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Experiences of Screening for Postpartum Depression in Non-Native-Speaking Immigrant Mothers in the Swedish Child Health Services

Nurses' and Mothers' Perspectives

Thesis for licentiate degree

Malin Skoog



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So basically.
What it all comes down to.
It's all about relationships.
A good nurse.

*Professor Frank Oberklaid
Stockholm, October 2014*

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Abstract

Postpartum depression (PPD) is globally recognized as a major public health problem, since it does not only affect the mother's own health but also her partner's, and primarily risks the baby's health and development. Immigrant mothers who have migrated during the last ten years and do not speak the language of their new country are found to be at particular risk of PPD. However, providing effective screening for PPD to immigrant mothers seems to be a challenging task for health care professionals due to language barriers, perceived inadequate assessment tools and difficulties in interpreting culture-specific signs and symptoms of PPD. Statistics suggest that current screening for PPD in immigrant mothers is inadequate. The aim of the thesis was therefore to increase the knowledge about screening for PPD in non-native-speaking immigrant mothers, in order to contribute, if possible, to more participation and better outcome of screening for this group of vulnerable mothers.

Individual interviews were conducted with 13 nurses in Child Health Services (CHS) and 13 non-native-speaking immigrant mothers (with help of interpreters). The data were analysed with latent content analysis using an inductive approach.

The CHS nurses' experiences showed that to be able to interpret a mother's mood a transcultural caring relationship needed to be established and deepened. Cultural knowledge was used to perceive signs of postpartum depression from observations and interactions. They also relied on their intuition when interpreting the non-native-speaking immigrant mother's mood. Lack of cultural competence caused frustration when trying to adapt the screening according to the given conditions and also when they tried to make the mother open or accept external help. The non-native-speaking immigrant mothers felt confirmed as a person when asked to participate in the screening just like all other mothers, even though the concept of PPD in general was unclear to them. Challenges to speaking about their mood were cultural beliefs about mental ill health, negative expectations connected to their perceived value as a woman, shame at not being grateful enough for their new life and negative experience of the interaction during the screening. The CHS nurses play an important part in decreasing the

powerful stigma attached to this condition. Based on the findings the following might contribute to a more effective screening of this group of mothers: offering customized information about PPD several times both before and after the delivery; providing assistance from an authorized female interpreter on-site during the screening; striving for a trusting clinical interview; and being attentive to challenges for the mother to speak about her mood. The findings may contribute to more effective screening for PPD of a vulnerable group of mothers.

Abbreviations

CHCC / BVC	Child Health Care Centre (CHCC) / Barnavårdscentral (BVC)
CHS / BHV	Child Health Services (CHS) / Barnhälsovård (BHV)
EPDS	Edinburgh Postnatal Depression Scale
FC	Family Centre / Familjecentral
MHS / MHV	Maternal Health Services (MHS) / Mödrahälsovård (MHV)
PPD	Postpartum depression

Original papers

This thesis is based on the following papers referred to in the text by their Roman numerals:

- I Skoog M, Hallström I, Berggren V. ‘There’s something in their eyes’ – Child Health Services nurses’ experiences of identifying signs of postpartum depression in non-Swedish-speaking immigrant mothers. *Scandinavian Journal of Caring Science*. 2017 Jan 25, volume 31, issue 4, pp. 739–747.
doi: 10.1111/scs.12392
- II Skoog M, Berggren V, Hallström I. “Happy that someone cared” – non-native-speaking immigrant mothers’ experiences of participating in screening for postpartum depression in the Swedish Child Health Services. *Journal of Child Health Care*. 2018 May 28, first published online.
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Introduction

Postpartum depression (PPD) has been globally recognized during the last decade as a major public health problem which in recent years has become the most common complication of childbearing in Western societies (World Health Organization, 2014). It is recognized as a transcultural phenomenon (Evagorou, Arvaniti & Samakouri, 2016) that usually occurs within 4 to 6 weeks after childbirth (O'Hara & Swain, 1996).

Early detection and support in mothers with signs of PPD are imperative, as untreated PPD can have long-term traumatic effects not only on the mother's own health but also on the relationship with her partner and on the baby's health (O'Mahony & Donnelly, 2010). Untreated maternal PPD risks affecting a child's emotional, cognitive and social development (Swedish National Board of Health and Welfare, 2014). Immigrant mothers are found to be at particular risk of contracting PPD. The prevalence of PPD among immigrant women (refugees, asylum seekers, relatives and labour immigrants) is estimated to be as high as 20%, almost twice as high as in indigenous Western populations (Falah-Hassani et al., 2015). Among the immigrant mothers the ones less proficient in the language of their new country of residence (Bandyopadhyay, Small, Watson & Brown, 2010) and/or those with recent immigration status (within the last 10 years) are confirmed to have the highest prevalence of PPD (Dennis, Merry & Gagnon, 2017).

The Edinburgh Postnatal Depression Scale (EPDS) in connection with a clinical interview is the most commonly used screening tool for detecting PPD (Cox, Holden & Henshaw, 2014). In 2010 the Swedish National Board of Health and Welfare introduced routine screening for PPD using the EPDS method in all new mothers when the baby is 6–8 weeks of age (Swedish National Board of Health and Welfare, 2010). The screening was included in the National Child Health Services (CHS) programme (Swedish National Board of Health and Welfare, 2014).

Earlier findings reveal that health care professionals experience screening of immigrant mothers as a challenging task (Teng et al., 2007, Massoudi et al., 2007)) and that immigrant mothers are not offered screening to the same extent as indigenous mothers (Centre of Excellence for Child Health

Services, 2018). Likewise, that immigrant mothers do not agree to participate in the screening to the same extent as indigenous mother (Centre of Excellence for Child Health Services, 2018). Considering the high prevalence among this group of mothers (Falah-Hassani et al., 2015), and the clear adverse effect on the child's health (Swedish National Board of Health and Welfare, 2014) it is important to increase the knowledge of how screening is experienced by CHS nurses and non-native-speaking immigrant mothers. To enable understanding of the sometimes complex interplay between the CHS nurse and non-native-speaking immigrant mother, two nursing theories related to transcultural and transpersonal nurse-patient relationship are used.

Background

Child Health Services

Sweden has a long tradition of child health services (CHS) in society and its history can be traced back to the 19th century. Inspired by a French operation, a forerunner of Child Health Care Centres (CHCC), called Mjölkdroppe (Milk Drop), opened in one of the poorest areas in the Swedish capital Stockholm. It was a charitable reception centre aiming to improve infants' health by providing medical advice and information to mothers, regular infant medical examinations and breastfeeding support. The Milk Drops spread throughout the country and in 1937 their functions were taken over by the state when the Swedish government decided to give grants to general free-of-charge maternal and child health services since children's health was a societal concern (Stenhammar et al., 2001). The institution had successively gone from being a reception centre for less wealthy infants to CHS for all children (0–5 years) (Hallberg et al., 2005).

CHS is still today free of charge and even though participation is voluntary almost 100% of children (0–5 years) and their parents attend. The CHCCs are run publicly or privately. They are arranged in connection with a primary health care centre, as part of a family centre (FC) or as independent units (Inquiry form, 2018). A FC is an extension of the general maternal health services (MHS) and CHS, which besides MHS and CHS consist of social services and an open preschool (Holmqvist, 2014). CHS plays an important part in the Swedish public health work since it aims at creating conditions for good health on equal terms for all children by promoting children's health and development, preventing ill-health in children and early identification and intervention concerning problems in children's health, development and environment.

The work of CHS is based on the United Nations Convention on the Rights of the Child and has the child's best interests and rights in focus (Swedish National Board of Health and Welfare, 2014).

The national Child Health Services programme

Based on a national CHS programme, universal efforts are offered to all children and their parents and further targeted efforts to all according to needs. The programme is universal as it is offered to all children and parents regardless of income or risk exposure. The theoretical assumption behind primary prevention strategies is that by providing preventive efforts to all, it is possible to decrease the proportion of the population who may develop problems later if no action is taken (Swedish National Board of Health and Welfare, 2014). The national CHS programme consists of three parts. The first describes the efforts aimed at all children and families, the second additional efforts to all according to need and the third further extended efforts to all. The programme is not divided into three separate programmes with clear boundaries; rather the starting point is that all children for a shorter or longer period may need additional efforts during their time in the CHS (Reuter, 2018).

The CHS interactions with children and parents are characterized by a health-promoting approach with the ambition to identify, strengthen and take into account the individual's own resources to promote his or her own health and also to prevent and manage disease (Swedish National Board of Health and Welfare, 2014). The programme has a variety of actions. Through health surveillance the child's health, development and living conditions are followed by assessment and examination of, among other things, growth, somatic examination, psychomotor development, language/contact/communication, child and parent bonding, relationships with other children and adults, and psychological and social family relationships. General screenings are carried out, for example, of linguistic development in children and for postpartum depression in mothers. In health promotion, the CHS focuses on different areas of relevance to the child's and the family's health, for example breastfeeding, lifestyle, dental health, child safety, child's development and parenting. The preventive work aims at preventing disease and other ill health by further identifying protective factors and risk factors. Parents are offered extended parental support, for example health guidance about lifestyle and counselling if symptoms of postpartum depression are identified. All children are offered immunizations based on a general child immunization programme and an extended programme is given to children at risk (Reuter, 2018).

The parents are offered support individually and in groups, during visits in their home or at the CHC centre (Reuter, 2018). In recent decades and a shift has been made, from a somatic perspective towards an increasingly public health and psychosocial perspective. Since the psychological and social

needs of the parents, mental health, and possibly cognitive difficulties have been shown to influence the child's development in different areas, it is important that the CHS not only focus on the child but also on the parents (Swedish National Board of Health and Welfare, 2014).

The role of the nurse in the Child Health Services

The quality of the CHS is dependent on the staff's competence. The team of different professions within the CHS – nurse, physician and psychologist – complement each other with their different competences and experiences (Swedish National Board of Health and Welfare, 2014). The nurse is the team leader and bears the main responsibility for the ongoing work in the CHS. She independently performs most of the tasks in the national CHS programme (Swedish National Guidelines for Nursing in the Child Health Services, 2017).

The nurses working in the CHS are registered nurses with an additional specialist nursing degree in paediatrics and/or public health care nursing. They may work only with CHS or with both grown-ups and CHS, what is called integrated CHS. Working only with CHS has shown some advantages in terms of more detailed knowledge within the field and continuity, while working in integrated CHS gives other advantages in the form of more knowledge about the parents' background and living conditions (Swedish National Board of Health and Welfare, 2014).

The CHS nurse builds a relationship with the family in order to familiarize herself with the individual child's and the family's living conditions. At the same time the relationship becomes the starting point for promoting health and preventing ill-health and for carrying out the content of different health visits according to the national CHS programme. The most important working tool for the CHS nurse is her ability to communicate and create an open dialogue with the families. Considering that each family is unique, the CHS nurse must be able to communicate on the basis of varying conditions (Olin Lauritzen, 1990). The responsibility for the relationship always lies on the CHS nurse even if both parties contribute to and affect its development (Dahlberg, 2010).

Immigrant families in Sweden

Among the Swedish population approximately 24 per cent are of foreign origin, which means either born abroad or having two parents who were born abroad (Statistics Sweden, 2017). Although Sweden is considered a relatively equitable society there are clear differences in social conditions for health among immigrants and the indigenous population. Despite the reason for migrating, as a refugee or asylum seeker or as a relative or labour immigrant, all groups report having poorer health than the indigenous population. Migrants born outside Europe report having the worst health, followed by those born in European countries who are not members of the European Union. The health patterns of migrants born in countries that are members of the European Union are more similar to the indigenous Swedish population. The reasons for experiencing poorer health are influenced by many factors such as language, housing, employment, education, ethnicity, lifestyle, marital status, economic and social factors (Hjern, 2012). Women who migrate are shown to face greater social disadvantage than men do, since they are at higher risk of exploitation and abuse, experience poorer socioeconomic conditions and more social isolation (Llácer et al., 2007).

Among immigrant families with children there is an increased proportion in need of support from society due to psychosocial vulnerability (Lagerberg, Magnusson & Sundelin, 2008). Parents born abroad, especially those born outside Europe, reports overcrowded housing to a higher extent than the indigenous population. They also report more financial stress compared to the indigenous population. Likewise, they are more likely to refrain from seeking health care for their child and to report lower access to emotional support in their daily life. Mental ill health is also more common among parents born abroad, especially if the parent was born outside Europe (Fridh et al., 2014).

Immigrant families in the Child Health Services

Contact with children and parents with other cultures and nationalities has become an important part of the work for the CHS nurse (Berlin, Nilsson & Törnkvist, 2010) since in this group there is an increased proportion of families with psychosocial vulnerability such as previous trauma (war and persecution), language difficulties, unemployment, overcrowding and economic problems (Lagerberg, Magnusson & Sundelin, 2008).

For most of the immigrant parents the encounter with CHS is a new experience, since similar health care cannot be found in their country of origin. The Swedish CHS are perceived by most immigrant parents as a well-organized service that treats everyone equally regardless of background. Parents express appreciation for home visits and for the involvement and engagement that the nurse exhibited (Mangrio & Persson, 2017). Immigrant parents feel accepted, calm and brave when they meet CHS nurses whom they perceive as humorous, cautious, praising and thoughtful. The immigrant family considers CHS nurses who give this kind of encounter easy-going and interested in their children (Berlin, Törnkvist & Hylander, 2010). CHS nurses think that it is necessary to be friendly, trustworthy, humorous and curious about people from other cultures to be able to work in the CHS (Samarasinghe, Fridlund & Arvidsson, 2010). If the parents perceive the CHS nurse as uncertain and hesitant in her appearance, they feel confused, puzzled and perplexed in the relationship. The family can feel vulnerable and questioned if they meet a CHS nurse who is not encouraging or thoughtful and who does her job but nothing more. They could become reluctant to visit the CHS if they perceive that it is impossible to establish a positive relationship with the CHS nurse (Berlin, Törnkvist & Hylander, 2010).

Communication difficulties could create problems between the CHS nurse and the immigrant parents. The parents appreciate the availability of interpreters and when the CHS nurse adjusted her language so that they could understand (Mangrio & Persson, 2017). On the other hand, the presence of the interpreter involves another person in the conversation and the CHS nurses feel that this could interfere when they are trying to develop a relationship with the family. Information tends to become compact if a large amount is given at the same time, which could lead to misunderstandings and adversely affect the parents' sense of security in the relationship (Pergert et al., 2007). Another consequence is that the CHS nurses do not know whether the parents understand the health advice and the information that is given (Berlin, Johansson & Törnkvist, 2006).

Lack of cultural competence makes it difficult for CHS nurses to understand immigrant families' living conditions and assess the health risks of immigrant children, as the task is to make this assessment combined with the challenge of interpreting a variety of parenting styles influenced by cultural tradition. Insufficient cultural skills could lead to time-consuming assessments of health risks because the CHS nurses have to redo each moment several times. The consequence of the time-consuming assessments is that interventions to ensure optimal development of the child's physical, mental and psychosocial health is delayed (Berlin,

Hylander & Törnkvist, 2008). In the long term this could lead to immigrant children receiving poorer health care than native-born children since identification of health problems is the first step towards action (Reijneveld et al., 2005).

Postpartum Depression

During the last decade, postpartum depression (PPD) has been globally recognized as a major public health problem, which in recent years has become the most common complication of childbearing in Western societies (World Health Organization, 2014). The postpartum period is a high-risk time for new mothers to be affected by mental ill health because of biological and psychosocial concerns such as the hormonal shifts occurring at childbirth, sleep deprivation and the psychological challenges of the transition to parenthood (Swain et al., 1997). PPD is defined as depression occurring after childbirth, usually within 4 to 6 weeks, and may last several months or even a year (O'Hara & Swain, 1996). In the Diagnostic and Statistical Manual of Mental Disorders PPD is not distinguished from depression occurring at other times. To be diagnosed with depression the patient must have had at least five of the following symptoms during a period of two weeks: feeling downhearted, anhedonia, weight or appetite changes, feelings of worthlessness or guilt, sleep disorder, loss of energy, decreased ability to think or concentrate, recurrent thoughts of death or suicide. One of the symptoms feeling downhearted and anhedonia must be present. The symptoms should cause clinically significant suffering or impaired functioning socially. The episode should not be attributed to the physiological effects of any substance or other medical condition (American Psychiatric Association, 2013).

Characteristic symptoms of PPD are feelings of inadequacy as a mother, of emptiness, tearfulness, anxiety and panic, despair, guilt, irritation and of not being oneself, which makes it difficult to manage everyday life (Wickberg & Hwang, 1997). It is conceptualized differently in diverse cultures but is recognized as a transcultural phenomenon (Falah-Hassani et al., 2015). The more non-West a culture is, the more tendencies there are for somatization of depressive symptoms (Evagorou, Arvaniti & Samakouri, 2016).

The prevalence among indigenous Western population is currently estimated at 13 per cent, and among immigrant mothers (refugees, asylum-seekers, relation and labour immigrants) 20 per cent. Immigrant women are accordingly almost twice as likely to be affected by PPD as indigenous

mothers (Falah-Hassani et al., 2015). Asylum seekers and refugees, especially those who recently migrated (within ten years), may be at even higher risk of being affected (Dennis, Merry & Gagnon, 2017). Immigrant mothers who are less proficient in the native language of their new country are also confirmed to be at particular risk (Bandyopadhyay et al., 2010). Likewise, immigrant mothers are more likely to develop depressive symptoms if they have lower levels of social support, poorer marital adjustment and perceived insufficient household income (Falah-Hassani et al., 2015).

Other important risk factors associated with PPD are previous history of depression, vulnerable personality traits, lack of social support, recent stressful life events, physical health problems during pregnancy, obstetric difficulties during delivery, lack of readiness for hospital discharge and infant feeding dissatisfaction (Dennis, Janssen & Singer, 2004). Experiences of worrying about family members left behind and food insecurity are also known risk factors (Dennis, Merry & Gagnon, 2017). Immigrant mothers may also struggle to cope with pre- and post-migration stressors (violence, war, natural disaster, shifting gender roles in the family and uncertain immigration status) as well as cultural factors (disparity between the original and the new culture), poor information about the health care system and not being able to carry out cultural rituals associated with childbirth. In many cultures PPD is also related to social stigma, which prevents mothers from seeking help. The reasons for the higher risk of postpartum depressive symptoms among immigrant women are complex but immigrant women may disproportionately face stressors in the transition to parenthood that increase their risk (Collins, Zimmerman & Howard, 2011).

Postpartum depression and its impact on the child

Maternal PPD is identified as a major childhood adversity, and effective interventions to reduce the long-term negative developmental outcomes among children are one of the most important public health strategies (Dennis & Dowswell, 2013). The PPD occurs at a time when the infant is maximally dependent on parental care to meet its basic need for health, protection, nurturing and stability. The infant is highly sensitive to the quality of the interaction with the parent and the symptoms of depression can make it difficult for the parent to interact in a responsive way with the child. There is a substantial body of evidence showing that PPD leading to poor maternal interaction may affect the infant's development in an adverse way. Children of depressed mothers, when compared with those of non-depressed mothers, are more fussy and have more difficult

temperaments. They react more negatively to stress and show delayed development of self-regulatory strategies (England, 2009). Children of postpartum depressed mothers show lower verbal intelligence as well as lower social competence when interacting with peers in the early school period (Kersten-Alvarez et al., 2012). They receive lower scores on measures of intellectual and motor development and exhibit poorer academic performance. Likewise they display lower levels of self-esteem, and higher levels of behavioural problems compared to children of non-depressed mothers (England, 2009). Children of depressed mothers have at age 16 a substantially increased risk of depression themselves compared to children of non-depressed mothers (Murray et al., 2011).

Screening for postpartum depression

Since 2010 systematic screening of all new mothers for postpartum depression, six to eight weeks after childbirth using the EPDS method, is recommended in Sweden by the National Board of Health and Welfare (2010). The CHS nurses bear the main responsibility for identifying mothers with signs of PPD and are considered to have excellent opportunities for early detection and intervention because of the families' regular visits (Wickberg & Hwang, 2003). Maternal and child health psychologists educate the CHS nurses in recognizing risk factors and symptoms, screening for PPD using the EPDS. They also provide training in implementing counselling and give regular tuition (Wickberg, 2017).

The EPDS is a ten-item self-report screening scale specially developed for screening for symptoms of PPD (Appendix I) (Cox, Holden & Sagovsky, 1987). EPDS is an aid and is used in connection with a clinical interview to evaluate the mother's responses to the scale (Swedish National Board of Health and Welfare, 2014). The scale has been translated to and validated in many languages and is one of the most commonly used screening tools for PPD in the world (Cox, Holden & Henshaw, 2014). The method requires that adequate measures are offered to the women who are screened out. In Sweden if severe symptoms of PPD have been disclosed, the CHS nurse refers the mother to a maternal and child health psychologist, a general practitioner (GP) at the primary health care centre or a psychiatric clinic (Wickberg & Hwang, 2003). Mothers with signs of a minor depression are offered person-centred counselling sessions, led by the CHS nurse, which were shown to decrease the level of symptoms of minor depression (Swedish National Board of Health and Welfare, 2010).

When screening a non-native-speaking immigrant mother a translated validated scale is to be used and the CHS nurse must be aware that the cut-off point may vary between different languages (Wickberg, 2017). Other circumstances to take into consideration that may influence the screening are the mother's literacy level and the quality of the interpreter's work, and also how different cultural interpretations of the questions can result in scores which do not reflect the mother's mood (Department of Health Government of Western Australia, 2006). Despite the recommendation of general systematic screening for PPD (Swedish National Board of Health and Welfare, 2010), statistics show that immigrant mothers are not invited to participate in screening to the same extent as indigenous mothers. Furthermore they do not agree to participate in screening to the same extent as indigenous mothers and are not screened out as frequently as could be expected in relation to the high prevalence (Centre of Excellence for Child Health Services, 2017). Research suggests that performing screening on immigrant mothers is challenging for healthcare professionals (Teng et al., 2007, Massoudi et al., 2007). This could be related both to language barriers and to perceived inadequate assessment tools (Teng, Robertson Blackmore and Stewart, 2007) as well as cultural barriers to interpreting culture-specific signs and symptoms of PPD (Teng et al., 2007, Onazawa et al., 2003). Immigrant mothers might experience both practical barriers such as language difficulties and cultural barriers such as fear of stigma as obstacles to participating in screening (Teng, Robertson Blackmore & Stewart, 2007).

Theoretical framework

In this thesis two theories related to transcultural and transpersonal nurse-patient relationship are used to enable an understanding of the sometimes complex interplay between a CHS nurse and an immigrant mother. To understand the relationship that develops between the CHS nurse and the immigrant mother, Leininger's theory of Culture Care is used. When the nurse meets the immigrant mother and starts to interact, a transcultural caring relationship develops, which means a professional relationship between cultures in order to care over cultural boundaries. The theory was developed with the goal of using culturally based research knowledge to provide culturally congruent holistic care for the individual family. Nurses who understand and value the practice of culturally competent care are able to effect positive changes in healthcare practices for clients of designated cultures. Sharing a cultural identity requires knowledge of transcultural nursing concepts and principles, along with an awareness of current

research findings. Health is a key concept in transcultural nursing. Because of the emphasis on the need for nurses to have knowledge that is specific to the culture in which nursing is being practised, it is acknowledged that health is seen as being universal across cultures but distinct within each culture in a way that represents the beliefs, values and practices of the particular culture (Leininger, 1991).

The other theory used is Watson's Theory of Human Caring, concerning a transpersonal caring relationship. It emphasizes the special human socializing between a patient and a nurse. The relationship starts when the nurse enters the patient's living space. Watson emphasizes that it is an art to develop a relationship with other people. The art is based on the fact that a person who accepts another person's expression of emotion, through hearing, vision and even intuition, may be involved in the same feeling that gave the other inspiration to express himself. The art of care and nursing is based on the ability of one person to accept another person's emotional expression and to experience these within herself. It is important that every nurse becomes aware of her strength in order to develop a relationship between herself and her patient. In order to be able to use Watson's theory as a nurse, she must be aware of herself to be able to use herself in a relationship. In addition, the nurse must be able to think in an overall perspective regarding body, spirit and soul. (Watson, 1985).

Rationale

Effective interventions to reduce long-term negative developmental outcomes among children are one of the most important public health strategies. PPD is identified as a major childhood adversity (Dennis & Dowswell, 2013) which children with immigrant mothers are at higher risk of being exposed to since the prevalence among immigrant mothers is almost twice as high as among indigenous mothers (Falah-Hassani et al., 2015). Due to the turbulent world situation in recent years, Sweden has many immigrants who recently migrated, and approximately 24 per cent of the population were either born abroad or both parents were born abroad (Statistics Sweden, 2017).

General screening for PPD, using the EPDS method, has been recommended in Sweden since 2010 (Swedish National Board of Health and Welfare, 2010) and is to be conducted by the nurse in the CHS who are considered to have excellent opportunities for detection and intervention because of the regular visits (Wickberg & Hwang, 2003). However, findings (Teng, Robertson Blackmore & Stewart, 2007) and statistics (Centre of Excellence for Child Health Services, 2017) suggest that current screening for PPD are challenging for health care professionals and screening of non-native-speaking immigrant mothers are inadequate.

Therefore, more knowledge about how screening for PPD is experienced by CHS nurses and non-native-speaking immigrant mothers could be valuable and possibly contribute to increased participation and better outcome of screening for this group of vulnerable mothers.

Aims

The overall aim of the thesis is to increase the knowledge of screening for postpartum depression in non-native-speaking immigrant mothers in the Swedish Child Health Services by elucidating the experiences of Child Health Services nurses and non-native-speaking immigrant mothers. The thesis is based on two papers, one from the perspective of CHS nurses and one from the perspective of non-native-speaking immigrant mothers.

Paper I: To elucidate Child Health Services nurses' experiences of identifying signs of postpartum depression in non-Swedish-speaking immigrant mothers in the Swedish Child Health Services.

Paper II: To elucidate non-native-speaking immigrant mothers' experiences of participating in screening for postpartum depression in the Swedish Child Health Services.

Methods

Design

A qualitative inductive approach was used, where individual interviews were followed by a latent content analysis (Elo & Kyngäs, 2008). This design was found suitable since qualitative methodology seeks to understand human experiences of life (Patton, 2002). Purposive sampling, as described by Patton (2002), was utilized which meant that participants with specific knowledge of the phenomena were chosen. An overview of the sample and methodology is provided in Table 1.

Table 1. Overview of sample and methodology

Paper	Design	Sample	Data collection	Analyses
I	Inductive, descriptive	CHS nurses (N=13)	Individual interview	Qualitative content analysis
II	Inductive, descriptive	Non-Swedish-speaking immigrant mothers (N=13)	Individual interview	Qualitative content analysis

Methodological framework

The research was guided by the Medical Research Councils (MRC) framework for developing and evaluating complex interventions. The framework, which is intended to give guidance to researchers, consists of four key elements: development, feasibility/piloting, evaluation and implementation (Figure 1). The four key elements are not to be followed linearly or cyclically, but are to interact with each other aiming to strengthen the intervention and the design. The studies included in this thesis involve the element of development by identifying the evidence base and theory, since earlier knowledge of the research area is sparse (MRC, 2008).

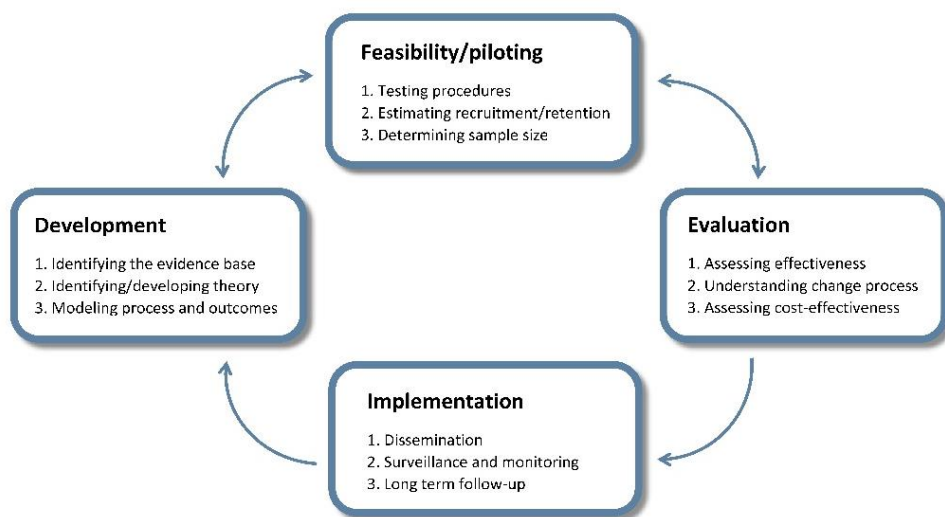


Figure 1. A framework for developing and evaluating complex interventions (MRC, 2008).

Context of the thesis

The studies were conducted in Skåne, a county in the south of Sweden, between May 2013 and November 2016. Skåne has an area of 11,035 square kilometres, consisting of both rural and urban areas with 1.3 million inhabitants (Facts Region Skåne, 2017). About 100,000 children, aged 0–5 years, are enrolled in one of the 148 CHCCs in the county (Centre of Excellence for Child Health Services, 2017). Forty per cent of them were either born abroad or both of their parents were born abroad (Statistics Sweden, 2016). The CHS is funded by the government and local county council (Swedish National Board of Health and Welfare, 2014).

Participants

This thesis is based on the perspectives of the CHS nurses and the non-Swedish-speaking immigrant mothers.

To recruit participants for the first study, CHS nurses who are in frequent contact with immigrant mothers who, due to their limited proficiency in

Swedish, require an interpreter’s assistance when visiting the CHS, annual statistics for BCG immunizations were used (Centre of Excellence for Child Health Services, 2014).

In Sweden BCG immunization is only given to children of foreign origin, and a high rate of BCG-vaccinated children at a CHCC indicates that many children of foreign origin are enrolled (Swedish National Board of Health and Welfare, 2014). The operations managers of the twenty-five CHCCs with the highest rates of BCG-vaccinated children were contacted for written consent and asked to suggest a suitable CHS nurse to participate in the study.

Consent was given by fifteen operations managers and the suggested CHS nurses were contacted. One of these nurses declined participation. Of the fourteen participants, it was not possible to set up an interview with one. The reason she mentioned for postponing the interview was high workload. Profiles of the participating CHS nurses, who all were woman, are presented in Table 2.

Table 2. Profile of the participating CHS nurses

Mean age was 54 years, range 33–65.
Years of experience working in the CHS ranged from 3–31 years, on average 18 years.
11 worked only with CHS, 2 with integrated CHS
9 had a specialist nursing degree in public health care nursing, 2 in paediatrics and 2 in both.
Responsible for on average 59 newborns each per year, ranging from 26–77.
1 had an immigrant background herself.

The recruitment of participants for the second study started by identifying Albanian, Arabic, Badinani and Turkish as the four languages for which an interpreter was most commonly used in the CHS. This was done by contacting CHS nurses, who according to statistics, worked at the 15 CHCCs that performed most screening for PPD with the help of an interpreter (Centre of Excellence for Child Health Services, 2014). Twenty-five nurses in seven different CHC centres, among the 15 centres that performed most screening for PPD with the help of an interpreter, agreed to act as

intermediaries and informed suitable mothers about the study in connection with their babies' 3-month check-up.

Eligible to participate in the study were immigrant mothers, speaking Albanian, Arabic, Badinani or Turkish, who had been screened with the help of an interpreter without showing any signs of PPD according to the CHS nurses' clinical assessment. Translated information in the mothers' native language was used in addition to verbal information with the help of interpreters. Four authorized female health care interpreters, one in each language, were used on-site in the interviews.

When a mother expressed interest in participating in the study, the doctoral student was notified and contacted the mother with the help of an interpreter to give further information and to offer participation and arrange the interview. Before the research interview started the mother was given information about qualitative research interviews and the nature of the study. Eighteen mothers expressed interest in the study but three of them declined participation after being given further information. One mother withdrew her participation after she had been interviewed. In total thirteen non-Swedish-speaking immigrant mothers were interviewed approximately one to two months after being screened for PPD. Profiles of the participating mothers are presented in Table 3.

Before the interviews, the doctoral student who performed all the interviews was not acquainted with any of the participants, except for one mother who was therefore excluded.

Table 3. Profile of the participating non-native-speaking immigrant mothers

Born in	
Syria	4
Kurdistan	3
Iraq	3
Kosovo	2
Libya	1
Age, range	19-34 years
Time in Sweden, range	9 months - 4.5 years
Reason for migration	
Refugee due to war	7
Political refugee	1
Family immigrant	5
Residence permit	
Yes	12
No	1
Education	
Tertiary	2
Sixth-form college	3
Basic schooling	6
Two years of basic schooling	1
No schooling	1
Living with	
Husband	11
Husband and extended family	2
Primiparous	7
Multiparous	6
Sick leave during pregnancy	3
Delivered by caesarean section	3
Physical problems postpartum	2
Religions	Christianity, Islam and Yezidism

Data collection

The qualitative research interviews were all performed as individual interviews in person, which gave the doctoral student the possibility to listen to each participant speaking and reflecting on her experience regarding the research question. The interview cannot be seen as a conversation between equals since it is the researcher who defines and verifies the state of the situation. The data material is produced in the interaction between the participant and the researcher and is dependent on the researcher's skills and personal judgement in asking questions as well as knowledge of the subject (Kvale & Brinkmann, 2014). For the interviews in the second study four female authorized health care interpreters were used, translating Albanian, Arabic, Badinani and Turkish. They were all employed at another interpreter agency than the one used by the CHS. There are several factors to consider when conducting a qualitative research interview through an interpreter, for example the interpreter's role, positioning of the parties during the interview and cultural factors (Freed, 1988). None of the interpreters was born in Sweden. They were all given information about the nature of the study, postpartum depression, the EPDS method and the qualitative research interview. During the interviews the interpreters performed consecutive translation and were seated next to the researcher and mother who were sitting opposite each other.

All interviews were performed at a place chosen by the participant. The interviews with nurses were performed from May to September 2013 in person at the CHS nurses' workplaces and lasted an average of 29 minutes (range 20–39 minutes), while the interviews with the mothers were performed from November 2015 until November 2016 with the help of female authorized interpreter in the mother's home or at her local CHC. They lasted an average of 54 minutes (range 37–94 minutes). All interviews were digitally recorded with the participant's permission and transcribed as close to verbatim as possible on a personal computer without internet access. Other interpreters than the ones used in the research interviews verified the material in the second study by listening to the recording and comparing it to the transcription.

The interviews were conducted using a semi-structured interview guide developed especially for each study. A semi-structured interview guide is appropriate when researchers wish to ensure that certain issues will be discussed within a qualitative interview. The researcher is given the opportunity for an open interview, but is at the same time limited to questions according to the subject of the study (Kvale & Brinkmann, 2014).

The different question areas in each interview guide are presented in Table 4. Probing questions such as “Can you explain more about that?” and “What are your thoughts about that?” were asked to elaborate on the participants’ thoughts in more detail.

Two pilot interviews were conducted in each study to test the interview guides. Since they did not result in any changes in the interview guides these interviews were also included in the research material.

Table 4. Question areas in the semi-structured interview guides.

Paper I	Paper II
Strategies to determine the mood of the non-Swedish-speaking immigrant mothers.	What affects the choice to participate in the screening?
Experience of screening for PPD in non-Swedish-speaking immigrant mothers using the EPDS.	Experience of the EPDS and circumstances for filling it out.
	Experience of the clinical interview.
	Thoughts of suitable follow-up if needed.

Analysis

There are several approaches for analysing qualitative data. Content analysis is used in many nursing studies and has a long history. The goal of content analysis is to provide knowledge and understanding of the phenomenon under study (Downe-Wamboldt, 1992, p. 314). Which type of content analysis approach is chosen varies with the problem being studied. Content analysis can be performed on a manifest or latent level. Both levels deal with interpretation but they vary in depth and level of abstraction. Manifest analysis deals the content aspect and describes the visible, obvious components, while latent analysis deals with what the text talks about, the relationship aspect and involves an interpretation of the underlying meaning of the text (Downe-Wamboldt, 1992).

Content analysis can be used in both an inductive and a deductive way. If knowledge of a phenomenon is sparse or fragmented the inductive approach is recommended since the categories then are derived from the data (Elo & Kyngäs, 2008). An inductive approach moves from each specific experience by combining it into larger general statements (Chinn & Kramer, 1999). A deductive approach is often used to retest existing data in a new context.

It is generally based on an earlier theory or model and either a structured or an unconstrained matrix of analysis can be used (Elo & Kyngäs, 2008).

The analyses started with the first and third author reading the material separately several times in order to immerse themselves in the data (Elo & Kyngäs, 2008). Text that appeared to elucidate the participants' experiences, 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 sub-categories named after a content-characteristic word. The sub-categories with similar content were organized under higher-order headings into categories through interpretation of how the different sub-categories were associated and connected with each other. The different sub-categories and categories were then verified by the second author after reading and analysing three interviews (Paper I) and all interviews (Paper II).

All three authors then discussed the list of categories, and compared and abstracted them as far as it was sensible to interpret the latent meaning of the text according to Elo and Kyngäs (2008). By abstracting the categories and interpreting the latent meaning of the text a theme connecting the text as a whole was formulated and agreed upon by all three authors (Elo & Kyngäs, 2008, Granehiem, Lindgren & Lundman, 2017).

The different steps in data analysis according to Elo & Kyngäs (2008) are presented in Table 5.

Table 5. Steps in data analysis (Elo & Kyngäs, 2008).

Preparation phase	
Emerging in the material	<ul style="list-style-type: none">- Reading the material to provide a sense of the whole.- Highlighting of text corresponding to units of analysis.
Organizing phase	
Open coding	<ul style="list-style-type: none">- Writing of keywords or phrases from the highlighted text in the margin.
Coding sheets	<ul style="list-style-type: none">- Collecting keywords and phrases from the margin on coding sheets.
Grouping	<ul style="list-style-type: none">- Sorting codes into sub-categories through interpretation of how they are linked and related to each other.- Naming each sub-category after its content.
Categorization	<ul style="list-style-type: none">- Comparing sub-categories and grouping them under generic categories.- Organizing generic categories under main categories.
Reporting phase	
Abstraction	<ul style="list-style-type: none">- Formulating a general description of the phenomenon by connecting the text as a whole, the content of the categories and the interpretation of the latent meaning of the text.

Preunderstanding

Previous knowledge about a specific phenomenon can be referred to as our preunderstanding (Dahlberg, Dahlberg & Nyström, 2008). The author of this thesis had several years' experience of working as a CHS nurse. It is an advantage in terms of having knowledge of the specific context in terms of easier being able to pose relevant probing questions (Kvale & Brinkmann, 2014). On the other hand, it might constitute a bias. In an attempt not to let this preunderstanding influence the studies in a subjective way, the studies were done in collaboration with other researchers with experiences from other areas of healthcare. The author's preunderstanding was reflected upon and discussed at regular supervision throughout the study process. The author had no personal or professional relationship with either the nurses or the mothers who participated in the interviews.

Ethical considerations

The study was planned and carried out in accordance with the WMA Declaration of Helsinki of 2013 (World Medical Association, 2013) considering autonomy, confidentiality and fairness and balancing benefits against risks, non-maleficence and beneficence. The studies were ethically approved by the Regional Ethics Committee in Lund, Sweden (case no. 2013/132 and 2015/96).

With respect for the participants' autonomy, for example, they were all informed, both verbally and in writing, about the study and they all gave their written informed consent. The CHS nurses (Paper I) were informed about the nature of the study, measures to preserve their confidentiality, freedom of participation and the possibility to withdraw their participation at any time. Their written consent for participating in the study was obtained. The non-native-speaking mothers (Paper II) received written and verbal information in their native language with the use of an authorized female health care interpreter about the nature of the study, measures to preserve their confidentiality, freedom of participation and the possibility to withdraw their participation at any time. They all gave their written informed consent.

In order to ensure confidentiality, the interviews were transcribed on a personal computer without internet access. After the transcription the interviews were given a code number and a code list was established. The code list was kept separately from the data material in a locked cabinet and only accessed by the author of this thesis. Profiles of the participants were presented on a group level to prevent any individual participant from being recognized and unique quotations were presented with code number. The data material will be handled according to the universities' guidelines and stored safely in a locked cabinet inaccessible for outsiders.

As to non-maleficence and beneficence, all the participants were informed about the possibility to receive counselling from a psychologist if they experienced distress or anxiety in any way after giving the interview. The time spent participating in the study might also be seen as a possible inconvenience by the individual CHS nurse but is hopefully balanced by the benefits of contributing to improved clinical guidelines for the CHS. Screening for PPD represents a cost for society, which makes it important to execute it in the most effective way not only for the sake of society but primarily for the sake of this vulnerable group of mothers and their babies.

Findings

The findings of the thesis are presented under the following headings: CHS nurses' experiences (Paper I) and non-native-speaking immigrant mothers' experiences (Paper II).

Child Health Services nurses' experiences

The experiences of CHS nurses of identifying signs of PPD in non-Swedish-speaking immigrant mothers were illustrated by the overarching theme "a constant challenge for deepening the transcultural caring relationship". The theme refers to the CHS nurses' (henceforth described as nurses) desire to constantly deepen their connection with the non-Swedish-speaking immigrant mothers (henceforth described as 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 follows: "establishing a transcultural supportive relationship", "interpreting the mother's mood using cultural knowledge" and "striving sometimes in vain when screening for PPD".

The first step to be able to identify signs of PPD was described as "establishing a transcultural supportive relationship" by the nurses. They expressed compassion, dedication and a genuine desire to meet the mothers and learn more about their culture and understand their situation. It was of great importance to be available whenever they came to the CHCC. Despite dedication in meeting the mothers they felt that they had to work harder to win their confidence compared to indigenous mothers. Standing or sitting close to the mother was described as a subtle way of expressing how dedicated they were in supporting her. To some extent using communication interpreters helped the nurses to bridge cultural differences, but they experienced an uneven quality in the interpreter's work. A list was kept of interpreters who did a satisfactory job and could be trusted, but the nurses preferred, if possible, to communicate in broken English instead of using an interpreter. In the nurses' endeavour to empower the mother in her role as parent they experienced that the general health promoting approach,

incorporating her own way of thinking, often did not suit these mothers who liked to be given hands-on advice. The nurses took different actions in helping the mother to build a network and thereby promote their mental health.

The established transcultural supportive relationship was used as a springboard for continuously interpreting the mother's mood based on observations and interaction during all visits to the CHCC. It was vital to reach a high level of cultural knowledge to be able to interpret the mother's mood since the concept of PPD was not recognized in some cultures. By "interpreting the mother's mood using cultural knowledge" they understood and found explanations for some of their impressions. Signs of PPD in mothers were not perceived as differing from signs observed in indigenous mothers. Looking tired, slouching and having a stiff facial expression, static movements, poor eye contact and an empty sad blank look in their eyes were perceived as signs of PPD. The facial expression and in particular the eyes were things the nurses specifically reflected on. Sometimes they noted the mother's lack of interest in the baby and slow or indifferent response to the baby's signals. Behaviours such as 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 constantly seeking help, could be interpreted as signs of PPD. The nurses also relied on their intuition which gradually grew from observing and interacting with the mother. They felt that their intuition was rarely wrong despite the cultural differences, but the relationship needed to be deepened before the subject could be addressed since it was a more delicate issue to bring up these mothers' mood compared to indigenous mothers. Sometimes they waited until the scheduled screening took place to be able to compare their intuition of the mother's mood with what emerged at screening.

The nurses experienced a feeling of professional failure when they felt they were "striving sometimes in vain when screening for PPD" in the sense that they saw signs of mental ill health but could not get the mother to open up to them. They adapted the screening procedure to the best of their ability given the circumstances but still it was found difficult to perform the screening without deviating too much from the original approach. Choices made for making it possible for the mother to fill out the scale depended on her literacy level, access to a translated validated scale in the mother's own language or not, the mothers as well as the nurse's own English language skills and the interpreters' capacity. The nurses were aware that the EPDS items could be interpreted in a different way in some cultures and needed further explanation and clarification. To obtain an overall impression of the mother's mood, earlier conversations and impressions were captured and

compared to the screening score and the interview. Their impressions were however challenged by the interpreter's ability to translate and convey the items as well as the interpreter's capacity to translate the mother's answers in a nuanced and exact way. The nurses reflected on difficulties in applying conversational technique as they were used to when using an interpreter in the conversation. They were aware of how the mothers' cultural standards and beliefs about mental illness might influence the conversation since mental ill health in many cultures was associated with guilt and shame. The nurses perceived that the mothers often spoke to them about how they were feeling, but they frequently experienced failure to motivate the mothers who showed signs of depression to seek help and support from some other professional than themselves. It was frustrating not to get the mother to accept external help, and the nurses sometimes felt they took on more difficult cases in person-centred counselling than they were supposed to handle.

Non-native-speaking immigrant mothers' experiences

The non-native-speaking immigrant mothers' experiences of participating in screening for PPD were illustrated by the overarching theme "exploring new contexts for replacing lost support and for empowerment". The theme refers to how participating in the screening reminded the mothers of their lack of support in their current life situation, but it was also seen as an opportunity to tentatively experience new ways of thinking about mental ill health and exploring new sources of support. Three main categories were identified, as follows "feeling confirmed as a person in the CHS", "challenging to speak about one's mood" and "a reminder of what is lost and possibilities to come".

Since mothers had the impression that the CHS was mainly directed to the child's health it was surprising for them to experience "feeling confirmed as a person in the CHS". The visits made them feel supported and that the nurse was interested in them and their feelings. Coming to the CHCC for the baby's regular check-ups was much appreciated by the mothers. They felt that they grew in their role as a parent and felt more secure when the nurse answered their questions. Even if the reason for offering the screening for PPD was somewhat unclear to most mothers when asked to participate, it made them feel even more confirmed as a person and that they were treated just like all other mothers. The relationship and the quality of the contact with the nurse

were of importance for them when deciding to participate in the screening and finding it meaningful. It was reassuring for the mothers to know that the nurse would identify signs of PPD in her clinical assessment if they did not recognize suffering from it by themselves.

Cultural beliefs about mental ill health and negative expectations connected to their perceived value as a woman made it “challenging to speak about one’s mood”. So too did shame at not being grateful enough for their new life and the experience of the interaction during the screening. The concept of PPD was in general unknown to the mothers and none of them had experienced general discussions about PPD in their society, as speaking about mental ill health was not common and not accepted in their country of origin. Speaking about their mood was also affected by not being used to getting attention as a person because of their gender. In their culture of origin being born as a girl meant different life conditions in terms of not having the possibility for education, not working outside the household, and having few rights within a marriage. Earlier negative encounters in healthcare and stories about how women had been mistreated by healthcare professionals in their country of origin also influenced the mothers’ ability to speak about their mood. One mother had heard stories that in Sweden babies were taken away by the Child Protective Services if a parent spoke about not feeling well mentally, which made her hesitate to speak about her mood. Feelings of guilt and shame and not being grateful enough for the comfortable life they now were living in Sweden were another hindrance to bringing up negative emotions. Some mothers were sensitive to the nurse’s availability and if they perceived her as stressed or in other way absent in the screening situation they did not want to burden her further despite experiencing a good relationship. The interaction during the screening was another challenge to speaking about their mood. Not all mothers had been given the opportunity to speak about their answers to the scale; they just filled out the EPDS by themselves or with the help of an interpreter. The mothers were generally content with the quality of the interpreter who was provided, but if possible, they preferred a female interpreter on-site since they found it difficult to speak about sensitive things in the presence of a man. All except the last questions in the EPDS were perceived as normal. The last one about harming oneself was found somewhat peculiar but still accepted since they saw it as being posed from a Western point of view.

Participating in screening was “a reminder of what is lost and possibilities to come”, such as their changed conditions for support in everyday life and how they tried to orient themselves to find new ways of support. Two of the mothers had previously experienced PPD and at the time of the interview several of them spoke of having sleeping disorders, feeling sadness and

crying for no reason, loss of interest in their daily life, suffering from fatigue, anxiety, anger or irritability, self-loathing and unexplained aches and pain. One mother told about having delusions and thoughts of harming herself. They had all experienced deep loneliness in their life since they migrated. Some missed having a job to go to and others missed sharing their everyday life with their extended family. The absence of their own mother was profound. If they still had been living in their country of origin the close family would have taken care of them if they had not felt well. Seeking professional support would only have been a last resort. Psychological support from relatives, which was received by phone and the use of social media, meant a lot to them, even though they hesitated to speak about their mood since they did not want to worry or burden their relatives. The only source of practical support was for most mothers their husband, but speaking to him about how they felt was not always an option because they did not want to burden him or did not have that kind of relationship. When not having anyone to talk to in their daily life they prayed to find strength. Crying helped them to feel better when the pressure was too high. The baby was described as important company in daily life, which gave it meaning and a reason to start learning the language and to make new acquaintances. The mothers started to build a network for support and company by visiting the open preschool or finding support among their neighbours. They also found strength in their own ability to care for their child. The mothers tried to orient themselves towards accepting other forms of available professional psychological support if needed. The relationship with the nurse was experienced as valuable and the home visits were highly appreciated.

Discussion

Methodological considerations

Two qualitative studies, with individual interviews, were conducted to elucidate CHS nurses' and non-native-speaking immigrant mothers' experiences of screening for PPD. The research followed the MRC (2008) framework involving the element of development, and the presented knowledge will be used for developing an intervention that can be tested for effectiveness.

Awareness of trustworthiness is an important part of the qualitative research process. In this thesis the concepts of credibility, dependability, transferability and confirmability are used to describe various aspects of trustworthiness. Although the terms represent different perspectives on trustworthiness, they should be seen as intertwined and linked to each other (Lincoln & Guba, 1985).

Credibility refers to the confidence in the truth of the data by considering the selection of appropriate methods and participants as well as the transparency in reporting the study procedure (Lincoln & Guba, 1985). To establish credibility, the participants in the studies were chosen by purposive sampling. In the first study nurses who were likely to have the most experiences relating to the research subject were chosen. It might be argued that this approach limits variation in the results, and that choosing the sample differently and also interviewing nurses with sparse experience of the subject might have revealed additional variations. Likewise, the use of another qualitative research method, for example phenomenology, could have offered more depth to the results. On the other hand, since there is little knowledge about the research subject, the chosen sample and qualitative research method offered a broad description of the subject. The authorized female healthcare interpreters used when interviewing the mothers were from another interpreter agency than the one the CHS used. This was to avoid the mother and the interpreter being acquainted with each other since it might have affected the interview. As for the mothers, they only represent a small group with three different languages, originating from five different

countries and it can be claimed that a larger sample would have strengthened the credibility of the results as additional variations could have been revealed. For ethical reasons mothers assessed as showing signs of PPD were excluded because of their vulnerable situation. Still, despite the relatively small sample of participating mothers, one cannot be certain that a larger sample would have revealed additional variation. However, it is claimed that no new information is provided after twelve interviews provided that the participants are a relatively homogeneous group, the objective is fairly narrow and an interview guide is used (Guest et al., 2006). Individual interviews were chosen for both studies for ethical reasons, since the research area might be considered a sensitive topic to speak about (Kvale & Brinkmann, 2014). Two of the mothers who expressed symptoms of PPD during the interview were referred, one to a mother and child psychologist and the other one to her CHS nurse for counselling. Two others were recommended to contact their CHS nurse for counselling but refrained since they said they felt better after participating in the interview.

Transferability refers to whether or not the findings can be transferred to other groups or settings than those studied (Lincoln & Guba, 1985). The researcher can suggest transferability, but it is for the readers to decide about the transferability of results to another context (Graneheim, Lindman & Lundman, 2017). In order to facilitate transferability, the context, the participants' characteristics, the sampling, the data collection and analysis process were described in as much detail as possible both in the papers and in the thesis. Even though the results are based on two qualitative studies, and the structure of the Swedish healthcare system might differ from other countries, the nurses' experiences might be transferable to other healthcare professionals who conduct screening for PPD according to the EPDS method.

Dependability refers to the stability of data over time and across conditions (Lincoln & Guba, 1985). In order to increase the dependability of the analysis, the process is described in detail both in text and in a table. The research material from interviewing non-native-speaking immigrant mothers was confirmed by other interpreters than the ones used in connection with the interviews. These interpreters were court interpreters. Confirmation of each interview was rigorous and took several hours. In total seven of the interviews were confirmed. Only minor changes to the transcribed interviews were undertaken, such as the addition of single words. To further increase dependability, results from both papers have been discussed in research seminars with junior and senior researchers.

Confirmability refers to the objectivity of data and interpretations (Lincoln & Guba, 1985). As the author of the thesis had several years' experience of working as a CHS nurse, this could represent a risk of bias. In an attempt not to let the preunderstanding influence the study in negatively, her preunderstanding was regularly discussed during both the data collection and the analysis. Researcher triangulation was used as the authors independently read the material and then conducted a parallel analysis which enables a consistency check of the results and reduces potential bias that might come from a single researcher analysing the material (Patton, 1999). In order to make the interpretations as transparent as possible for the reader, each category was enriched with quotations from the participants' answers (Kvale & Brinkmann, 2014).

General discussion

The overall aim of this thesis was to contribute to the knowledge about screening for postpartum depression in non-native-speaking immigrant mothers by elucidating the mothers' experiences of participating and CHS nurses' experiences of identifying signs of PPD in this vulnerable group of mothers. The findings are discussed in relation to Leininger's theory of culture care and the theory of human caring by Watson (Leininger, 1991, Watson, 1985).

The findings address the importance of establishing a transcultural supportive relationship with the mother in order to be able to interpret her mood. The nurses expressed compassion, dedication and a genuine desire in meeting the mothers and learn more about their culture and understand their situation. Watson emphasizes how being skilled in conversational techniques and having a therapeutic approach are not enough for the relationship with the patient to develop and to be genuinely caring. This process is about the importance of the nurse meeting the patient in a way that make her feel seen and respected as a person. The nurse needs consciously to direct her attention to the patient as a person to create possibilities for a deep transpersonal contact, namely a contact where people meet and are affected by each other (Watson, 1985). The nurses seemed successful in their attempts to establish a transcultural supportive relationship since the mothers expressed how they perceived the nurse as being interested in them and making them feel confirmed as a person. Earlier findings showed that immigrant mothers saw trust, rapport and faith as essential components for having a positive perception of a relationship

with a healthcare provider, likewise feeling the provider's genuine commitment and interest in her and awareness of her background (Donnelly et al., 2011). Watson believes that a life-giving relationship can be an intervention in itself, but it also forms the basis for other interventions partly because it contributes to the nurse's understanding of the patient and what she needs, partly because it makes it easier for the patient, for example, to receive information (Watson, 1985). The nurses were aware that they needed to be successful in establishing a relationship as this was the first step to being able to identify signs of PPD in the mother. They felt how they needed to work harder to win their confidence compared to native-born mothers. Leininger describes how delivering culture care requires the nurse to be courageous and willing to go beyond her own limits and look at the world and her own work with new eyes (Leininger, 1991). The mothers had the impression that the CHS was mainly directed to the child's health and it was surprising for them to experience that the nurse was interested in how they were feeling. For the mothers the relationship and the perceived quality of the contact with the nurse were important for them when deciding to participate in the screening and finding it meaningful. Previous research found the quality of the relationship between the nurse and mother as crucial for conducting effective screening for PPD, particularly for immigrant mothers who need to feel comfortable with the process of screening to answer the questions honestly (Tobin et al., 2015).

Furthermore, the findings elucidate the nurses' strategies for interpreting the mother's mood. Both Leininger and Watson argue that there is no contradiction between scientific knowledge and other types of knowledge. On the contrary, they complement each other. Scientific knowledge is just one type of knowledge, and for a nurse it is a creative approach to use all forms of available knowledge as a basis for one's decision (Leininger, 1991, Watson, 1985). The nurses used the established transcultural relationship as a springboard for continuously interpreting the mother's mood during all visits to the CHC centre. When interpreting the mother's mood the nurses relied on their intuition, which gradually grew from observing and interacting with the mother and picking up details. The nurses especially focused on interpreting the look in the mother's eyes. Bearing this in mind, we see the need to develop new ways of transferring knowledge, which nurses gain as they constantly encounter context-specific patient care situations, from experienced nurses to less experienced nurses. The nurses also perceived it as vital to reach a high level of cultural knowledge to be able to interpret the mother's mood. Leininger emphasizes that in order to enable culturally competent nursing, the nurse needs to acquire theoretical knowledge of other cultures and ethnic groups. However, the nurses must

be aware that individuals within the group are different (Leininger, 1991). Despite their long experience the nurses occasionally perceived lack of cultural competence, which caused frustration among them. This frustration was previously found among CHS nurses who frequently interacted with children and parents of foreign origin, and it was explained by their higher awareness of other cultures which made it more likely to become conscious of various problems (Berlin et al., 2006).

Another finding concerns the nurses' challenges for assessing the mother's mood using the EPDS. The nurses perceived that the concept of PPD was not recognized in some cultures. This was confirmed by the mothers and the reason for offering the screening was in general unknown. The mothers felt reassured that the nurse would identify signs of PPD if they did not recognize suffering from it by themselves. In earlier research it has been shown that when immigrant mothers were made aware of services and had more knowledge about PPD, their access to help was facilitated (O'Mahony et al., 2012). Likewise, immigrant mothers articulate the need for written resources about PPD in their own languages and making them available on the Internet and in public places (Riggs et al., 2012). This raises the question of health literacy. The World Health Organization (WHO) points out that health literacy means more than being able to read pamphlets and being able to successfully make appointments. Health literacy is defined as cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health (World Health Organization, 2009). Watson draws attention to the significance of trying to understand the patient's unique reference frame and adapt the pedagogy in the nursing intervention to that understanding (Watson, 1985). Both nurse and mothers were positive towards the screening, but the nurses considered it challenging to adapt the screening without deviating too much from the original approach. The nurses experienced that the non-native-speaking immigrant mothers' educational level affected their ability to understand and fill out the EPDS. The use of Likert scales is known to be problematic for migrants with poor educational attainment (Flaskerud, 2012). It emerged that some of the participating mothers experienced physical symptoms such as back pain and aches. Such physical symptoms may be the expression of distress and could be missed when using a single-time psychological screening instrument (Lansakara et al., 2009). Furthermore, the expression of PPD in the EPDS are shown to be influenced more by the level of education and continent of living than by ethnicity and race. Women with lower education are less likely to report crying and self-harm and more likely to report anhedonia (Di Florio et al., 2017). The mothers perceived the questions in the EPDS as

normal but it appeared that some of the mothers had not been given the opportunity to speak about their answers in the EPDS. This could be related to the fact that they only gave “good” answers, leading the nurse to believe that they were feeling well and not in need of a trusting dialogue within the clinical interview. Recent findings suggest that immigrant mothers are more likely to report “good” answers on the scale, rather than one that might necessarily reflect their feelings or circumstances more accurately. “Good” answers portrayed the mother as happy and contented and coping with family and community demands. Happiness was also perceived as an indicator of marital relations. A contented wife conveyed a positive message to the outside world, being treated well by her husband. Women could not admit to feeling unhappy (item 7) without implicating their husband (Stapleton, Murphy and Kildea, 2013). The mothers were in general content with the interpreter who assisted them during the screening, but if they could choose they would prefer a female interpreter on-site to assist them. However, the nurses felt that the meaning of some items was perceived as difficult to communicate with or without the use of interpreter. This finding was previously presented by Stapleton et al. (2013), who question whether the EPDS is adequate for screening of immigrant mothers since the healthcare professionals are heavily reliant on the interpreter’s skills in translating or sometimes rephrasing the items so that they make sense to the immigrant mother in her culture-specific context. This highlights the need to explore the mother’s cultural environment (including education) and be careful and not stereotype mothers on the basis of their ethnic/racial background (Di Florio et al., 2017). As a complement to the more comprehensive assessment with the EPDS a verbal two-question screening tool for depression, relating to feelings of hopelessness or feeling down and lack of interest or pleasure, could be used (National Institute for Clinical Excellence, 2017).

Lastly, the findings elucidating the mother’s challenges to speaking about her mood, such as social stigma connected to mental ill health, negative expectations related to their perceived value as a woman, shame at not being grateful enough for their new life and negative experience of the interaction in connection with the screening. The CHS nurses can play an important part in decreasing the powerful stigma attached to PPD by giving customized information on several occasions about the condition. However, Watson emphasizes that the nurse needs to be aware of her own attitude and its importance for the patient not only for receiving the information but for processing it (Watson, 1985). Knowledge of PPD as social stigma may risk affecting the nurse when presenting the screening and make her hesitate for fear of jeopardizing the relationship with the mother. Understanding their

own barriers and challenges is a first step for health professionals in overcoming difficulties in working effectively with immigrant mothers (Donnelly, 2011). Leininger emphasizes the need to have a critical attitude towards your own culture in order to become aware of how it affects your view of health, quality of life and nursing (Leininger, 1991). Using the EPDS on this vulnerable group of mothers is complex and underlines the importance of a trusting dialogue within the clinical interview to be able to assess the mother's mood. The nurses were not able to encourage the mothers with symptoms of PPD to accept external help to any great extent, which sometimes was frustrating. If the mother agreed to accept help it was usually when being offering person-centred counselling led by her nurse. This finding concurs with earlier research, where mothers saw the community nurse as the most important source of support outside the family (Morrow, Smith & Jaswal, 2008). Watson emphasizes how the nurse, just by being present and supporting the patient in expressing herself and her feelings, gives a caring and healing intervention in itself. By listening to the patient without judging and without trying to avoid the feelings that come with it, the patient gets an opportunity to be herself and feel respected in her vulnerability. The nurse helps the patient to express herself and having her feelings validated, which increases her understanding of her own situation (Watson, 1985).

Conclusions and relevance to clinical practice

In order to be able to interpret non-native-speaking immigrant mothers' mood, a transcultural caring relationship needs to be established and deepened. The relationship is used as a springboard for continuously interpreting the mother's mood based on observations and interactions. The relationship and the quality of the contact with the CHS nurse are of importance for non-native-speaking immigrant mothers when deciding to participate in the screening and finding it meaningful. The concept of PPD and the reason for offering screening are somewhat unclear to most mothers, and cultural beliefs about mental ill health, negative expectations connected to their perceived value as a woman, shame at not being grateful enough for their new life and negative experience of the interaction during the screening challenges the mother in speaking about her mood. Lack of cultural competence caused frustration when trying to adapt the screening according to the given conditions and also when they tried to make the mother open or accept external help. Tacit knowledge appeared to be an invaluable asset when interpreting a non-Swedish-speaking immigrant

mother's mood. Based on the findings, we recommend: offering customized information about PPD and available support several times both verbally with the help of interpreter and in writing using translated material; providing assistance from an authorized female interpreter on-site during the screening; striving for a trusting clinical interview; and being attentive to challenges to the mother to speak about her mood.

Further research

The non-native-speaking immigrant mothers who participated in Study II all had a positive attitude towards screening. However, there is a great need to find out more about how mothers with a less positive attitude to screening experience participating and also what makes the non-native-speaking immigrant mothers decline participation.

The CHS nurses used intuition as a valuable complement to screening to identify signs of PPD in non-native-speaking immigrant mothers. It might be valuable to investigate ways to enable the transfer of tacit knowledge from experienced nurses to less experienced ones. Furthermore, based on the findings it would be interesting to develop and test an intervention directed towards the CHS nurses in more culturally sensitive screening for PPD.

Svensk sammanfattning

Postpartum depression (PPD) är ett globalt folkhälsoproblem. Mödrar som migrerar till ett annat land har en ökad risk att drabbas av PPD. Förekomsten av PPD bland utlandsfödda mödrar beräknas vara så hög som 20 procent, vilket nästan är dubbelt så hög som bland inhemsk västerländsk befolkning. Asylsökande och flyktingar är särskilt sårbara grupper som löper en ännu högre risk att drabbas, speciellt de som migrerat inom 10 år. Likaså de mödrar som inte talar språket i sitt nya hemland. PPD uppstår vanligtvis fyra till sex veckor efter förlossningen och kan ha långvariga traumatiska effekter inte bara på moderns egen hälsa utan även på hennes partners och framförallt på barnets hälsa och utveckling. Mot bakgrund av detta rekommenderar Socialstyrelsen att screening av nyblivna mödrar för PPD regelmässigt genomförs av sjuksköterskan i barnhälsovården (BHV) sex till åtta veckor efter förlossningen. Screeningen genomförs med hjälp av Edinburgh Postnatal Depression Scale (EPDS), som är en skala översatt och validerad till många olika språk. Skalan består av tio olika påståenden speciellt utvecklade för screening för PPD. Skalan används i kombination med ett samtal för att bedöma moderns psykiska mående. Vid screening av icke-svenskspråkiga mödrar instrueras sjuksköterskorna att använda ett översatt validerat formulär, ta hänsyn till moderns läs- och skrivkunnighet, tolkens arbete samt hur olika kulturella tolkningar av påståendena i skalan kan påverka resultatet. Screening av utlandsfödda mödrar har visat sig vara en utmanande arbetsuppgift för sjuksköterskorna. Tidigare forskning pekar på att dessa mödrar inte erbjuds delta i screening i samma omfattning som den inhemska befolkningen. Statistik visar också att invandarmödrar i större utsträckning väljer att tacka nej till att delta i screening och likaså att bland de som deltar är det inte så många som förväntat som screenas ut i förhållande till den höga förekomsten av PPD i gruppen.

Det övergripande syftet med studierna var att öka kunskapen om screening för PPD av icke-svenskspråkiga invandarmödrar genom att belysa deras och BHV-sjuksköterskors erfarenheter. Ett ändamålsenligt urval användes vilket innebar att deltagare med erfarenheter av ämnet erbjöds delta i individuella intervjuer. Det insamlade textmaterialet analyserades med latent innehållsanalys med induktiv ansats. Det är en deskriptiv kvalitativ

metod som syftar till att förutsättningslöst skapa kategorier och teman i avsikt att beskriva fenomenet för att öka förståelsen och kunskapen. Vid latent innehållsanalys tolkas även det underliggande budskapet i texten.

Med syftet att belysa hur BHV-sjuksköterskor identifierar tecken på PPD hos icke-svenskspråkiga invandarmödrar genomfördes 13 individuella intervjuer. Resultatet visade att en förutsättning för att kunna tolka den moderns sinnesstämning var etablerandet av en trans-kulturell vårdrelation som fördjupades. Sjuksköterskorna använde sig av kulturell kunskap för att uppfatta och tolka tecken på PPD i interaktionen med modern och i observationer av samspelet mellan mamma och barn, med tolken och anhöriga. Samtidigt orsakade bristande kulturell kompetens frustration hos sjuksköterskorna när de försökte anpassa screeningen efter de givna förutsättningarna och även när de försökte få mamman att öppna sig eller ta emot extern hjälp. Sjuksköterskorna förlitade sig även på sin intuition när de tolkade mammans sinnesstämning.

För att få kunskap om hur icke-svenskspråkiga invandarmödrar upplever att delta i screening för PPD i BHV intervjuades 13 med albanska, arabiska eller badinani som modersmål. Andra tolkar än de som användes i intervjusituationen lyssnade på ljudinspelningarna och validerade det utskrivna materialet. Resultatet visade att deltagandet i screeningen påminde mödrarna om deras brist på stöd i sin nuvarande livssituation, men sågs även som en möjlighet att erfarra andra sätt att tänka kring psykisk ohälsa och nya källor till stöd. Kvalitén på relationen med sjuksköterskan var av betydelse för om modern valde att delta i screening och uppleva den som meningsfull. Innebörden av PPD var i allmänhet oklar, men möjligheten att delta i screening och därigenom bli behandlad som alla andra mödrar uppskattades. Kulturella föreställningar om psykisk ohälsa, negativa förväntningar kopplade till sitt upplevda värde som kvinna, skam över att inte vara tillräckligt tacksam för sitt nya liv och negativa upplevelser av interaktionen i samband med screeningen gjorde det utmanade för dem att tala om sitt mående. Studierna visar att screening för PPD av icke-svenskspråkiga invandarmödrar kan underlättas av upprepad information om PPD både muntligt med hjälp av tolk, men även genom översatt material, ett förtroendefullt samtal med assistans av kvinnlig auktoriserad kontakttolk samt kunskap hos BHV-sjuksköterskor om olika utmaningar hos dessa mödrar för att kunna tala om psykiskt mående. Den förtrogenhetskunskap som erfarna BHV-sjuksköterskor besitter och använder sig av för att tolka icke-svenskspråkiga mödrars mående behöver ytterligare studeras. Det är också av intresse att undersöka om utbildning av BHV-sjuksköterskorna i kulturkänslig screening kan göra att screeningen av denna sårbara grupp av mödrar mer effektiv.

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