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‘There’s something in their eyes’ – Child Health Services nurses’ experiences of identifying signs of postpartum depression in non-Swedish-speaking immigrant mothers

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‘There’s something in their eyes’ – Child Health Services nurses’ experiences of identifying signs of postpartum depression in non-Swedish-speaking immigrant mothers

Background: Due to the current world situation, Sweden has one of the highest asylum applications within the European Union. Immigrant mothers, specifically those who have immigrated during the last ten years and do not speak the language of the new country, are found to be at particular risk of being affected by postpartum depression.

Aim: In this study, we elucidate Swedish Child Health Services nurses’ experiences of identifying signs of postpartum depression in non-Swedish-speaking immigrant mothers.

Methods: Latent content analysis was used when analysing data material from 13 research interviews.

Results: Being able to interpret a non-Swedish-speaking immigrant mother’s mood required establishing and constant deepening of a transcultural caring relationship, the use of cultural knowledge to perceive signs of postpartum depression from observations and interactions and to rely on intuition.

Conclusion: There are both challenges and key factors for success in interpreting the mood of non-Swedish-speaking immigrant mothers.

Implications: This study provides information to healthcare professionals about challenges with adapting the screening with the Edinburgh Postnatal Depression Scale to immigrant mothers not speaking the language of residence. Tacit knowledge and cultural competence among healthcare personnel are invaluable assets when interpreting mental health in this vulnerable group of mothers.

Keywords: postpartum depression, transcultural nursing, immigrants/migrants mothers, semi-structured interviews, content analysis.

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Introduction

Sweden is a country in Northern Europe which due to the current world situation has one of the highest rates of asylum applicants registered among the member states in the European Union (1). Postpartum depression (PPD) has during the last decade been globally recognised as a major public health problem which immigrant mothers are found to be at particular risk of being affected by. The prevalence of PPD among immigrant mothers is estimated to be as high as 20% (2) compared to 13% among resident mothers living in Western societies (3). The recently migrated mothers are found to be a specifically vulnerable group with five times higher risk of developing PPD than native-born women (4). Another vulnerable group is immigrant mothers less proficient in the language of their new country (5).

In 2010, the Swedish National Board of Health and Welfare recommended that all mothers should be invited to participate in a routine screening for PPD 6–8 weeks after giving birth since left untreated (6), a PPD could have long-term traumatic effects not only on the mother’s own health but also the relationship with her partner (7) and foremost on the baby’s health and development (8). In Sweden, the nurses in the Child Health Services (CHS) bear responsibility for identifying mothers with signs of PPD. The CHS are a voluntary primary health services which are provided for free and play an important part in Swedish public health work since it reaches almost all families with children between zero and six years of age including groups that could be
difficult to reach, for example immigrant families (9). When the CHS nurse meets and starts interacting with an immigrant family, a transcultural caring relationship develops, which is described by Leininger as a professional nursing relationship across cultures (10).

The CHS nurses are educated in recognising risk factors and symptoms and in screening for PPD using the Edinburgh Postnatal Depression Scale (EPDS) by maternal and child health psychologists who also provide training in implementing counselling and who give regular tuition (11). The ten-item self-report screening scale, EPDS, is used as guidance in connection with a clinical interview to assess the mothers’ mental health 6–8 weeks postpartum (12).

Providing effective screening for PPD to immigrant mothers seems to be a challenging task for healthcare professionals (13, 14). Earlier findings show that immigrant mothers are not offered screening to the same extent as resident mothers (15). Likewise, statistics show that immigrant mothers do not agree to participate in the screening to the same extent as resident mothers (16). Despite the increased risk of PPD in this vulnerable population, our knowledge few studies have explored healthcare professionals’ experiences of identifying mental ill health in immigrant mothers who do not speak the language of their country of residence. The aim of the study was to elucidate CHS nurses’ experiences of identifying signs of PPD in non-Swedish-speaking immigrant mothers.

Methods

Design

A qualitative inductive approach was chosen, where interviews were followed by a latent content analysis. The method was chosen since qualitative methodology seeks to understand human experiences of life (17). An inductive approach is appropriate when existing research of the phenomena is limited since it allows the categories to derive from the data in an unprejudiced way during the analysis (18).

Setting

The study was conducted in the Child Health Care (CHC) centres in the county of Skane, in the south of Sweden, where 96,000 children are enrolled in the CHS (16). Thirty-seven per cent of the children, aged 0–4 years, have at least one foreign-born parent (19).

Selection of participants

Purposive sampling, as described by Patton (20), was utilised. Annual statistics for BCG vaccinations were used to target the CHS nurses with the most contact with immigrant mothers who, due to their limited proficiency in Swedish, require an interpreter’s assistance when visiting the CHS. A high rate of BCG-vaccinated children indicated that many of the children listed at the particular CHC centre were of foreign origin, since BCG vaccination is only routinely given to those children in Sweden (16). The operations managers of the 25 CHC centres with the highest rates of listed BCG-vaccinated children were contacted for written consent and for proposal of a suitable CHS nurse to participate in the study. Consent was given by 15 operations managers and the proposed CHS nurses were contacted. All except one chose to participate. The participating CHS nurses were all women, with a mean age of 54 years. One of them had an immigrant background herself. They had worked as CHS nurses in average for 18 years and were responsible for about 59 newborns each per year.

Data collection

The interviews were performed from May to September 2013 in person at the participants’ workplaces and lasted between 20 and 39 minutes. The first author who conducted the interviews, was prior to the interviews not acquainted with the participants. The interviews were digitally recorded with the participant’s permission and transcribed verbatim. A semi-structured interview guide covering the following two areas was used: (i) the CHS nurses’ strategies to determine the mood of the non-Swedish-speaking immigrant mothers and (ii) their experience of screening for PPD in non-Swedish-speaking immigrant mothers using the EPDS. Examples of posed questions are ‘Could you please describe how you go about to interpret the mood of a mother who doesn’t speak Swedish?’ Probing questions were asked to elaborate on the CHS nurses’ thoughts in more detail. Two pilot interviews were conducted in order to test the semi-structured interview guide. Since the pilot interviews did not result in any changes to the interview guide, they were also included in the research material. After the eleventh interview, nothing new was found to emerge, but for confirmation another two interviews were performed.

Data analysis

The research material was analysed by performing a six-step latent content analysis in order to achieve a concentrated and broad description of the research topic (18). By performing a latent content analysis, the underlying meaning of the text was also interpreted (21). The material was read individually by the first and third author several times in order to immerse themselves in the data. Text that appeared to elucidate the participants’ experiences, as being the unit of analysis, was highlighted. Keywords or phrases from the highlighted text were
written in the margin, so-called open coding. The codes were discussed and sorted into different subcategories named after content-characteristic words. The subcategories with similar content were organised under higher-order headings into generic categories through interpretation of how the different subcategories were associated and connected with each other. The generic categories were finally brought together under main categories. The different subcategories, generic categories and main categories were then verified by the second author after reading and analysing three interviews. All three authors then discussed the list of main categories, and compared and abstracted them as far as it was sensible to interpret the latent meaning of the text (18). A theme connecting the text as a whole, the content of the categories and the interpretation of the latent meaning of the text was agreed upon by all three authors (22). Examples of meaning units, codes, subcategories, generic categories and main categories are described in Table 1.

Results

An overarching theme ‘a constant challenge for deepening the transcultural caring relationship’ emerged illustrating the CHS nurses’ experiences of identifying signs of PPD in non-Swedish-speaking immigrant mothers. The theme refers to the CHS nurses’ desire to constantly deepen their connection with the non-Swedish-speaking immigrant mothers, in order to be able to support the mothers, interpret their mood and overcome obstacles when screening for PPD and offering external help. Three main categories were identified as following: ‘establishing a transcultural supportive relationship’, ‘interpreting the mother’s mood using cultural knowledge’ and ‘striving – sometimes in vain – when screening for PPD’. The different generic and main categories are described below (see Table 2).

Establishing a transcultural supportive relationship

The CHS nurses described ‘establishing a transcultural supportive relationship’ as the first step of being able to identify signs of PPD. This meant overcoming communication difficulties, creating trust and making a connection with the non-Swedish-speaking immigrant mother not only to make it possible to interpret the mother’s mood but also to be able to empower the mother and strengthen her mental health. The CHS nurses expressed compassion, dedication and a genuine desire to meet the mothers and learn more about their culture and understand their situation.

… that they feel that I welcome them as I welcome any fellow human being and that I don’t look down on them or think that they are different, but that we … I was about to say become friends, but it’s the wrong word … but that we have a good relationship. That they feel they are liked and that I listen to them. I think that’s the main thing […] then they trust me […] that’s how I think it works (no. 6).

Being available, receptive and responsive to the non-Swedish-speaking immigrant mothers whenever they came to the CHC centre was of great importance for the CHS nurses. The Swedish-speaking mothers were to a greater extent referred to telephone hours and scheduled appointments. Despite the CHS nurses’ dedication in meeting the non-Swedish-speaking immigrant mothers, they felt that they had to work harder to win the non-Swedish-speaking immigrant mothers’ confidence compared to native-born mothers who considered the CHS activities more a matter of course. Physical closeness (standing or sitting close) during the appointment was seen as more relevant in the relationship with the non-Swedish-speaking immigrant mother compared to the resident mothers. The CHS nurses described it as a subtle way of expressing to the non-Swedish-speaking immigrant mother how dedicated they were in supporting her.

To some extent, the use of communication interpreters also helped the CHS nurses to bridge cultural differences. They did, however, experience an uneven quality in the interpreters’ work and they kept a list of interpreters that did a satisfactory job and were trusted. The quality of the interpreters’ work was assessed by the CHS nurses by being attentive to signs from the non-Swedish-speaking immigrant mother, such as giving short answers, poor eye contact and starting to focus on the baby instead of on the conversation, which were interpreted as not being comfortable with the interpreter or not trusting the interpreters’ confidentiality. The CHS nurses had experienced that the interpreters could become too friendly which might lead to the mother subsequently feeling uncomfortable in describing how she really was feeling. Thus, it was the case that the CHS nurses preferred to communicate in broken English instead of using an interpreter.

The CHS nurses strived to reach their perceived professional aim, empowering the non-Swedish-speaking immigrant mothers in her role as a parent by incorporating her own cultural way of thinking about how to care for a child. In their endeavour, they experienced a challenge in that the general health promoting approach used in the CHS often did not suit the non-Swedish-speaking immigrant mothers.

I have many immigrant parents who like to be given hands-on advice, if it doesn’t work try this and try that. The younger nurses might not be doing this, instead they want the parents to figure out the solution themselves and isn’t always that easy for them (no. 12).

The CHS nurses described different examples of actions taken to help the non-Swedish-speaking immigrant...
mothers to build a network and thereby promote the non-Swedish-speaking immigrant mothers’ mental health such as introducing them to the open preschool, trying to get them to attend parent groups and bringing mothers who spoke the same language together.

Interpreting the mother’s mood using cultural knowledge

The established transcultural supportive relationship was used by the CHS nurses as a springboard for continuously interpreting the non-Swedish-speaking immigrant mother’s mood based on observations and interactions during all the mothers’ visits to the CHC centre. The CHS nurses experienced that the concept of PPD was not recognised in some cultures. Reaching a high level of cultural knowledge was therefore expressed as vital for being able to interpret the non-Swedish-speaking immigrant mother’s mood and for understanding how migration might affect her daily life. Their cultural knowledge helped them to understand and explain some of their impressions.

This thing about the evil eye. So we look the baby straight in her eyes, but her mother, she doesn’t look her in the eyes and then we come to the conclusion that the mother must be depressed (no. 5).

Perceived signs of PPD in non-Swedish-speaking immigrant mothers did not differ from signs observed in resident mothers. A non-Swedish-speaking immigrant mother with signs of PPD was described as looking tired, slouching and having a stiff facial expression, static movements, poor eye contact and an empty sad blank look in their eyes. The facial expression and in particular the eyes were things the CHS nurses specifically reflected on when assessing a non-Swedish-speaking immigrant mother’s mood. When the CHS nurses recognised signs of PPD, they sometimes noted the mother’s lack of interest in the baby and slow or indifferent response to the baby’s signals. Likewise, the CHS nurses were attentive to behaviours as the mother being a little absent and quiet, not giving information and asking few questions, and being in a constant hurry at visits, or alternatively worried and anxious with a lot of questions and

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constant seeking help which both behaviours could be interpreted as signs of PPD.

It feels as if they distance themselves from both me and the baby. They don’t hold the baby as I would if it was my baby. There’s something in their eyes or rather there’s something missing. Because it doesn’t matter how tired you are or how hard the nights are or how much the baby cries or how unsure you feel as a mother [...] there is still a spark in most [of the mothers’ eyes], and if I don’t see it I feel worried (no. 13).

The CHS nurses also relied on their intuition when interpreting non-Swedish-speaking immigrant mothers’ moods. The intuitive feeling gradually grew from observing and interacting with the mother. Despite the cultural differences, the CHS nurses felt that their intuition was rarely wrong, but the relationship needed to be deepened before the subject could be addressed. The CHS nurses’ thought that it took longer time to deepen the relationship with non-Swedish-speaking immigrant mothers, compared to resident mothers, and it was a more delicate issue to bring up the mothers’ mood. In some cases, the CHS nurses waited until the scheduled screening took place to be able to compare their intuition of the mother’s mood with what emerged at screening.

**Striving – sometimes in vain – when screening for PPD**

Generally, the CHS nurses were positive to screening with the EPDS, but it was found difficult to perform without deviating too much from the original approach.

The choices made by the CHS nurse for making it possible for the mother to fill out the questionnaire depended on the mothers’ literacy level, access to translated validated questionnaire in the mothers own language or not, the mothers as well as the nurse’s own English language skills and the interpreters’ capacity. The CHS nurses adapted the screening procedure to their best ability given the circumstances and emphasised how the non-Swedish-speaking immigrant mothers’ educational level affected their ability to understand and fill out the EPDS.

The CHS nurses were aware of that the EPDS statements could be interpreted in a different way in some cultures and needed further explanation and clarification. Likewise, the Arabic and Turkish versions of the translated validated questionnaires were sometimes perceived as lacking in their translation from the original English version.

To assess the non-Swedish-speaking immigrant mother’s mental health, it was important for the CHS nurses to obtain an overall impression of her mood. This was done by capturing earlier conversations and impressions and comparing this with the screening score and the interview. Their impressions were, however, challenged in different ways. For example, they were unsure of the interpreter’s ability to translate and convey the statements as well as the interpreter’s capacity to translate the non-Swedish-speaking immigrant mother’s answers in a nuanced and exact way. The CHS nurses reflected over difficulties in applying conversational technique as they were used to when using an interpreter in the conversation. The CHS nurses were well aware of that the mothers’ cultural standards and beliefs about mental illness also might influence the conversation. They recognised a zero screening score as sometimes being related to the fact that mental illness is associated with guilt and shame in many cultures. Still the CHS nurses experienced feelings of professional failure when they saw signs of mental illness but could not get the mother to open up to them.

It’s ‘us and them’. I am an authority figure to them. Other cultures keep things in the family and if you aren’t feeling well or have a problem you don’t go to an authority figure like we Swedes do; you turn to your mother or mother-in-law. (no. 8).

On the other hand, the CHS nurses perceived that the non-Swedish-speaking immigrant mothers often did speak to them about their feelings. But the CHS nurses frequently experienced failure to motivate the mothers who showed signs of depression to seek help and support from the maternal and child health psychologists, social workers at family centres or general practitioners (GP). The only remaining option, they felt, was to offer the mother person-centred counselling led by the CHS nurses themselves. The CHS nurses experienced that most of the mothers were positive about coming to the person-centred counselling sessions and they were in general positive about

### Table 2 An overview of generic categories, main categories and theme

<table>
<thead>
<tr>
<th>Generic category</th>
<th>Main category</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expressing professional compassion</td>
<td>Establishing a transcultural knowledge</td>
<td>A constant challenge for deepening the relationship</td>
</tr>
<tr>
<td>Facilitating communication</td>
<td>Supportive relationship</td>
<td>Transcultural caring relationship</td>
</tr>
<tr>
<td>Empowering the mother</td>
<td>Interpreting the mother’s mood</td>
<td>Caring relationship</td>
</tr>
<tr>
<td>Being aware of risk factors related to culture and migration</td>
<td>Using cultural knowledge</td>
<td>Striving – sometimes in vain – when screening for PPD</td>
</tr>
<tr>
<td>Perceiving signs of PPD from observation and interaction</td>
<td>Screening procedure</td>
<td>Vain – when screening for PPD</td>
</tr>
<tr>
<td>Listening to intuition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adapting the EPDS screening procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Struggling to get the mother to open up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Challenging to offer external help</td>
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*Postpartum depression.

*Edinburgh Postnatal Depression Scale.*

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performing them. Still it was frustrating not to get the non-Swedish-speaking immigrant mother to accept external help, and the CHS nurses sometimes felt they took on more difficult cases than they were supposed to handle.

You can be pretty tired afterwards and feel that you give and you give. Even if you don’t say that much, it still takes a lot of energy because you have to be in the here and now and kind of give of yourself all of the time. I think you sometimes feel really exhausted afterwards (no. 10).

Discussion

In this study, CHS nurses’ experiences of identifying signs of PPD in non-Swedish-speaking immigrant mothers were elucidated. The CHS nurses were aware of the importance of establishing a transcultural supportive relationship as a first step for being able to assess the non-Swedish-speaking immigrant mothers’ mood. Previous research found that the quality of the relationship between the nurse and the women in her care is central to effective screening for PPD, particularly for immigrant mothers who need to feel comfortable with the process of screening to answer the questions honestly (14). The CHS nurses interpreted the non-Swedish-speaking immigrant mother’s mood continuously throughout all the visits leading up to the 6- to 8-week screening. Sometimes the CHS nurse approached the non-Swedish-speaking immigrant mother prior to the screening if they felt the mother was not feeling well, but in other cases cultural differences caused difficulties in interpreting her mood. An interesting finding of this study was that the nurses (who had been working in the CHS for an average of 18 years) expressed that they perceived that they occasionally lacked cultural knowledge and that was a hindrance to their healthcare work. This was earlier described by Berlin et al. (23) who found that experienced CHS nurses, who frequently interacted with children and parents of foreign origin, described more difficulties compared to less experienced CHS nurses. The experienced CHS nurses had a higher awareness of other cultures which made it more likely that they became conscious of various problems compared to the less experienced CHS nurses (23). Further education to increase cultural knowledge might be beneficial, but one might keep in mind that cultural knowledge is not enough to perform transcultural nursing since it is just one part of being culturally competent. In the model of cultural competence in delivery of healthcare services, becoming culturally competent is described as an ongoing process and consists of five different constructs: ‘cultural awareness, cultural knowledge, cultural skills, cultural encounters and cultural desire’ (Campinha-Bacote, p. 181). These constructs involves becoming culturally aware of one’s own culture, seeking education in cultural knowledge of other cultures, obtaining cultural skills to be able to perform culture-based assessments, being familiar with cultural encounters and having desire to engage in the process of becoming culturally competent (24). In addition to obtaining more cultural knowledge, we suggest that the model of cultural competence in delivery of healthcare services could be introduced as part of the CHS nurses’ day-to-day work to provide guidance and support when striving to promote mental health in a culturally competent manner. By incorporating education in cultural competence already when training new CHS nurses in screening and then offer regular tuition better circumstances for supporting maternal mental health in immigrant mothers are created.

The CHS nurses’ intuition appeared to be an important tool when interpreting the non-Swedish-speaking immigrant mothers’ mood. In literature, intuition is known as skills, unarticulated knowledge or ‘know-how’, but a more accurate term is tacit knowledge. Polanyi described tacit knowledge as knowledge taught through practice and experience rather than from lectures (25). More recently, tacit knowledge was defined in more detail as ‘knowledge in practice: developed from direct experience and action; highly pragmatic and situation specific; subconsciously understood and applied; difficult to articulate; usually shared through interactive conversation and shared experience’. (McAdam, Mason & McCrory, p. 46) (26). Scientific knowledge is generally seen as being of greater importance than other forms of knowledge when it comes to making a decision in today’s evidence-based health care. Earlier findings, however, show that nurses, when rating different knowledge sources in nursing, prefer knowledge originating from experiences and interactive knowledge over more traditional formal sources such as books and scientific journals (27). Bearing this in mind, and reflecting on tacit knowledge as an invaluable asset to the CHS nurses when interpreting the non-Swedish-speaking immigrant mother’s mood, we see the importance of developing new ways that enable the transfer of tacit knowledge from experienced CHS nurses to the less experienced.

When it comes to the screening itself, the result showed that the CHS nurses were in general positive to the EPDS, but administering the scale was considered difficult without deviating too much from the original approach. The meaning of some of the statements was perceived as difficult to communicate to the non-Swedish-speaking immigrant mothers with or without the use of interpreter. This finding matches earlier research presented by Stapleton et al. (28) who question whether the EPDS scale to some extent is adequate for screening immigrant mothers since the healthcare professionals are heavily reliant on the interpreters’ skills in translating and sometimes rephrasing the statements so it makes sense to the immigrant mothers in their culture-specific context. Moreover, it was the CHS nurses’ understanding
that the non-Swedish-speaking immigrant mothers’ educational level affected their ability to understand and fill out the EPDS. This is consistent with previous results showing that the use of Likert scales is problematic for migrant populations, especially those with poor educational attainment (29). To our knowledge, the EPDS has not been validated for use through an interpreter, pending that we suggest that providing the CHS nurses’ access to authorised interpreters familiar with the EPDS might facilitate the use of the scale.

The result also revealed that the CHS nurses felt that they, in spite of striving, were not able to encourage the mothers with symptoms of PPD to accept external help to any great extent. This result concurs with earlier research, where immigrant women did not see health professionals and GPs as an appropriate or available form of support (30). However, the CHS nurses had positive experiences of the non-Swedish-speaking immigrant mothers who agreed to receive help being generally positive about coming to person-centred counselling sessions led by the nurses. This finding is confirmed by a prior study showing that immigrant mothers suffering from PPD consider the community health nurse to be the most important source of support outside the family (31). In the light of these findings, we believe further research from the perspective of mothers who do not speak Swedish concerning their experiences of participating in screening would be useful in terms of learning more about how it is perceived also learning more about their thoughts on what kind of support would be helpful for them.

Methodological considerations

To establish credibility, the participants were chosen by purposive sampling, which in this case meant choosing to interview CHS nurses who were likely to have the most experience relating to the research subject. It might be argued that this approach limits variation in the results and that choosing the sample differently might have revealed additional variation. On the other hand, since there is lack of knowledge about the research issue, the chosen sample and qualitative research method offered a broad description of the subject. In order to increase trustworthiness in the results, the authors independently read the material and then conducted a parallel analysis using researcher triangulation. Researcher triangulation enhances a study’s credibility since it enables a consistency check of the results and reduces potential bias that might come from a single researcher analysing the material (32). Furthermore, to increase the dependability of the analysis, the process is described in detail both in the text and in a table. Each category was enriched with quotations from the participants’ answers in order to make the interpretation transparent for the reader (17). Likewise, the context and the participants were described in as much detail as possible to facilitate transferability of the results, even if the participants only represent a small group. When conducting the present study, the first author had several years’ experience of working as a CHS nurse, which is an advantage in terms of having knowledge of this specific healthcare context. On the other hand, it might constitute a bias. In an attempt not to let this pre-understanding influence the study in a subjective way, and to strengthen the study’s credibility, the analyses were done in collaboration with other researchers with different experiences.

Conclusions and policy implications

Lack of cultural competence caused frustration among the CHS nurses when trying to adapt the screening, getting the non-Swedish-speaking immigrant mothers to open up or to accept external help. Tacit knowledge appears to be an invaluable asset when interpreting the non-Swedish-speaking immigrant mothers’ moods. Based on our findings, we recommend the following to strengthen the CHS nurses’ trust in their own ability to support this vulnerable maternal population’s mental health: (i) providing the CHS nurses access to authorised interpreters familiar with the EPDS; (ii) obtaining extended tuition and support to the CHS nurses from the maternal and child health psychologists; and (iii) finding new ways which enable the transfer of tacit knowledge to less experienced nurses insolar as it is possible. It could also be valuable to introduce the model of cultural competence in delivery of healthcare services in the CHS nurses’ daily work to improve their cultural competence in order to make them more satisfied and successful in their healthcare work with promoting mental health in these mothers and ultimately also their babies.

Author contributions

MS designed the study, collected and analyzed the data and drafted the manuscript. IH analyzed the data and drafted the manuscript. VB designed the study, analyzed the data and drafted the manuscript.

Ethical approval

Ethical approval for the study was obtained from the Regional Ethics Committee (case no. 2013/132). The CHS nurses were informed about the nature of the study, measures to preserve their confidentiality and the possibility to withdraw their participation at any time. Their written consent for participating in the study was obtained.

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