, and relationships with meaningful others (including parents).³³ All of these areas point to opportunities for the PHN to explore and potentialize family members’ experiences and perspectives to optimize health and well-being. Moreover, if particular issues are identified as common within families, the PHN can generate school- and community-level health promotion campaigns to address such identified health and social challenges.

The First Postnatal Visits and the Newborn Baby

The PHN has a role in fostering and monitoring the new baby’s health welfare and development. The postnatal visit marks the commencement of a schedule of routine developmental checks as prescribed by *Best Health for Children*.⁵¹ This involves using skills of examination and observation to determine age-related growth and development.⁵² A comprehensive physical examination provides a baseline data set in areas such as gross and fine motor development, reflexes, weight plotting, skin condition, and so forth. Each subsequent visit correlates data so that growth can be plotted in terms of the individual child as compared to normal growth expectations. The PHN also considers issues such as the baby’s feeding, elimination, and sleep patterns. Using his/her expertise in assessing the newborn, the PHN can identify practice intervention foci, enhancing development and supporting parental self-efficacy.

The First Postnatal Visit and the Mother

Birth can be a traumatic event for mothers with some studies pointing to the occurrence of posttraumatic stress disorder,^{53,54} which has been linked to postnatal emotional distress and postnatal depression.⁵⁵ The flurry of excitement usually associated with a new birth can obscure the mother’s feelings, and thus, the opportunity

to authentically and confidentially discuss and acknowledge emotions and experiences is important.⁵⁶ The articulation of these feelings can be difficult due to a myriad of reasons such as depression, anxiety, a fear of failure, embarrassment, apathy, or fear of disclosing challenges in adjusting easily to mothering responsibilities.²⁰ Therefore, a discussion on the birth experience may elicit stressful details for the mother and father and could be an indicator of a higher propensity to postnatal depression.⁵⁵ The adaptation to caring for a new baby can be stressful as additional competencies are negotiated and parental self-efficacy has been associated with a positive mental health status.²² Consequently, assessment of parental self-efficacy is an important aspect of the PHN’s role as particular coping challenges can indicate the potential for risk.⁵⁷ Social expectations of motherhood can overwhelm a new mother and may lead to a perceived sense of failure as the experienced reality may not match such idealism. Accordingly, careful listening and empathy are important competencies for PHNs so that cues may be identified resulting in appropriate, realistic goals being articulated in collaboration with the family. Inherent in this therapeutic conversation is the need to acknowledge the normality of finding parenthood challenging and empowering parents to overcome challenges. Social support is also an important aspect of adapting to motherhood and in particular grandparents, peer-mothers, and various community supports.⁵⁸⁻⁶⁰

The National Institute of Clinical Excellence⁶¹ postnatal guidelines provide a comprehensive framework to assess the mother at the PHN’s first visit. These guidelines assist in acknowledging the normality of challenges in becoming a parent and encompass physical, psychological, and practical adaptation to the newborn child within the family structure. For the first postnatal visits, supporting and discussing the mother’s choice of infant feeding, managing the baby’s hygiene needs, patterns of crying, addressing exhaustion, advice on when to wean, social welfare benefits, sudden infant death syndrome, community support systems, sun safety, play development, immunization, medical postnatal checks constitute the universal areas of discussion. Simultaneously, the PHN can use his/her skills to identify more specific areas of concern, such as managing an additional child, social isolation, or feeling unsupported. The PHN can, therefore, assume a supportive role and negotiate possible referrals to other agencies and further home or clinic visits according to the individual needs of the family.

Discussion

The first postnatal visit offers the PHN unique access to the private domain of the family, where optimum health is

facilitated through the PHN's synergy of practice. A baby's birth has an impact on family functioning as the family's schedule is realigned and the baby's care demands accommodated for. In engaging in the first postnatal visit, the PHN uses expertise to begin a relationship focused on enhancing each family member's health and well-being. However, developing a relationship with the family is a metaphorical "tango," where interactions cohere together, adapting, learning, and ultimately optimizing health. Central to this relationship is an egalitarian focus where power is not located in a hierarchy, but the family is viewed as a self-defining, independent entity. There may be a danger of the first postnatal visit obscuring the family by focusing only on the mother and baby.² This represents a lost opportunity as the family needs to be considered as a whole, functioning unit with interrelationships and interdependencies as well as having individual realities for each member. Consequently, facilitating a family ethos enhances both the health of the family and members within the family. In this way, the PHN can understand individual subjectivities as well as discussing possibilities for health enhancement and supporting subsequent care goals.

This article has illuminated 3 essential areas of the PHN's work in relation to the postnatal visit. First, effective communication is paramount to develop therapeutic relationships. The first postnatal visit is fundamental to establish the basis of positive communications that will endure for a substantial period of time. Second, the family as a unit needs to be explored in terms of functioning, relationships, networks, and possible threats. This encompasses a review of the family as a nested social unit in the community. Finally, a focus on the collective members of the family should not be at the expense of the individual realities of each family member. In cohering these 3 approaches in the first postnatal visit to the home, the PHN has a unique opportunity to engage in positive health for families, which, in turn, contributes to health communities and populations.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

References

1. Hanafin S, Cowley S. Multidisciplinary communication in the Irish public health nursing service: a study. *Br J Community Nurs*. 2003;8:544-549.
2. Tammentie T, Paavilainen E, Tarkka MT, Asted-Kurki P. Families' experiences of interaction with the public health nurse at the child health clinic in connection with mother's post natal depression. *J Psychiatr Ment Health Nurs*. 2009;16:716-727.
3. Economic and Social Research Institute. *Perinatal Statistics Report, 2010*. Dublin, Ireland: Economic and Social Research Institute; 2012.
4. Eurostat. Population and population change statistics. http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Population_and_population_change_statistics. Published May 2014. Accessed June 2, 2014.
5. Leahy-Warren P. First time mothers: social support and confidence in infant care. *J Adv Nurs*. 2005;50:479-488.
6. An Bord Altranais. *Requirements and Standards for Public Health Nurse Registration Education Programmes*. Dublin, Ireland: An Bord Altranais; 2005.
7. Clarke J. Public health nursing in Ireland: a critical overview. *Public Health Nurs*. 2004;21:191-198.
8. Nic Philibin C, Griffiths C, Byrne G, Horan P, Brady AM, Begley C. The role of the public health nursing in a changing society. *J Adv Nurs*. 2010;66:743-752.
9. Phelan A. *A Phenomenological Exploration of Learning Experiences on the Higher Diploma in Public Health Nursing* [Unpublished MSc thesis]. Dublin, Ireland: University College Dublin; 2003.
10. Rigatto Witt R, Puntel de Almeida MC. Identification of nurses' competencies in primary health care through a Delphi study in Southern Brazil. *Public Health Nurs*. 2008;25:336-343.
11. Department of Children and Youth Affairs. *Report of the Task Force on the Child and Family Support Agency*. Dublin, Ireland: Department of Children and Youth Affairs; 2012.
12. O'Dwyer P. *A Report on the Child and Family Health Needs Assessment Framework Project in the HSE Dublin Mid Leinster Public Health Nursing Service Areas of Laois, Offaly, Longford and Westmeath*. Mullingar, Ireland: HSE: Dublin Mid Leinster; 2012.
13. Begley C, Brady AM, Byrne G, Macgregor C, Griffith C, Horan P. *A Study of the Role and Workload of the Public Health Nurse in the Galway Community Care Area*. Dublin, Ireland: Trinity College Dublin; 2004.
14. Department of Health & Children. *Memo 41/00: Job Description—Public Health Nurse*. Dublin, Ireland: Department of Health & Children; 2000.
15. Government of Ireland. *Health Act*. Dublin: Stationery Office; 1970.
16. Carper BA. Fundamental patterns of knowing in nursing. *Adv Nurs Sci*. 1978;1:13-23.
17. Pearsall J. *Oxford Concise English Dictionary*. 10th ed. Oxford, England: Oxford University Press; 2001.
18. Garner R. *Supporting Families: Child Protection in the Community*. Chichester, England: Wiley; 2003.
19. Smith SR, Hamon RR, Ingoldsby BB, Miller JE. *Exploring Family Theories*. 2nd ed. New York, NY: Oxford; 2009.
20. Leahy-Warren P, McCarty G, Corcoran P. First-time mothers: Social support, maternal parental self-efficacy and post-natal depression. *J Clin Nurs*. 2012;21:388-397.

21. Government of Ireland. *Childcare Act*. Dublin, Ireland: Stationery Office; 1991.
22. Kartalova-O'Doherty Y, Tedstone Doherty D, Walsh D. *Family Support Study: A Study of Experiences, Needs and Support Requirements of Families With Enduring Mental Illness in Ireland*. Dublin, Ireland: Health Research Board; 2006.
23. Miller WR, Rollnick S. Ten things that motivational interviewing is not. *Behav Cogn Psychother*. 2009;37:129-140.
24. Rogers CR. *A Way of Being*. New York, NY: Houghton Mifflin; 1996.
25. Almond P, Yardley J. An introduction to communication. In: Childs LL, Coles L, Marjoram B, eds. *Essential Skill Clusters for Nurses—Theory & Practice*. Chichester, England: Wiley-Blackwell; 2009:3-18.
26. Whyte DA. Reflections on family nursing. In: Whyte DA, ed. *Explorations in Family Nursing*. London, England: Routledge; 1997:204-219.
27. Green JW. *Cultural Awareness in Human Services*. Englewood Cliffs, NJ: Prentice-Hall; 1982.
28. Korbin JE. Issues of culture. In: Wilson K, James A, eds. *The Child Protection Handbook*. Edinburgh, Scotland: Baillière Tindall; 2007:134-141.
29. Allender JA, Rector C, Warner K. *Community Health Nursing: Promoting and Protecting the Public's Health*. Baltimore, MD: Lippincott Williams & Wilkins; 2009.
30. Phelan A. Elder abuse: an introduction. In: Phelan A, ed. *International Perspectives on Elder Abuse*. London, England: Routledge; 2013:1-31.
31. Canavan J. Family and family change in Ireland: an overview. *J Fam Issues*. 2012;3:10-28.
32. Government of Ireland. *Bunreacht na hEireann (The Irish Constitution)*. Dublin, Ireland: Stationery Office; 1937.
33. NUI Galway. *Health Behaviour in School Aged Children (HBSC). Factsheets on Health Behaviour in School Aged Children*. Galway, Ireland: NUI Galway; 2010.
34. Mead GH, Strauss AL. *Social Psychology of George Hebert Mead*. Chicago, IL: University of Chicago Press; 1956.
35. Parsons T. *The Social System*. London, England: Routledge & Kegan Paul; 1951.
36. Duvall E, Hill R. *Report of the Committee on the Dynamics of Family Interaction*. Washington, DC: National Conference in Family Life; 1948.
37. Kupko K. *Parenting Styles and Adolescents*. New York, NY: Cornell University Press; 2007.
38. Anderson LM, Shinn C, St Charles J, et al. Community interventions to promote healthy social environments: early childhood development and family housing. A report on the recommendations to the Task Force on Community Preventative Services. *MMWR Recomm Rep*. 2002;51(RR-1):1-8.
39. Department of Health, Department for Education and Employment, and the Home Office. *Framework for the Assessment of Children in Need and Their Families*. London, England: Department of Health; 2000.
40. Health Service Executive Child Safety Awareness Programme. Child safety and injury prevention publications. http://www.hse.ie/eng/health/child/childsafety/publications/csap_res.html. Published 2014. Accessed May 4, 2014.
41. Malterud K, Hollnagel H, Witt K. Gendered health resources and coping—a study from general practice. *Scand J Public Health*. 2001;29:183-188.
42. Maxwell N, Scourfield J, Featherstone B, Holland S, Tolman R. Engaging fathers in child welfare services: a narrative review of the recent research evidence. *Child Fam Soc Work*. 2012;17:160-169.
43. Ferguson H, Gates P. Early intervention and holistic, relationship-based practice with fathers; evidence from the work of the family nurse partnership [published online March 21, 2014]. *Child Fam Soc Work*. doi:10.1111/cfs.12059.
44. Mulkeen M. Gendered processes in child protection: “mother-blaming” and the erosion of men’s accountability. *Irish J Appl Soc Stud*. 2012;12:74-88.
45. Featherstone B, White S. *Dads Talk About Their Lives and Services*. London, England: Family Rights Group; 2006.
46. Segre LS, O'Hara MW, Arndt S, Beck CT. Nursing care for postpartum depression, part 1: do nurses think they should offer both screening and counseling? *MCN Am J Matern Child Nurs*. 2010;35:220-225.
47. Paulson JF, Bazemore SD. Prenatal and postpartum depression in fathers and its association with maternal depression. *JAMA*. 2010;303:1961-1969.
48. Sawicki JA. Primary care approaches. Sibling rivalry and the new baby: anticipatory guidance and management strategies. *Pediatr Nurs*. 1997;23:298-302.
49. Green C. *New Toddler Taming*. London, England: Vermillion; 2006.
50. Irish Society for the Prevention of Cruelty to Children. *ISPC: Always Here for Children: Consultation on Tackling Bullying in Schools*. Dublin, Ireland: Irish Society for the Prevention of Cruelty to Children; 2012.
51. Programme for Action for Children & Health Service Executive. *Best Health for Children Revisited*. Dublin, Ireland: Health Service Executive; 2005.
52. Sharma A, Cockerill H. *Mary Sheridan's From Birth to Five Years: Children's Developmental Progress*. 4th ed. London, England: Routledge; 2014.
53. Von Son M, Verekerk G, Van der Hart O, Komproe I, Pop V. Pre-natal depression, mode of delivery and perinatal dissociation as predictors of post-partum posttraumatic stress: an empirical study. *Clin Psychol Psychother*. 2005;4:297-312.
54. Söderquist J, Wijma B, Thorbert G, Wijma K. Risk factors in pregnancy for post-traumatic stress and depression after childbirth. *Br J Obstet Gynaecol*. 2009;116:672-680.
55. White T, Matthey S, Boyd K, Barnett B. Post natal depression and posttraumatic stress after childbirth: prevalence, course and co-occurrence. *J Reprod Infant Psychol*. 2006;24:107-120.
56. Turner KM, Chew-Graham C, Folkes L, Sharp D. Women’s experiences of health visitor delivered listening

- visits as a treatment for post-natal depression: a qualitative study. *Patient Educ Couns*. 2010;78:234-239.
57. Salonen AH, Kaunonen M, Astedt-Kurki P, Jarvenpaa A, Isoaho H, Tarkka M. Parenting self-efficacy after childbirth. *J Adv Nurs*. 2009;65:2324-2336.
 58. Bloomfield L, Kendall S, Applin L, et al. A qualitative study exploring the experiences and views of mothers, health visitors and family support centre workers on the challenges and difficulties of parenting. *Health Soc Care Community*. 2005;13:46-55.
 59. World Health Organization. *The World Health Report 2005: Make Every Mother and Child Count*. Geneva, Switzerland: World Health Organization; 2005.
 60. Leahy-Warren P, McCarty G. Postnatal depression: prevalence, mother's perspectives and treatments. *Arch Psychiatr Nurs*. 2007;21:91-100.
 61. National Institute for Clinical Excellence. *Postnatal Care: Routine Postnatal Care of Women and Their Babies*. London, England: National Institute for Clinical Excellence; 2006.