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A hermeneutic study of integrating psychotherapist competence in postnatal Child Health Care: Parents' perspectives

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ABSTRACT

A child's emotional and social development depends on the parents' provision of optimal support. Many parents with perinatal distress experience difficulties in mastering parenthood and seek help from professionals within primary healthcare. A clinical project was launched in Stockholm, where psychodynamic psychotherapists provided short-term consultations at Child Health Centers. This study qualitatively explored parents' experiences of perinatal distress and of receiving help by nurses and therapists in the project. Thirteen parents were interviewed, and their responses were analyzed with a hermeneutical method. Three main themes crystallized; accessibility of psychological help and detection of emotional problems; experiences of therapy at the Child Health Center; and the therapists' technique. Parents were also clustered into three so-called *ideal types*: the insecure; parents in crisis; and parents with lifelong psychological problems. Parents experienced obstacles in accessing psychological care within primary healthcare. Psychotherapists with a holistic family perspective and who managed to oscillate between insight-promoting and supportive interventions were especially appreciated. Patient categories who benefitted from insight promotion and support, respectively, were identified.

KEYWORDS

Child Health Centers, hermeneutics, parent–infant psychotherapy, postpartum depression, perinatal mood and anxiety disorder (PMAD)

1 | INTRODUCTION

Emotional problems among future parents, and among infants and their parents, are a widespread health issue. About 20% of parents report regulatory problems in their infants (Cierpka, 2016). Apart from the distress that this entails for the entire family, they are also associated with an increased prevalence of later child problems such as behavioral disorders and attention deficit hyperactivity disorder (Hemmi, Wolke, & Schneider, 2011). As for the mothers, depression during pregnancy is a common complication (Marcus et al., 2011), affecting 30 to 40% (Field, 2011). During the child's first year, depression afflicts mothers with a combined prevalence up to around 20%, and fathers with about half that number (Paulson & Bazemore, 2010). Depression among pregnant or newly delivered women is about as common as that for women generally in their childbearing years (Gaynes et al., 2005). One might therefore argue that perinatal depression is not entitled to any overstated attention by researchers and clinicians. There is, however, a vital counterargument: its associations with negative effects on fetus and child (Chronis et al., 2007; Field, 2010; Murray et al., 2010; Olson, Bates, Sandy, & Schilling, 2002; Stein et al., 2014). Depressed mothers exhibit more negative affects toward the baby (Field, Healy, Goldstein, & Guthertz, 1990; Tronick, 2007); less optimal dyadic states of consciousness (Weinberg & Tronick, 1997), affiliative behavior, attachment representations, and distress management (Feldman, Weller, Leckman, Kuint, & Eidelman, 1999; Leckman et al., 2007). In addition, their infants indicate less social engagement and play (Edhborg,

Lundh, Seimyr, & Widström, 2003), less mature regulatory behaviors, and more negative emotionality (Blandon, Calkins, Keane, & O'Brien, 2008; Feldman et al., 2009; Moehler et al., 2007; Weinberg, Olson, Beeghly, & Tronick, 2006) as well as less propensity to develop secure attachment patterns in early childhood (Toth, Rogosch, Manly, &Cicchetti, 2006).

These findings have stimulated efforts to detect perinatal depression early and to treat it via pharmacological and/or psychological approaches. Due to the intimate relationship of mother and child, therapies should preferably focus on parental sensitivity and positive parent–infant interactions (Bolten, 2013). In the parent–infant field, psychotherapies generally rely on psychodynamic and attachment theories and often include mother and baby, and sometimes also the father (Salomonsson, 2014a). Many therapy modes have been subjected to randomized controlled trials (Salomonsson, 2014b). Most methods have shown good results on mothers' mood, and some also on their sensitivity while effects on the baby were less conspicuous.

Concerning how women experience professional psychosocial support for postpartum depression, a systematic qualitative review of 17 Western World studies (Hadfield & Wittkowski, 2017) showed that women found it difficult to seek help in primary healthcare and mental health services. Barriers were reported from all countries; women felt dismissed by healthcare professionals, their self-perceptions were at a low point, and they thought that being an unhappy mother was shameful. In the United Kingdom, many women were unclear about the health visitor's role, which they believed only related to the child's well-being, and therefore believed that they should not discuss their mental health with her. Women often perceived healthcare services as underresourced and unable to meet their needs. Women who, nevertheless, had received a psychological and/or psychosocial intervention felt more positive and confident afterwards and experienced better relationships with their infant. Thus, it has been argued that perinatal healthcare staff should receive regular reflective supervision (Heffron, Reynolds, & Talbot, 2016; Salomonsson, 2019; Weatherston, Kaplan-Estrin, & Goldberg, 2009). This was also emphasized in an interview study with nurses (Kornaros, Zwedberg, Nissen, & Salomonsson, 2018).

1.1 | Clinical project and the treatment mode

Today's healthcare problem is not so much that we are unaware of the importance of detecting postnatal depression; the challenge is rather to organize healthcare and train professionals to enable more parent–infant dyads to come to qualified treatment at an earlier stage. Among parents, postnatal depression is still surrounded by guilt and shame. Among professionals, their lack of training in how to detect it and address it is a challenge (Gibb & Hundley, 2007; Heneghan, Morton, & DeLeone, 2007; Highet, Gemmill, & Milgrom, 2011; McCauley, Elsom, Muir-Cochrane, & Lyneham, 2011; Rollans, Schmied, Kemp, & Meade, 2013; Ross-Davie, Elliott, Sarkar, & Green, 2006). Aston (2002) highlighted new mothers' desire to be advised about mothering from healthcare professionals rather than obtaining information from their own social network. Yet, a U.S. survey has shown that about one third of mothers who received a postpartum checkup felt that their health concerns were not addressed (Declercq, Sakala, Corry, Applebaum, & Risher, 2002). Larkin and Biggerstaff (2018) described how women feel alienated and "not belonging" when they are transfered from a familiar environment in a midwifery-led unit to a more "medicalized" setting of a unit headed by the obstetrician. The authors highlighted the need of strengthening continuity of care, which could facilitate the adjustment process.

To address this challenge, a clinical project was launched in 2013 in Stockholm, Sweden. The aim was to integrate postnatal healthcare with psychological therapy. The idea was to lower the healthcare nurses' thresholds for detecting postnatal distress in parents and babies, and to facilitate referrals by placing psychotherapists at 11 Child Health Centers (CHCs). These are nationwide units, where almost all mothers come for regular checkups of children 0 to 5 years and with nurses specialized in pediatric care and/or public health. The therapists were psychoanalysts experienced in working with adults and parent–infant dyads. They should (a) supervise nurses to enhance their interest and skills in detecting and addressing perinatal emotional problems and (b) offer families "Short-term Psychodynamic Infant-Parent Interventions at Child Health Centers" (SPIPIC; Salomonsson, 2018) of one to five sessions at a CHC.

SPIPIC's psychodynamic framework implies considering the parents' conscious and unconscious attitudes toward each other and their child. It also focuses on the family interactions and the members' emotional attitudes vis-à-vis the therapist. The theoretical basis acknowledges that the biological imbalance in the postnatal period may contribute to emotional distress. Thus, it seeks to combine a natural and a human-scientific view (Boudreau & Fuks, 2015). SPIPIC theory recognizes that perinatal distress can be affected by biological causal factors, and in parallel, it can also be interpreted from an individualistic perspective in dialogue with the patient (Gadamer, 1975/1989). The therapist's interventions are geared mainly by a view that such distress is a *psychological crisis reaction* during one of life's most tumultuous and challenging periods.

1.2 | Research study

The research project comprises one quantitative study and three qualitative interview studies with nurses, parents, and psychotherapists. It encompassed the six CHCs that agreed

to take part in the research study. An outcome study will investigate the effectiveness of SPIPIC on mother-reported depression and infant social and emotional functioning. For that study, there will be 80 families in each group. The three qualitative studies were performed on smaller subsamples.

1.3 | Aims

In a previous study (Kornaros et al., 2018), the CHC nurses were interviewed. The present study aimed to primarily analyze *parents'* experiences of nursing care and psychotherapy at the CHC of emotional problems during the perinatal period. Second, we aimed to research which emotional problems the parents perceived in themselves, their babies, and their spousal relationship.

1.4 | Research questions

We aimed to address five research questions in this study:

RQ1. Which kind of distress made the parent seek help?
RQ2. How did he or she experience the nurse's reception?
RQ3. What were the parents' expectations of psychotherapy?
RQ4. How did therapy proceed?
RQ5. How did they experience the outcome?

2 | METHOD

2.1 | Ethics approval and consent to participate

Approval and consent were obtained from all participants prior to the interviews. The study received permission from the Regional Ethical Vetting Board in Stockholm (Dnr 2013/1311–31/3).

The interview questions could evoke uncomfortable feelings. Hence, the interviewer pointed out that the informant was welcome to raise such worries or questions during or after the interview. In cases of sensitive information, we used pseudonyms to protect the identity of the informants.

2.2 | Sample selection

Psychotherapists at the CHC provided SPIPIC to families that had been recommended by their CHC nurse to get help for their perinatal emotional distress. Inclusion criteria were that a parent had received SPIPIC treatment and had mastered Swedish or English. Exclusion criteria were postpartum psychosis, drug addiction, child developmental inhibition, or child neuropsychiatric disorder. The diagnostics and symptoms were evaluated by the CHC nurse, who assessed if the patient should be recommended to see the psychotherapist. The decision as to continue working with SPIPIC rested upon the therapist.

The interviewer asked each psychotherapist to suggest candidate parents of varying age, gender, country of origin, educational level, emotional problems, treatment durations, and outcomes, as assessed by the therapist. Of the 28 proposed parents, 7 were unavailable, and 5 declined to be interviewed. Of the 16 remaining participants, 13 were interviewed (9 mothers, 4 fathers). Parents' mean age was 34 years, and their educational mean was 14.2 years. The infants included 7 girls and 6 boys, with a mean age of 6.4 months when therapy started. After 13 interviews, we estimated that we had reached saturation for the qualitative analysis; problem constellations started to reoccur among the interviewees (e.g., parental insecurity and triggering factors for their crisis).

2.3 | Procedure

Informants were recruited in the Stockholm area from three CHCs, whose catchment areas had an acceptable geographical and socioeconomic variability. Each CHC hosted three to eight female nurses specialized in pediatric care and/or public health. Every family had been routinely assigned to a personal nurse. Interviews took place December 2015 to January 2017, and were done by the first author.

2.4 | Interview format

Interviews took place at the CHCs. First, the interviewer went through the study aims and clarified routines of confidentiality. Participation was voluntary, and if a parent decided to leave the study, his or her data were deleted. All participants consented by signing an agreement. The interview format was built on 10 questions posed in an order that suited the topics broached by the parent. When relevant, the interviewer could probe further into one area. Interviews lasted 1 hr and were audio-recorded and transcribed verbatim.

2.5 | Interview questions

We asked the participants 10 interview questions:

1. What was your concern that made you get in contact with the psychotherapist?
2. How do you think the CHC nurse paid attention to your concerns?
3. Which expectations did you have on the therapy?
4. How did you feel meeting with the therapist for the first time?
5. How did you feel the therapist approached you in the first session?
6. How did you experience the ensuing sessions?
7. If more family members took part in sessions, which person(s) did the therapist focus on?
8. How was therapy termination brought up?

9. When you look back on the therapy, how did it match your expectations?
10. What did your CHC nurse contact mean to you?

2.6 | Data analysis

We chose a hermeneutic approach, which is well-represented in the nursing literature (Charalambous, Papadopoulos, & Beadsmoore, 2008; Debesay, Nåden, & Slettebø, 2008; Fleming, Gaidys, & Robb, 2003; Lopez & Willis, 2004; Thomson, Dykes, & Downe, 2012) and in studies of specific perinatal experiences (Crowther, Smythe, & Spence, 2014; Grassley & Nelms, 2008). More specifically, this study relies on Gadamer's (1975/1989) hermeneutics, according to which one approaches truth by entering an unfolding "dialogue" with the material. The interpreting researcher is bound to rely on language and traditions; that is, an ongoing process of understanding one's experiences (*Erfahrungen*); truth develops as we speak with each other, and question our preconceptions. Our historical awareness also contributes to deepening how we understand phenomena.

Gadamer (1975/1989) valued a systematic approach to understanding, in which the researcher structures the research process. Yet, an interviewer cannot but "fall into" (p. 401) a conversation with his or her respondent because a genuine dialogue will never be "the one that we wanted to conduct" (p. 385). Instead, our understanding will emerge through fusion of our and the respondent's *horizons*. The researcher strives for horizons to approach, or even fuse, in a *hermeneutic spiral* that deepens his or her understanding. Accordingly, an interpretation will always depend on who the interpreter is, when and where the interpretation was made, and so on. We sought to achieve such fusions by creating a group of interpreters from different professional traditions: one social worker, two midwives, and one psychoanalyst.

We worked according to a Gadamerian research strategy outlined by Fleming et al. (2003). Every group member began with a naïve reading, which aimed to find expressions that reflected the fundamental meanings of an entire text. Second, we met as a group and analyzed three interviews each time, and started to uncover themes. Sentences and sections were investigated to expose their meanings. Next, we related every sentence or section to the entire interview's meaning, which thus expanded. The last stage involved identifying passages that were representative of the shared understanding between group members. When we encountered a paradoxical statement, our interpretations relied on a combination of what the informant objectively said and what our subjectivities indicated.

We also applied an abductive approach (Houser & Kloesel, 1998; Tavory & Timmermans, 2014) of identifying ideal types. Based on the information about the participants, we categorized the participants into clusters according to a method introduced in sociology (Weber, 1904) and psychotherapy research (Kächele, Schachter, & Thomä, 2018; Wachholz & Stuhr, 1999). The aim was to discover typical cases and to label them with succinct expressions. The concept has nothing to do with ideal as in "perfection." Instead, it represents the world of ideas and cannot be found in reality. It is thus a concept arising in the observer's mind through a process of induction (Wachholz & Stuhr, 1999).

3 | RESULTS

All names are pseudonyms. When an informant mentions the therapist's name, we have replaced it with "Anna." The hermeneutic analysis crystallized into three main themes: (a) accessibility of psychological help and detection of emotional problems, (b) experiences of therapy at the CHC, and (c) the therapists' technique. The abductive analysis clustered the parents into three ideal types: the insecure; parents in crisis; and parents with lifelong psychological problems. RQ1 ("Which kind of distress made the parent seek help?) and RQ2 ("How did he or she experience the nurse's reception?") have been answered in Theme 1 and by the clustering of ideal types. RQ3 ("What were the parent's expectations of psychotherapy?"), RQ4 ("How did therapy proceed?"), and RQ5 ("How did they experience the outcome?) were resolved in Themes 2 and 3.

3.1 | Accessibility of psychological help and detection of emotional problems

3.1.1 | Difficult to get psychological help

Parents brought up that it was difficult to get to a CHC that provided specialized psychological care. *Lucas*, a father of a 6-month-old baby, was a well-functioning man with a good social network. Now he was in a profound crisis after delivery when his wife unexpectedly passed away.

> ***Lucas**: I call and ask them if there's someone I can talk with. Then they call me from X [a hospital] and I describe the situation on the phone. Then I get a referral or something. I don't know, I should go to X and meet someone there. Then I get to talk with some psychologist for half an hour, who … And I thought I was supposed to get counselling, to get help so to speak. But he was only there to send me to this counselor whom I eh, experienced, was not what I needed! … I felt that the people I met were, like, they just sat there and weren't interested.*

3.1.2 | Detection and therapy: A long take-off

Parents also brought up their inability to express their emotional concerns, and expected the CHC nurse to capture them.

Sometimes, reality overturned these expectations. *Martin*, a father of a 3-month-old daughter, struggled with his feelings about his partner's postpartum depression. He had eight SPIPIC sessions, the last one including the baby girl. When asked if the nurse had paid attention to Martin's worries before therapy started, he answered:

> *Eh … well she did, but I can sense it is both ways, it took time until she realized. Perhaps I wasn't good at telling her. It wasn't like [snapping fingers] she got it instantly, that "this couple is in crisis, now I have to use this resource [the therapist]." Rather, it was a long take-off.*

The challenge with addressing one's problem with a nurse was not due to any mistrust. Rather, parents had different views of the psychotherapists' and the nurses' competences. They imagined that the nurse should handle the child, and the psychotherapist should handle the parents. Still, they wanted the nurse to detect their emotional problems and then refer to the therapist. When she did this, parents expressed an increased faith in her commitment. In contrast, they would not have felt confident if the nurse had suggested to receive them herself in family counseling. In fact, they did not even know that such counseling was included in her duties, and they doubted that she had the qualifications in talking about emotional problems. *Ulrika* went five times with her baby to the therapist. She was an anxious and sad mother and had difficulties with the transition to motherhood.

> *I think, she [the CHC nurse] doesn't have the experience of talking to people that way. She has this role of giving advice and handy tips on how to take care of children. But eh, I don't know. It's possible that she could have managed that, too. It also has to do with how open she is to receive [if I were to tell her about my problems].*

3.1.3 | Caring about the whole package

Fanny, a mother of a 5-month-old boy, had three sessions, one including the baby. She had a traumatic delivery, obsessive thoughts of harming the child, and difficulties with the transition to motherhood. Fanny described her CHC nurse as professional due to her ability to detect her distress. As a first-time mother, she did not know whether her absence of feelings towards her child and her doubts about her maternal capability were "normal or not." The nurse's ability to detect her distress made Fanny view her as "even more professional … she didn't just care about my son's development but the whole package."

Donna was an immigrant and had an emergency cesarean section followed by mastitis, paranoid thoughts, anxiety, and sadness. She also had a lifelong exposure of domestic and marital violence. She was satisfied with being asked about her emotional problems during the second appointment at the CHC. This resulted in eight SPIPIC sessions with her 6-month-old boy present.

> *She [the nurse] asked me "how [is it at] home, how does John [the boy] sleep?" [She asked] if I was fine and I told her "hmm, not so good." Suddenly, I exploded and started to cry. And she said, "what happened to you?"*

When the parents finally got in contact with the therapist, they often expressed this in terms of "luck." They were aware of the difficulties in getting an appointment with a therapist in primary care, which made them less prone to signal their problems. Thus, the nurses' skills in making contact with the parent and detecting his or her emotional worries and addressing them were all crucial for being quickly referred to the psychotherapist. There were thus two obstacles to getting qualified psychological help: to access a healthcare unit where such help was offered and to meet a nurse who observed and addressed her or his problems.

3.1.4 | In a middle-land

Jenny was a mother of a 1-year-old boy at the time of the interview. She had a good relationship with her husband, but a poor social network. She was sad and exhausted, with a faint interest in playing with her 4-year-old child. She was on selective serotonin reuptake inhibitors since delivery. She said it was hard to get therapeutic help since she was in a "middle-land;" she was not "bedridden," but still felt sad.

> *I called Y [a psychiatric unit] but it felt like "it has to be an emergency to get help." That's why I thought of trying it out here, because I knew there are some links [between her emotional state and the possibility of receiving psychological care at the CHC]. I didn't know if I … if it [this CHC] was suitable for taking care of my problems or if it had to be… . So it was pure luck! [The nurse] said they had a fantastic opportunity with someone [the therapist] actually coming here every week.*

3.2 | Experiences of therapy at the CHC

3.2.1 | Facing an unknown psychotherapist

Some parents had no one with whom to share their emotional burdens. All her life, Fanny had felt like a "parent to her mother" until her mother died in Fanny's early adolescence due to alcohol and substance abuse. The therapist was seen as a professional outsider who could get through Fanny's

isolation. This required that she was prepared to disclose the problems and be honest with the therapist.

> *It was a trial, to bare myself to a person I'd never met before … to reach a meeting on a higher level.*

Relatives and friends seldom had time to listen to the parents' concerns, or they brushed them aside. Once they met the therapist and managed to cross the barrier of uncovering themselves to an unknown person who empowered them to talk truthfully, it was essential in helping them.

In contrast to Fanny, *Nils* could not open up to the therapist during his three sessions. He could not "read" his 15-month-old son and needed to rely on concrete signals such as the time of the day, rather than the boy's behavior, to determine if he was hungry. Nils had lifelong psychological problems and low self-esteem. During the interview, he spoke incoherently of his suspicions about the helping profession. He emphasized the nurse's positive attributes and thought she could take care of everything concerning his and his child's well-being. To the interviewer, he seemed an insecurely attached person who depended profoundly on the nurse. We interpret that this made him less interested in receiving help from an unknown therapist since this also would have implied being abandoned by his nurse.

3.2.2 | Expectations of therapy modes

Most parents said that they had no expectations of the therapy in advance. Lucas implicitly voiced contrasting opinions by first saying that he had no expectations. Then he said therapy is "an effort at taking responsibility of one's mental health." The following statement suggests that he viewed the therapist as an expert.

> *I thought the therapist should … assess that I was doing well and that I would make it.*

The SPIPIC model was experienced as vague in content and aims and having unclear frames. Yet, as sessions progressed, therapists and parents seemed to work out common goals and procedures. SPIPIC also was said to be "dynamic and unconstrained," and this was felt to be "relieving and frightening at the same time" (Martin).

Nils wanted the CHC nurse to be cognitive behavior therapy (CBT) trained to "extract the demons," by which he meant uncovering early and anxiety-provoking experiences. He did not seem to recognize these opposing expectations. Ulrika had explicit thoughts about various therapy modes and was hesitant about the SPIPIC model, but her position changed during treatment. First, she was impatient and annoyed about "not getting anything out of it." Later, she appreciated that the therapist let her speak out and confirmed and normalized her distress by "taking the sting out of it."

> *She [the therapist] was not [using] the CBT-thing with a "quick-fix" at all. Her approach seemed to be more like accepting, "this is a huge adaptation in life, a lot has happened in a short time, no wonder you are feeling tired."*

When Ulrika doubted her feelings and questioned herself, the therapist empowered her to "feel it and talk about it instead of finding a quick solution to get rid of the anxiety."

3.2.3 | The baby in therapy

Some parents brought their child to the sessions because the nurse had suggested it; others brought them simply because it was practical. The interviews did not clarify how often the therapists encouraged parents to bring their babies. Parents whose babies were present in the sessions felt comfortable and appreciated that the therapist also observed and addressed the baby, particularly when they had bonding difficulties with the child. Primiparous anxious mothers were relieved by the therapist's affirmative way of overseeing the interaction.

> ***Ulrika**: She [the therapist] was pretty affirmative and said, "You know what's best. What I see is a content baby. He doesn't scream much, you give him food, you dress him, you take care of him." She was very affirmative and said, "You do it right, continue like this." I needed to hear that.*

Lucas brought his 6-month-old son to the sessions. Bringing the baby to therapy was part of the healing process after his wife's death.

> *Sometimes, her [the therapist's] focus was a lot on him [the baby] and so, but it didn't matter much. It yields … yielded a different dynamic than if we had been alone [the therapist and Lucas]. He was such a big part of my [mourning] work, so it was quite natural to include him.*

Some mothers' bonding difficulties were aggravated by their traumatic delivery experiences and the guilt that this generated. By bringing the child, they could get feedback on the mother–child interaction and talk about their worries of not being a good-enough mother.

> ***Fanny**: I barely dared to touch my son, because I was scared to harm him again as I thought I had done [during delivery] since it ended with a*

> *vacuum extraction… . In one way it felt that she [the therapist] focused more on the interaction between me and him [the baby]. I think that was good because she probably got a wider perspective. She could see that he was doing well with me even if I doubted it. I reckon that as something positive and a little step forward for me.*

In our interpretation, the traumatic delivery had damaged the mother's belief in her capacities as a woman and mother. Having had an alcoholic mother in her teens and now no mother at all to rely on also made it difficult for her to identify as a mother and bond with the child. Furthermore, perhaps her obsessive thoughts of harming the baby made her feel guilty. The therapist's affirmative comments decreased such negative feelings, and she reported a better mother–child relationship.

3.3 | The therapists' technique

3.3.1 | Insight-promoting versus supportive interventions

The informants gave a varied and rich picture of the therapists' modes of working, which appeared to alternate between two kinds of interventions. In the *insight-promoting* mode, they called in question the parent's established thoughts and suggested new perspectives, with the aim of helping him or her to uncover unconscious conflicts, affects, and attitudes. *Georgia*, a mother of a 1-month-old girl, had paranoid thoughts after a traumatic labor. She feared being attacked or abducted, or that someone would grab her daughter and throw her to the ground. Georgia had two sessions with the baby and said, "The therapist talked truthfully to me." The therapist had given her insight about the roots of the paranoid thoughts:

> *She [the therapist] brought up, she made me realize that I had changed as a person; from being very tough and strong [before pregnancy] to now when I've become a mother. I've someone to take care of and I must think things through more properly and see any danger coming up… . On top of that, I was injured [during delivery] and I couldn't escape from it! … I felt she understood me when she said, "Earlier, you were tough and now you feel vulnerable." It felt like everything got clear, crystal clear.*

Georgia had not realized that her physical fragility made her emotionally brittle. This fragility was taxing for her, with a self-image of "tough woman." The therapist helped her see the connections between the traumatic delivery, the change in her self-image, and her fantasies of being attacked. She reacted to these interventions both with an interest what a new piece of insight may elicit, and with a feeling of support because the therapist understood her. In contrast, the therapist did not seem to assist her in more deeply investigating the roots of Georgia's fantasies about her baby being harmed. One could interpret that they also contained elements of unconscious resentment or hostility towards the baby. Yet, such an investigation was not mentioned by Georgia. One could say that her "crystal clear" insight reached down to a certain level, beneath which she and the therapist had not probed.

Tina brought her 2-month-old baby to the three sessions, two of which were extended to couple therapy. She had grown up in a dysfunctional home with substance abuse and had been involved in destructive love relationships. While pregnant, she was ambivalent about keeping the child. During therapy, Tina was also ambivalent about unveiling her past.

> *We [the therapist and I] perhaps didn't have a great contact but I perceived that still … still she knew her thing. She snatched up the few things I said, and yes she could, interpret them reliably.*

Tina was asked to give an example of the therapist snatching up:

> *This thing about wanting the baby or not, it also has to do with my trust in others and … I had thought of starting to focus on myself in life, and now it didn't turn out that way [because of the pregnancy]. I hadn't thought that far myself.*

Tina now lived with "the kindest man in the world" and lived the life she had longed for. She appreciated that the therapist clarified the conflict between these wishes and the arrival of a baby. In contrast, she experienced the therapist's supportive approach and advice on breast-feeding as redundant:

> *I felt it wasn't her thing to give me advice about it… . These sessions were supposed to be about me and not about my breastfeeding.*

Nevertheless, Tina felt fine with this advice because the therapist acknowledged that she had focused too much on breastfeeding. We interpret that the therapist's allowable manner and sincerity also made Tina feel comfortable with the thought that honesty with oneself is essential. This made her less anxious when talking with the therapist about her inadmissible negative feelings toward her child. If, as we interpreted in Georgia's case, the fantasies of harm being done to her baby also were rooted in unconscious hostility, then this was not made explicit in the sessions. In Tina's case, embarrassing feelings came out more in the open, which helped her acknowledge that she had felt uncomfortable with having her child, who competed with her wishes of living a life of her

own. The therapist's insight-promoting approach seemed to be of help to both Georgia and Tina.

In the supportive mode, the therapist followed the parent's narrative and gave positive feedback and advice. The aim was to strengthen his or her self-esteem, and decrease guilt and feelings of being abnormal. Jenny had a tense relationship with her 4-year-old daughter when the second child was born. She was tired and found it difficult to cope with the big sister's jealousy.

> *I didn't even think it was fun having kids, so I got sort of … I was obligated, and then when I got to speak to Anna she gave me a more open picture like: "You do the best you can [as a mother] and having siblings is tough… . Elsa [Jenny's 4-year-old] is longing for her mother and you are longing for her." We also got concrete advice, such as me having time only with Elsa.*

In this quotation, the therapist did not address Jenny's ambivalence towards motherhood. Instead, she empowered her as a mother and backed up with the advice of being alone with her older daughter sometimes. The citation earlier from Ulrika's interview also exemplifies a supportive approach, with her therapist's affirmative comment: "You do it right, continue like this."

The supportive approach also implied confirming the parent's feelings. *Iris* had quarrels with her husband and two daughters, and felt lost in her parental role. She had two sessions of couple therapy and six sessions with the psychotherapist alone:

> *She [the therapist] said: "You are simply bullied in your present family, alienated from the others. [She did not mean] that anybody did it knowingly but that's how it was, really. I recall it was a relief to hear because I wasn't sure about those [feelings] either.*

The therapist might have questioned Iris's part in the quarrels, but chose not to. We interpret this as a supportive intervention in that it aimed at acknowledging her perceptions and feelings. This might, at least temporarily, enhance Iris's self-esteem.

3.3.2 | Receptive and proactive style

The therapists also alternated between a *receptive* and a *proactive* style. The former term implied the therapist's technique of listening and reflecting on the interaction between the persons in the room. The latter term comprised a more prescribing style in which the therapist interacted more actively with the parent. No therapist belonged to one single category, but some seemed more prone to oscillate between the two. A citation by Lucas portrays a receptive attitude:

> *I recall that she was, eh (long silence). She was happy and pleasant and receptive and listening and asked a little… . I never got the impression that she had a plan like "we shall fish Lucas through this serpentine until he reaches goal."*

It was unclear to what extent parents who appreciated the receptive approach did this because they thought it would enable the therapist to reflect on their communication and promote insight into their suffering, or if it would give the parents leeway to talk without being interrupted by any challenging interventions. Indeed, some informants found the therapist's receptive and silent attitude supportive rather than insight-promoting. The reason was that they wanted company and confirmation by a therapist they could talk *to*, not *with*. Paradoxically, this did not prevent them from being frustrated by the therapist's passivity and silence. Nils thought his therapist was too receptive, not supportive, and did not lead him into talking by asking questions. On the other hand, he feared that she might become too active in "letting out my demons." Thus, much ambivalence toward the receptive approach emerged.

The proactive approach was described by one informant as "tough love—psychology-style." Jenny talked about her therapist as being "concrete" in that she talked straight and contested and questioned a certain statement or description:

> *I felt she understood the problem quickly and she is ehm, she is quite concrete. It isn't so woolly. Instead she put it straight like this: "It sounds as if you've a very negative view of yourself." I needed to hear that most of all, I think… . She didn't take me down a peg because she listened very much, but it was indeed like she said, "We have to break this pattern."*

Therapists seemed to work according to diverse modes with the same patient. For example, Jenny's therapist worked in the proactive ("concrete"), supportive ("like a cozy grandmother"), and receptive ("listened very much") modes. The difference between the receptive and the proactive approaches are illustrated by how Lucas and Jenny spoke of their therapists. Lucas's therapist did not seem to work according to a plan on how to cope with his grief and loss; she did not "fish" him to reach "goal." In contrast, Jenny's therapist possibly had a plan of breaking a maladaptive pattern.

3.4 | Ideal types

During the analyses of the interviews, three ideal types crystallized; the insecure; parents in crisis; and parents with lifelong psychological problems. Each type will be illustrated by a typical case.

3.4.1 | The insecure

This type included primiparous mothers who had difficulties with their transition to motherhood. They were uncertain if they could love and take care of their child. They often had low self-esteem, questioned their parental skills, and were concerned about what other people might think and say. Some had obsessive thoughts of harming the child, and some had paranoid ideas of being attacked with their baby. The delivery was often traumatic. Some had grown up with a dysfunctional parent.

Nora grew up with a father described as "a psychopath." She was in personal therapy for 2 years with a therapist who was not specialized in parent–infant interactions. Nora had a 7-month-old daughter and was worried that their interaction was unsatisfactory. In her view, there were three kinds of parents; the ones who "don't even have a cell phone at home because they want to protect the child from radiation," the "sound parents" who can assess the risks in a realistic way, and "the super-analyzing parents," like herself, who keep asking about every risk. When driving her car, she let her daughter use the iPad so that she could focus on the traffic, but she felt guilty about it:

> *When you are an insecure person and feel "Am I good enough?", "Is it OK to do like this or will I lose the child," then you give all your trust to one person and to what she says… . At that time, Anna was like a judge in the court who said like, "Nora, you are not a bad mother. A lot of people let their babies watch iPad and you're not the only one."*

Nora was satisfied with the therapist's comments. To this day, she felt like "hearing Anna's voice inside" signaled that her way of taking care of the infant was fine, as long as she "had a good intention" behind her iPad policy. After one session, she returned to her ordinary therapist because Anna confirmed that her interaction with the baby was fine.

3.4.2 | Parents in crisis

These parents felt like they had been tossed into shocking responsibilities due to their partner's factual or emotional absence. They appreciated the therapist's receptive approach, but initially were more hesitant. They had expected to be given advice and tools, "like in CBT" as one informant stated, and some thought that they received poor directives by the therapist. Martin, whose life was chaotic, requested an explicit therapy agenda. In our interpretation, he needed a fixed frame such as knowing about frequency of appointments, length, and aims of therapy. He concluded that when the therapist asked if he wanted another session, she actually did not want to see him again. We placed Martin in this type because his partner had a serious mental breakdown after delivery:

> *We got a huge crisis a month after she got a baby. It was this thing with breastfeeding difficulties and she got a fever from the wound. She was so ambitious about breastfeeding, which led to a burnout. She broke down physically or mentally, so she was hospitalized as an emergency.*

Martin talked about his "harsh loneliness," which prevented him from celebrating the arrival of the child. In contrast to his uncertainty about the therapist's willingness to see him again, he appreciated that she provided a scheduled meeting every week. He felt that she was the only one he could talk to about the troubles with his wife.

3.4.3 | Parents with lifelong psychological problems

These parents reported feeling like outsiders and being exploited since childhood. They had very low self-esteem and felt branded as "second class client" (Nils), "worthless human being for sale" (*Omar*), and "bloody immigrant" (Donna). Some had received psychiatric care without feeling helped. They reported having "buried their demons" (i.e., traumas and painful memories) and also felt alienated from society and its privileges. Omar immigrated 15 years ago. He had a traumatic experience of his daughter's emergency delivery and had four sessions with the therapist. He felt inexperienced with the healthcare system and also exploited by it:

> *I'm like a machine. You buy it, you use it, then when it gets old, you throw it away. You don't even look at it again.*

These parents suffered from childhood trauma. Now, they reported paranoid and obsessive thoughts, attention difficulties, and spoke incoherently in the interview. The immigrants also had language limitations. They claimed that the therapist listened and gave advice, but it was not enough. Either they could not open up to the therapist or they had difficulties in making use of her response.

4 | DISCUSSION

If parents with perinatal distress need to meet with a qualified psychotherapist, this will often come about by referral to a unit separate from the CHC. To bring psychological and somatic healthcare into closer cooperation, a clinical project was launched; parents with babies who revealed their emotional distress to their CHC nurse were suggested to see a therapist

onsite. The project thus aimed to integrate routine healthcare with brief psychotherapy and to enhance the competence and the incentive among nurses to handle perinatal psychological problems by receiving reflective supervision (Salomonsson, 2019; Weatherston et al., 2009) by these local therapists.

This study investigated parents, who were interviewed about how they experienced psychological support within this new framework of healthcare. The interviews were transcribed and analyzed via a hermeneutic procedure in which themes were extracted inductively and labeled into three themes: accessibility of psychological help and detection of emotional problems, experiences of therapy at the CHC, and the therapists' technique. We then clustered parents into ideal types according to their similarities in symptoms of distress; "parents insecure about parenthood," "parents in crisis," and "parents with long-standing psychological problems."

We will present the discussion under the following subcaptions: (a) how parents experienced baby worries and their expectations and experiences of SPIPIC therapy, (b) how they experienced the role of the nurse, and (c) which measures could be suggested regarding organizations and professional skills to enhance the quality of perinatal mental healthcare.

4.1 | Baby worries: Experiences and expectations of help

Parents who were insecure about parenthood (Ideal Type 1) and in crisis (Ideal Type 2) spoke more positively about therapy and the therapists than did parents with lifelong psychological problems (Ideal Type 3). This is unsurprising since the interventions were brief—on average, seven sessions—which was too short to alleviate the Type 3 informants' difficulties with attention, stress regulation, and shame. Such overt symptoms were easy to detect, but the nurses and therapists seemed unaccustomed with handling them. Some appreciated that the therapist was kind and offered advice, but their distress and incoherence seemed hard to deal with in short-term therapy. A parallel process (Morrissey & Tribe, 2001; Searles, 1955) was noted by the interviewer; she became comforting and had difficulties sticking to her questions and frame, a relational pattern that these informants also reported from their contacts with nurses and therapists.

The challenges for parents of Types 1 and 2 were different from those of Type 3 parents—to tell the nurse about their distress, which seemed to come out of the blue and made them fear that they were crazy. Their initial silence was mainly related to shame, guilt, and a sense of shock in the new life situation. In the interviews, they blamed themselves for not having told the nurse earlier. Had they been more outspoken, the situation would have gotten less severe. Nurses seemed to differ in their skills in detecting these parents' problems. One evident reason was that these parents' symptoms were less conspicuous than were those in Type 3 parents.

To explain the varying therapy experiences among Types 1 to 3, we emphasize their *characterological differences*. We invoke a well-researched paradigm; the division into anaclitic and introjective characters (Blatt, 1992). The two reflect a "fundamental polarity between relatedness and self-definition" (Blatt & Zuroff, 2005, p. 465). The anaclitic type depends on other people and needs to obtain their approval. This type seems related to an anxious ambivalent attachment (Werbart, Brusell, Iggedal, Lavfors, & Widholm, 2016). The introjective type focuses on perfectionism and autonomy, and is linked with avoidant attachment. People with anaclitic traits primarily utilize avoidant defenses whereas those with introjective traits use "counteractive defenses" (Blatt, 1992, p. 696) such as intellectualization and reaction formation. Blatt's articles and other studies applying this typology to young adults (Werbart et al., 2016) support that our Types 1 and 2 parents had more introjective traits, and our Type 3 parents had more anaclitic traits. To illustrate, we bring out the difference between Nora's brooding whether she was a good-enough mother with Nils's clinging relationship with his nurse.

This typology has an interesting relation to the transition to motherhood, a period of life that challenges the woman to reassess "issues both of self-definition and interpersonal relatedness" (Besser, Vliegen, Luyten, & Blatt, 2008, p. 398). These issues correspond well with the introjective and the anaclitic types, respectively. Besser, Vliegen, Luyten, and Blatt (2008) studied postnatally depressed mothers and found that self-criticism was related to postpartum depressive symptoms. In contrast, dependency seemed to reduce its development if the mother was able to enlist social support from family members and the nurse. Such support raised their self-esteem and diminished their loneliness and depression.

Individuals with introjective traits respond better to insight-oriented therapy, especially long-term, (Luyten, Lowyck, & Blatt, 2017) whereas anaclitic patients benefit more from supportive psychotherapy. In the area of perinatal therapy, Salomonsson and Sandell (2011) showed that mothers typed as "Participators"—characterologically similar to Blatt's introjective persons—improved their sensitivity more by mother–infant psychoanalytic treatment (Norman, 2001) than by standard CHC care. Such differential effects were not found for the "Abandoned" type corresponding to mothers with anaclitic traits.

The polarity of anaclitic/introjective was reflected in our interviews. Type 3 informants appreciated that the therapist was "kind" and "gave advice." In contrast, Types 1 and 2 appreciated a more insight-oriented intervention. They were prepared to "cross the barrier," as one informant put it, to overcome embarrassment, guilt, uncertainty, disappointment, and so on connected with how they experienced parenthood. This readiness seemed to be a condition for reaching "a meeting on a higher level" with the therapist, as one mother expressed.

The interviewer also asked about the parents' *expectations* of therapy. Some denied having any. Others expected expert advice or a "CBT-like" therapy. They were surprised that, nevertheless, the SPIPIC sessions with "vague content and unclear frames" were beneficial. They were also helped by the psychotherapist's neutrality, defined as an attitude of "keeping the countertransference in check, avoiding the imposition of one's own values upon the patient, and taking the patient's capacities rather than one's own desires as a guide" (Moore & Fine, 1990). This enabled parents to talk "with someone I'd never met before." The quoted mother felt listened to and relieved of her guilt and self-absorption by a therapist whom she experienced as nonjudgmental and empathic, both being ingredients of therapeutic neutrality. Expressed in other terms, patients like this mother had enough of a mentalizing capacity and "epistemic trust" (Fonagy & Allison, 2014) to appreciate taking part in an exploration of their conflicting emotions and behaviors.

Another aspect of neutrality—that of being reticent and nonresponsive—was problematic for Type 3 informants. When one man in this group described the therapist as "exhausted and withdrawn," this might reflect such sensitivity. His dependence on the CHC nurse, in our interpretation, points to substantial anaclitic traits. He preferred being offered something by the therapist, and therefore her neutrality induced anxiety.

Thus, far from every parent "crossed the barrier" and opened up to the therapist. In our interpretation, the therapists would need to quickly consolidate a central preoccupation or a "core conflictual relationship theme" (Luborsky & Barrett, 1994). She or he needs to be flexible in technique (Owen & Hilsenroth, 2014); that is, adapt to the client's mood and readiness to open up. This may imply that she or he will oscillate between insight-promoting and supportive approaches, and receptive and proactive styles. Many parents expressed such wishes. In terms of the two personality configurations, the therapist–patient match is essential for therapeutic outcome; that is, "the therapists' early adjusting their orientation on relatedness or self-definition to their patients' predominant personality configuration" (Werbart, Hägertz, & Ölander, 2018). We claim that such therapeutic agility is essential, especially when parents have tumbled into an unexpected crisis situation from which they want to emerge quickly.

The therapists had difficulties mostly with Ideal Type 3 clients. A problematic background with traumas and/or childhood disorder may have made this group fragile and wary of therapy. This, in combination with their anaclitic traits, would make them need more support than insight from the therapist. This is in unison with findings by Sandell et al. (2000); therapists who reported working with a more insight-oriented psychoanalytic technique had less optimal results than did colleagues reporting higher on kindness, support, and so on. These authors warn therapists against an uncritical transfer of the psychoanalytic stance into psychotherapeutic practice. Perhaps Type 3 informants were especially sensitive to such a reticent, "anonymous" therapist stance. We aim to shed more light on the therapists' contributions in an upcoming interview study.

When the therapist is working in low-frequency and brief treatments, she or he needs to consider the extent to which she or he should be receptive or proactive. The value of the proactive approach, has been discussed in a review by Camoirano (2017). One way of working proactively is to inspire the patient to reformulate the problem, somewhat similar to Socratic questioning (Garefalakis, 2004; Paul & Elder, 2008). Applying Paul and Elder's (2008) scheme to therapy technique, once curiosity is aroused in the patient, the therapist asks about their narrative and probes their thinking, for example, by asking for evidence or reasons for their position or by asking them to paraphrase an opposing view. The client thus becomes concerned with what she or he thinks is reasonable or unreasonable. By exploratory questions, the therapist can discover areas or issues of interest or controversy: "What is loneliness for you? What is the difference between wanting something and needing it?" When the core conflictual relationship theme is found, the therapist can probe an issue in depth and clarify, sort, analyze, and evaluate thoughts and perspectives.

In most cases, therapies with Ideal Types 1 and 2 seemed to weave psychodynamic therapy (PDT) with CBT traits (Gordon & Nath, 2010), which yielded a positive outcome. When the therapists were skilled in oscillating between the techniques, it paved the way for the parents' experiences of SPIPIC as being not only "relieving" but also "frightening," as one father expressed. Some parents wanted the therapist to be more directive, pedagogic, and future-oriented, ingredients more typical of CBT than of PDT (Blagys & Hilsenroth, 2002; Jones & Pulos, 1993). We assume that these parents could have benefited by a therapy technique that was more proactive in the Socratic sense.

4.2 | Role of the nurse

According to a Cochrane review (Dennis & Dowswell, 2013), "flexible, individualized postnatal care provided by a professional that incorporates postpartum depression screening tools appears to be promising" (p. 20). Swedish authorities have concluded that "individually tailored treatments (psychosocial or psychological) instituted soon after delivery are the most effective" (SBU, 2014, p. 1). The question is to what extent our interviewed parents experienced that the CHC nurse, who is centrally placed to detect such conditions, met these expectations.

Judging from the parent interviews, the nurses seemed insecure about how to detect emotional problems in Types 1 and 2 and therefore relied on the Edinburgh Postnatal Depression

Scale (EPDS; Cox, Holden, & Sagovsky, 1987) screening. If these parents showed their distress openly, they were referred directly to the therapist. In contrast, if they concealed their worries, they were handled only several months after registration. Thus, unless the parents explicitly conveyed their suffering to the nurse, they risked not getting adequate help.

The parents did not always feel that the nurse had observed their predicament or addressed it. This is in line with studies of today's increasing demands on child health nurses to also focus on psychological issues. Midwives reported feeling frustrated by asking the Whooley questions (McGlone, Hollins Martin, & Furber, 2016), and our group (Kornaros et al., 2018) made similar findings concerning the EPDS questionnaire (Cox et al., 1987). Such inhibitions are deplorable since "midwives are ideally positioned to identify women at potential risk of developing PMH [Perinatal Mental Health] difficulties because of their unparalleled opportunity for contact with women during the continuum of pregnancy, birth and motherhood" (Madden et al., 2018). Evidently, this conclusion applies to CHC nurses as well.

In our previous study (Kornaros et al., 2018), we used Aristotelian concepts (Aristotle, 1999) to explicate the dynamics between the nurses' tacit experiential knowledge (*phronesis*) and the technical rules that they had learned in their training (*techne*). Here, an important source of clinical wisdom is waiting to be explored. Belle and Willis (2013) found that child health nurses conceived of maternal sadness as a "complex phenomenon arising from the interplay of social, economic, political, and cultural forces within an individual woman's life;" that is, they possessed a distinct specialist knowledge base. In Aristotelian terms, they applied phronesis to understand the woman's situation. In contrast, not all parents in our project felt that the nurses met them within such a framework.

Another important factor, apart from the nurse's use of phronesis, seems to be whether the mother feels that her CHC nurse can formulate her distress in a way that acknowledges and normalizes "her feelings of distress, struggle and hardship experienced by women in response to the transition to motherhood, rather than labelling or problematizing them (Emmanuel & St John, 2010). In other words, can the nurse address the mother in a way that is comprehensible and nonjudgmental, yet perceptive? This question leads us to the final part of the discussion: how to organize perinatal care and how to train and supervise CHC nurses.

4.3 | Conclusions on organization of perinatal mental healthcare

Our results show two major organizational obstacles for the CHC nurse to detect and refer parents with emotional problems. The first obstacle is her insufficient confidence in handling baby worries, as discussed previously. The second obstacle is the lack of a powerful implementation plan in primary healthcare of how to handle new parents with emotional problems. A recent governmental investigation (Socialdepartementet, 2018) emphasized, in line with Agenda 2030 (United Nations, 2015), that the Swedish primary healthcare system needs to become more accessible, extensive, and "designed for human beings" (p. 14).

One subsidiary report (Socialdepartementet, 2017) brings out the nurse's task of triaging parents in need of specialized psychological care. To achieve this, she needs sufficient support in her decisions. Our results show that such support is weak for the CHC nurses who, also, have few alternatives for referral to a relevant profession. Our previous study (Kornaros et al., 2018) has described the nurses' satisfaction with such support when psychotherapists were integrated at their CHC.

Another Swedish guideline on child healthcare (Socialstyrelsen, 2014) has recommended access of a psychologist at CHCs for consultations of individual parents. These guidelines do not exactly correspond to our suggestions. Our results point to the advantages of having therapists integrated in the primary healthcare system and becoming a team member at the CHC. If this is to be realized, therapists need to be trained in perinatal competence and supervision skills. They also need to adapt their technique to the parents' assets, problems, and treatment preferences.

One final problem is the local variations between CHCs. The national guidelines (Socialstyrelsen, 2014) aside, each CHC has some freedom in how to implement healthcare (Socialdepartementet, 2018). This was illustrated by our participants expressing meeting with the therapist as "pure luck." Thus, less "lucky" parents at certain CHCs risk not getting adequate help, which also may incite their mistrust in the healthcare system. This is especially unfortunate with parents corresponding to our Ideal Type 3 informants because they already have had discouraging experiences with psychiatric care.

4.4 | Limitations

The psychotherapists were asked to suggest candidate parents. Two abstained because they did not consider any case to be suitable for being recommended for an interview. All 13 interviewed parents came from only three CHCs. It would have been more optimal if all therapists and all CHCs had been represented. Nevertheless, the three CHCs had a notable geographical and socioeconomic variability.

The reason we asked the therapists to recommend candidates for interviews was that we thought that they best knew their cases' emotional problems. This might yield a biased selection in that they would choose their successful cases. With this risk in mind, we asked them to also suggest nonsuccessful cases; our interviews show that they responded to this request. Alternatively, we could have asked the nurses or made a random selection from the files. This probably

would have given a better distribution among CHCs. Yet, we thought that we would be more certain to receive interview candidates by asking the ones who were most committed to the therapies: the therapists themselves.

CONFLICT OF INTEREST

The authors have no conflicts of interest.

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