Self-Efficacy and Postpartum Depression Teaching Behaviors of Hospital-Based Perinatal Nurses

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ABSTRACT

Based upon the Self-Efficacy Theory, this study examined the relationship between self-efficacy, self-efficacy-related variables, and postpartum depression teaching behaviors of hospital-based perinatal nurses. Findings revealed that teaching new mothers about postpartum depression is related to a perinatal nurse's self-efficacy in postpartum-depression teaching, self-esteem, and the following self-efficacy-related variables: social persuasion (supervisor's expectations for teaching); mastery (postpartum depression continuing education and teaching experience); and vicarious experience (observing other nurses teach new mothers about postpartum depression). Teaching new mothers about postpartum depression can assist mothers in overcoming barriers to depression treatment. Nurse educators and managers play an important role in encouraging postpartum depression education for perinatal nurses.

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Approximately 13% of new mothers experience depression in the first year after childbirth, and predictors include low socioeconomic status, low social support, and stress (Beck, 2008; Gaynes et al., 2005; O'Hara & Swain, 1996). Postpartum depression (PPD) has deleterious effects on a new mother's relationships, her ability to work and function in other life roles, and her ability to care for her infant (Logsdon, Wisner, Hanusa, & Phillips, 2003; Wisner, Parry, & Piontek, 2002). After depression is identified, it is important to begin treatment as soon as possible. Delay in depression treatment leads to a longer course of depression (England, Ballard, & George, 1994). Both psychotherapy and antidepressants, especially selective serotonin reuptake inhibitors, are effective treatments for PPD (Wisner et al., 2002), but many new mothers do not receive treatment.

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Barriers to treatment for PPD include stigma toward mental illness and mental health treatment (Edwards & Timmons, 2005) as well as a knowledge deficit about PPD (e.g., symptom identification, treatment availability, treatment options, and uncertainty of where to seek treatment) (Logsdon, Hines-Martin, & Rakestraw, 2009; McCarthy & Mahon, 2008). Learning needs of new mothers are not always met within the early postpartum period (Bowman, 2005; Mantha, Davies, Moyer, & Crowe, 2008), and they may feel unprepared upon arriving home (George, 2005). Perinatal nurses and childbirth educators have a unique opportunity to educate new mothers about symptoms of PPD, mental health treatment, and sources of community support. In a study of new mothers with PPD, 97% identified that they had a problem with functioning; however, only 32% related their problems with functioning to PPD, and only 12% discussed their symptoms with a health-care provider (Garg, Morton, & Heneghan, 2005).

In addition to unrecognized symptoms of PPD, fragmentation of health care for new mothers makes it difficult to identify providers' responsibility for diagnosis, patient education, and treatment of the disorder (Epperson, 1999). The obstetrician's contribution to a new mother's health care largely ends at 6 weeks postpartum, and the new mother may not have regular contact with a primary care provider. The new mother usually has regular contact with a pediatrician, but the object of pediatric care is the infant.

As previously mentioned, stigma has been identified by new mothers experiencing PPD as a barrier to care. Postpartum depression is associated with fear of disclosure, feelings of being a bad mother, issues with accessing mental health service, and label/diagnosis attachment (Edwards & Timmons, 2005). Consequently, dialogue between the new mother and the perinatal nurse can potentially remove the stigma that surrounds PPD and may initiate treatment-seeking behavior by the new mother.

Perinatal nurses and childbirth educators have a unique opportunity to educate new mothers about symptoms of postpartum depression, mental health treatment, and sources of community support.

REVIEW OF LITERATURE

The present study was guided by the Self-Efficacy Theory (Bandura, 1977, 1986, 1995). Perceived self-efficacy is "the belief in one's capabilities to produce a given attainment" (Bandura, Pastorelli, Barbaranelli, & Capara, 1999, p. 258). Self-efficacy governs an individual's behavior, thought processes, motivation, and feelings and is situation specific (Bandura, 1994). Self-efficacy is impacted by an individual's feelings of self-esteem, mastery, social persuasion, vicarious experiences, and attitudes such as stigma (Bandura et al., 1999).

Self-efficacy applies to personal and work behavior. Therefore, health-care providers, such as perinatal nurses, are influenced by self-efficacy in their specific practice behaviors. For example, in primary care, providers' self-efficacy in patient screening has been noted as a significant predictor of actual provider screening, as described below.

Ozer et al. (2004) studied provider screening self-efficacy in relation to actual provider screening behavior for health promotion and risky behavior in adolescents. The Provider Efficacy Questionnaire, an assessment of confidence in one's ability to deliver preventative services to adolescent patients, was developed for this study. Five separate scales were created to screen for adolescent risky behavior with seat-belt use, tobacco use, alcohol use, helmet use, and sexual behavior. Each scale had 2–8 items. Providers rated each item on an 11-point Likert scale, ranging from 0 (not at all confident) to 10 (extremely confident). Provider self-efficacy scores for each scale were calculated by taking the mean of the summed scores. No psychometric data were provided for the instrument. Sixty-six pediatric providers completed the study. In three of the five screening areas, provider self-efficacy was a statistically significant predictor of actual provider screening behavior ($r = .51$, $p < .05$).

In a second study, Cabana et al. (2004) examined pediatricians' self-efficacy in counseling parents of asthmatic children on smoking-cessation. The sample consisted of 1,000 pediatricians who were members of the American Medical Association. Surveys were mailed, and there was a 55% return rate of eligible respondents. Self-efficacy was measured by an investigator-developed tool. Respondents were asked to rate their confidence in the ability to perform four skills related to smoking cessation: (1) ask if the parents smoked; (2) ask if the adolescent smoked; (3) counsel the parent to stop smoking; and (4) counsel the adolescent to stop smoking. The questionnaire used a 5-point scale to rate self-efficacy, ranging from 1 (not confident) to 5

For more information about perinatal depression, see the guest editorial in this issue, "Four Research Findings That Will Change What We Think About Perinatal Depression," by Kathleen Kendall-Tackett (pp. 7–9).

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(extremely confident). No psychometric data on the instrument were provided. Lack of provider self-efficacy for smoking-cessation counseling was identified as a barrier to counseling frequency in practice, and formal training in smoking-cessation counseling significantly enhanced self-efficacy. Though the investigations conducted by Cabana et al. (2004) and Ozer et al. (2004) did not focus on samples of nurses, findings from these studies demonstrate the impact of self-efficacy on the practice of health-care providers.

In summary, nursing interventions may be influenced by the nurse's self-efficacy (belief in the capability to produce a given attainment) for specific nursing practice behaviors (Bandura et al., 1999). Self-efficacy affects the tasks that nurses perform, how much effort they put into each task, and how they feel while doing the tasks. Nurses' behavior is based upon their beliefs and expectations (prior mastery), modeling and observing others (vicarious experiences), and reaction to the judgments of others (social persuasion).

PURPOSE

The purpose of the current study was to describe the relationship between self-efficacy and PPD teaching behaviors of perinatal nurses (in this case, hospital-based registered nurses in labor and delivery units and in mother/baby units). The Self-Efficacy Theory and related literature guided the choice of additional predictor variables: demographics, self-esteem, personal and family experience with mental illness, and stigma toward mental illness. Decreased self-esteem is thought to be associated with higher stigmatizing attitudes (Kurzban & Leary, 2001), but the relationship between a nurse's stigma toward mental illness and PPD teaching for new mothers is unknown. It is also unknown how a provider's personal and familial experience with mental health influences stigma and, in turn, influences patient teaching related to PPD. Thus, the current study aimed to inform the science on how perinatal nurses' stigma toward and experiences with mental illness may influence their patient teaching about PPD. The following research questions guided our investigation:

1. What variables are associated with self-efficacy related to PPD teaching behaviors of hospital-based perinatal nurses?
2. What variables are associated with PPD teaching behaviors of hospital-based perinatal nurses?

STUDY DESIGN AND METHODS

Design

The cross-sectional, descriptive, correlational study focused on hospital-based perinatal nurses from a private, suburban hospital (2,500 births per year) in the southern United States. Data were collected from self-report instruments measuring self-efficacy, self-esteem, stigma and attitude toward mental disorders, and descriptive questions related to the Self-Efficacy Theory. Correlation coefficients were calculated to test (1) what variables were associated with self-efficacy related to PPD teaching and (2) what variables were associated with PPD teaching.

Procedure

After receiving human studies approval from the participating university and hospital, questionnaire packets were placed in the hospital mailboxes of all labor and delivery ($n = 75$) and mother/baby ($n = 75$) registered nurses, inviting them to participate in the study. A preamble cover letter of invitation was used rather than informed consent so that no identifying information was collected. Respondents returned their completed questionnaire packets by placing them in a sealed box located on each hospital unit. Members of the research team retrieved the packets from the boxes.

Sample

The sample consisted of 43 hospital-based perinatal nurses (labor and delivery registered nurses and mother/baby registered nurses). To protect anonymity, race statistics were not collected because the nurses in the study location were primarily Caucasian. A power analysis indicated that data from 37 individuals were required to adequately power (greater than 80%) the current study design. Analyzing data from 43 individuals afforded the current study 87.4% power.

Instruments

Based upon variables related to self-efficacy, instruments included a research-team-developed measure of self-efficacy related to confidence and PPD teaching (Bandura, 1995); the Rosenberg (1965) Self-Esteem Scale; the Attitudes Toward Seeking Professional Psychological Help Scale (Fischer & Farina, 1995); the Stigma Scale for Receiving Psychological Help (Komiya, Good, & Sherrod, 2000); and descriptive questions related to the Self-Efficacy Theory.

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A self-efficacy measure was developed for this study to evaluate confidence and PPD teaching. Because self-efficacy is situation specific, a global measure of self-efficacy would not have been appropriate. The self-efficacy measure consisted of four questions related to a perinatal nurse's confidence in performing the following activities: assessing a new mother's baseline knowledge about PPD; assessing a new mother's symptoms of PPD; counseling a new mother about PPD; and teaching a new mother about PPD. The content of the questions was based upon self-efficacy literature and the first author's clinical experience with pregnant and postpartum women. The format of the questions was based upon health-care provider self-efficacy research by Ozer and colleagues (2004), as described earlier. The internal consistency reliability score (alpha coefficient) for the instrument was .90.

The Rosenberg (1965) Self-Esteem Scale consists of 10 items that measure feelings about self. Items are rated on a score from 0 (strongly disagree) to 3 (strongly agree). Total scores range from 0 to 30, with scores below 15 suggesting low self-esteem. The instrument has been used in diverse populations. The internal consistency reliability score (alpha coefficient) for Rosenberg's (1965) original studies with adolescents ranged from .77 to .88. The internal consistency reliability score (alpha coefficient) for the current study was .85.

The Attitudes Toward Seeking Professional Psychological Help Scale is a 10-item, 4-point scale used for measuring attitudes toward seeking psychological help. The instrument has been used with diverse populations and ages. Respondents rate each statement in a Likert-type response format consisting of the following alternatives: agree, partly agree, partly disagree, and disagree. The range of scores is 0 to 30, with a high score indicating a positive score toward seeking help (Fischer & Farina, 1995). The internal consistency reliability score (alpha coefficient) for the original study was .84; for the current study, it was .87.

The Stigma Scale for Receiving Psychological Help was designed to assess an individual's attitude toward how stigmatizing it is to receive psychological treatment. The instrument consists of five questions and has been used in diverse populations. Each question is rated from 0 (strongly disagree) to 3 (strongly agree), with higher scores indicating greater stigma (Komiya et al., 2000). For the original study, the internal consistency reliability score (alpha coefficient) was .72. For the current study, the alpha coefficient was .79.

Based upon the Self-Efficacy Theory (Bandura, 1986), additional individual questions measured the nurse's experience with prior mastery (teaching about episiotomy, education about PPD in basic nursing program, continuing education on PPD), vicarious experience (observing other nurses teach about PPD), and social persuasion (supervisor's expectations regarding PPD teaching). There were also three questions that asked the perinatal nurse about personal or family experience with PPD.

TABLE 1
Descriptive Statistics of Study's Sample (*N* = 43)

	n	%
Years in practice (≥ 16 years)	27	62
Education		
Associate degree in nursing	17	40
Bachelor of science in nursing degree	17	40
Diploma in nursing	9	20
Education about postpartum depression (PPD)		
Educated about PPD in nursing school	31	72
Continuing education units on PPD	11	26
No PPD education reported	1	2
Experience with PPD		
Personal history of PPD	7	16.3
Family member with PPD	7	16.3
Friend with PPD	13	30.2
No experience with PPD	16	37.2
Frequency of teaching new mothers about PPD		
Always	3	7.0
Most of the time	8	18.6
Occasionally	6	14.0
Rarely	11	25.5
Never	12	27.9
Missing data	3	7.0

RESULTS

Out of the 150 perinatal nurses who were contacted to participate in the study, 43 completed and returned the questionnaires, representing a response rate of 29%. The sample's descriptive statistics are presented in Table 1. The perinatal nurses were experienced clinicians with an average of more than 16 years in practice. Though most of the perinatal nurses had received education about PPD in nursing school, few had personal experience with PPD

Postpartum depression causes deleterious effects on the new mother's quality of life, her ability to work and to care for her infant, and her relationships.

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TABLE 2
Frequency of Hospital-Based Perinatal Nurses Teaching New Mothers About Postpartum Depression, by Work Area*

	Always	Most of the Time	Occasionally	Rarely	Never
Nurses in labor and delivery unit ($n = 17$)	2	0	0	6	9
Nurses in mother/baby unit ($n = 23$)	1	8	6	5	3

Note. *Three of the 43 study participants did not respond. Responses under each of the categories of "always," "most of the time," and "occasionally" indicate 43% (17/40) of the perinatal nurses taught new mothers about postpartum depression; 58% (23/40) of the perinatal nurses "rarely" or "never" taught new mothers about postpartum depression.

or had chosen to pursue continuing education related to PPD (see Table 1). Forty-three percent of the perinatal nurses who responded to this item reported that they taught new mothers about PPD (i.e., replied that they taught new mothers about PPD either always, most of the time, or occasionally). The mother/baby nurses taught new mothers about PPD more frequently than the labor and delivery nurses ($X^2 = 16.9$, $p = 0.002$). Fifty-eight percent of the sample rarely or never taught new mothers about PPD (see Table 2).

Many participants (42%) had never been told by their supervisor that they were expected to teach new mothers about PPD. Predictors of self-efficacy related to PPD teaching behaviors were observing other nurses teach about PPD, expectations from the nurse's supervisor, and self-esteem (see Table 3). Teaching new mothers about PPD was associated with the nurses' self-efficacy related to PPD teaching ($r = .51$, $p = .001$); expectations for teaching from their supervisor ($r = .41$, $p = .009$); self-esteem ($r = .35$, $p = .001$); PPD continuing education ($r = .35$, $p = .02$); teaching experience on other topics, such as episiotomy care ($r = .72$, $p = .01$); and experience with observing other nurses teach patients about PPD ($r = .31$, $p = .04$) (see Table 4).

DISCUSSION AND IMPLICATIONS FOR PRACTICE

Approximately 13% of new mothers experience PPD in the first year after childbirth (Gaynes et al., 2005). Postpartum depression causes deleterious effects on the new mother's quality of life, her ability to work and to care for her infant, and her relationships (Logsdon et al., 2003; Wisner et al., 2002). Few new mothers recognize that they are experiencing PPD (Garg et al., 2005). Perinatal nurses play an important role in teaching new mothers about symptoms of PPD and how to seek treatment. It is important to individualize teaching, based upon the new mother's existing knowledge base (Freda, 2002). Women need advice and support from perinatal nurses, in addition to evidence-based care (Mantha et al., 2008). Dialogue between a new mother and the nurse can help to remove the stigma of PPD and may initiate treatment-seeking behavior by the woman (Edwards & Timmons, 2005).

Because health-care providers are influenced by self-efficacy in their specific practice behaviors (Cabana et al., 2004; Ozer et al., 2004), nurses' self-efficacy (confidence) may determine their PPD teaching behaviors. Nursing interventions are influenced by one's self-efficacy (belief in one's capability

TABLE 3
Predictors of Self-Efficacy Related to Hospital-Based Perinatal Nurses' Teaching About Postpartum Depression

	r
Postpartum depression continuing education units	*ns*
Observe staff teach new mothers about postpartum depression	.38*
Teach new mothers about episiotomy	*ns*
Supervisor tells me I can teach about postpartum depression	.49**
Self-esteem	.42**
Attitude toward professional psychological treatment	*ns*
Stigma toward mental illness	*ns*

Note. Numbers reflect correlation coefficients: *$p < .05$; **$p < .01$.

TABLE 4
Predictors of Postpartum Depression Teaching Behavior in Hospital-Based Perinatal Nurses

	p
Postpartum depression continuing education units (mastery)	.35*
Self-efficacy	.51**
Self-esteem	.35*
Supervisor tells me I can teach about postpartum depression (social persuasion)	.41**
Observe staff nurses teach about postpartum depression (vicarious experience)	.31*
Teach episiotomy care (mastery)	.72**
Stigma toward mental illness	*ns*

Note. Numbers reflect correlation coefficients: *$p < .05$; **$p < .01$.

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TABLE 5
Suggested Clinical Implications for Hospital-Based Perinatal Nurses Teaching About Postpartum Depression

- Nurse educators and nurse managers should directly communicate to perinatal nurses that they expect all new mothers to be taught about postpartum depression.
- Preceptors for new perinatal nurses should model excellent teaching behaviors that include teaching about postpartum depression.
- Continuing education programs on postpartum depression for perinatal nurses, including Web-based activities, should be encouraged and rewarded.
- Perinatal nurses should be encouraged to assess their own attitudes toward mental disorders and professional psychological treatment. If attitudes are negative, they should ask for assistance from educators and counselors.

to produce a given attainment) for specific practice behaviors (Bandura et al., 1999). Self-efficacy affects the tasks that nurses perform, how much effort they put into each task, and how they feel while doing the tasks. Nurses' behaviors are based upon their beliefs and expectations (prior mastery), modeling and observing others (vicarious experiences), and reaction to the judgments of others (social persuasion).

Thus, we recommend nurse leaders be encouraged to directly communicate to nursing staff that new mothers need to be taught about PPD. To enhance nurses' self-efficacy in teaching PPD, preceptors of new nurses can model PPD teaching behaviors, and it is recommended that continuing education programs on PPD for perinatal nurses be mandatory. Results of the current investigation mirrored findings from a study by Cabana et al. (2004), who found that formal training in smoking cessation enhanced provider self-efficacy. Similarly, in the present study, education about PPD predicted PPD teaching behaviors of perinatal nurses.

We also recommend perinatal nurses be encouraged to take personal responsibility for assessing their attitudes about mental disorders and treatment and to take steps to improve any negative attitudes. A survey by The Mental Health Foundation found that 32% of individuals with mental illness reported discrimination from health-care professionals (De Ponte, Bird, & Wright, 2000). In contrast, other authors have reported the beneficial role health-care professionals can play by providing support and helping individuals overcome barriers to mental health treatment (Kai & Crosland, 2001).

The instrument to measure self-efficacy was developed specifically for the present study. The beginning psychometric properties of the instrument are promising. High internal consistency reliability was obtained (alpha coefficient = .90), and there was beginning evidence for construct validity. The self-efficacy measure had significant correlations with variables that measured social persuasion (supervisor tells me that I can teach about PPD), vicarious experience (observe staff teach new mothers about PPD), and mastery (self-esteem), as predicted by the Self-Efficacy Theory (Bandura et al., 1999). Further research is needed with larger and more diverse samples of nurses in order to determine the ultimate utility of this self-efficacy instrument.

CONCLUSIONS

The present study's findings are limited by one sample, one data collection site, and the low response rate. However, the findings inform the science in describing theory-based predictors of hospital-based perinatal nurses' teaching behavior about PPD. Prior mastery (teaching about PPD, self-esteem, and continuing education), vicarious experience (observing other nurses teach about PPD), and social persuasion (supervisor's expectations regarding PPD teaching) were all related to PPD teaching behaviors of perinatal nurses. Thus, the Self-Efficacy Theory (Bandura, 1977, 1986, 1995; Bandura et al., 1999) was an appropriate framework to guide this study.

Knowledge from this study can lead to interventions that foster self-efficacy in staff nurses related to teaching about PPD (see Table 5). This knowledge can assist in identifying nurse leaders for postpartum patient teaching and in tailoring education to nurses identified as less likely to perform patient teaching. In modeling teaching behaviors, communicating the expectation that new mothers are to be taught about PPD, and influencing the choices for continuing education on PPD, nursing leaders may play an important role in improving the health of two generations of citizens: postpartum women and their babies.

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