From Department of Women's and Children's Health
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# Treating postpartum emotional distress

## by a short-term psychodynamic infant-parent intervention integrated with Child Health Center care

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Karolinska Institutet

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# Treating postpartum emotional distress

## by a short-term psychodynamic infant-parent intervention integrated with Child Health Center care

THESIS FOR DOCTORAL DEGREE (Ph.D.)

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*Dedicated to my dear husband Charalampos*

*and to our beloved children Aphrodite, Georgios and Odysseus*

# ABSTRACT

**Objective:** The thesis had two aims. (1) To qualitatively explore the perspectives of CHC nurses' (study I) parents' (II) and psychotherapists' (III) in receiving/offering SPIPIC (Short-term Psychodynamic Infant-Parent Intervention at Child health centers) and CHC nurses and psychotherapists' experiences of participating/offering supervision at CHC (I and III). (2) To quantitatively evaluate SPIPIC outcomes on parent-reported depression and child social-emotional functioning (IV).

**Methods:** Data collection was conducted on six CHCs. The first aim was achieved through in-depth interviews with 15 CHC nurses, 13 parents and eight psychotherapists. The material was interpreted using hermeneutic analysis method. The second aim was achieved through a naturalistic survey at CHC where SPIPIC treatments also took place. Two subsamples participated; (1) Families that signaled emotional distress constituted the "SPIPIC Group". Initially 100 mothers and 59 fathers participated. (2) Families that did not signal any emotional distress during recruitment constituted the "Norm Group". Initially, 81 mothers and 60 fathers participated.

**Instruments:** Ages and Stages Questionnaire: Social Emotional (ASQ:SE), Edinburgh Postnatal Depression Scale (EPDS), social and medical background data and patient and treatment factors estimated by the psychotherapists after completion of treatment.

**Results: Study I**. The nurses appreciated the availability, the opportunity to learn more about emotional problems, and the psychotherapist as a beneficial resource for parents and children. The criticism included that sometimes there was no transparency on the part of psychotherapists as well as clear frameworks for therapy and supervision. **Study II**. The parents appreciated nurses who asked about their emotional distress and SPIPIC's easy accessibility. Psychotherapists who had a holistic family perspective and succeeded in switching between insight promotion and supportive efforts were particularly appreciated. Especially, "the insecure parent" and "the parent in crisis" were served by SPIPIC. **Study III**. Therapists corresponding to the adaptive approach found ways of collaborating with the nurses and were well integrated in the CHC paradigm. Their supervisions helped the nurses to bridge somatic and psychological perspectives. This approach required that the psychotherapist had a positive view of herself as a therapist, had a high transparency in her work, courage to raise uncomfortable questions and that she worked on the nurses' commission. The psychotherapist also needed to encompass complex socio-cultural situations in junction with parents' emotional problems. **Study IV**. Multilevel growth modeling analysis showed a significant decrease in mothers' depression and children's social-emotional functioning. The proportion of mothers who were depressed according to the index "clinically significant change" was halved, from 2/3 to 1/3. Half of them reached "reliable change" on depression estimates and 14% on children estimates. Mothers with higher initial depression estimates tended to have more therapy sessions. Single mothers initially had higher rates of depression than those living with the child's father. The higher the level of education, the faster the mothers' depression estimate dropped. Child function estimation was associated with whether or not the child had a medical diagnosis. Fathers' depression outcomes were inconspicuous, but their ratings of infant functioning improved.

**Conclusions:** SPIPIC seems to contribute to reducing maternal depression and concerns about the child's social-emotional functioning in both parents. Psychotherapists should work at CHC to allow parents access to psychological care. CHC nurses should receive frequent supervision from the psychotherapist to develop skills, observation and identification of these families as well as good interprofessional collaboration.



**Keywords:** Child health centers, interprofessional collaboration, parent-infant psychotherapy, postpartum emotional distress

# SVENSK SAMMANFATTNING – SWEDISH SUMMARY

**Syfte:** Avhandlingen hade två syften. (1) Att kvalitativt utforska BVC-sjuksköterskors (studie I), föräldrars (studie II) och psykoterapeuters (studie III) perspektiv på att ta emot/erbjuda SPIPIC (Short-term Psychodynamic Infant-Parent Intervention at Child health centers) samt BVC-sjuksköterskors och psykoterapeuters erfarenhet av handledning på BVC (studie I och III). (2) Att kvantitativt utvärdera SPIPICs utfall på egen föräldra-rapporterad depression och barnets social-emotionella funktion (studie IV). **Metoder:** Datainsamlingen gjordes på sex BVC. Mål (1) uppnåddes genom djup-intervjuer med 15 BVC-sjuksköterskor, 13 föräldrar och 8 psykoterapeuter, vilka tolkades med hermeneutisk analysmetod. Mål (2) uppnåddes genom en naturalistisk enkätstudie på BVC där SPIPIC-behandlingarna ägde rum. Två undergrupps-urval deltog; (1) Familjer som signalerade emotionell distress konstituerade ”SPIPIC-gruppen”. Där deltog initialt 100 mammor och 59 pappor. (2) Familjer som inte signalerade några emotionella svårigheter vid rekrytering konstituerade ”Norm-gruppen”. Där deltog initialt 81 mammor och 60 pappor. **Instrument:** Ages and Stages Questionnaire: Social Emotional (ASQ:SE), Edinburgh Postnatal Depression Scale (EPDS), Sociala och medicinska bakgrundsfaktorer, samt patient- och behandlingsfaktorer som skattats av psykoterapeuterna och samlats in efter avslutad behandling. **Resultat: Studie I**. Uppskattade aspekter var tillgängligheten, möjligheten att lära sig om emotionella problem och psykoterapeuten som en gynnsam resurs för familjerna. Kritik restes när transparens saknades från psykoterapeuternas sida liksom klara ramar för terapi och handledning. Överlag behövde sjuksköterskorna mer teoretisk och praktisk kunskap för att kunna hantera psykologisk problematik. **Studie II.** Föräldrar uppskattade sjuksköterskor som ställde frågor om deras psykiska problematik, SPIPICs lättillgänglighet och att terapeuten också inkluderade barnet. Särskilt uppskattades psykoterapeuter med ett holistiskt familjeperspektiv och som skickligt kunde växla mellan insiktsbefrämjande och stödjande insatser. ”Den osäkra föräldern” och “föräldern i kris” gynnades mest av SPIPIC. **Studie III.** Psykoterapeuter med ett “adaptivt förhållningssätt” samarbetade väl med BVC-sjuksköterskorna. Handledningen hjälpte BVC-sjuksköterskorna att sammanväva somatiska och psykologiska perspektiv. Förhållningssättet krävde att terapeuten hade en positiv uppfattning om sig själv, hade en hög transparens i sitt arbete, mod att lyfta obekväma frågor och vilja att arbeta på sjuksköterskornas uppdrag. Psykoterapeuten behövde också ha klara ramar för terapi och handledning och kunna omfatta komplexa sociokulturella situationer. Överlag behövde psykoterapeuterna mer teoretisk och praktisk kunskap för att handleda sjuksköterskorna. **Stude IV.** Multilevel growth modelling-analyserna visade på signifikant minskning av mammornas depression och barnets social-emotionella fungerande. Andelen mammor som var deprimerade enligt ”clinically significant change” sjönk från 2/3 till 1/3. Hälften av föräldrarna som deltog nådde ”reliable change” på depressionsskattningen och 14% på barn-skattningen. Prediktor-analyserna visade att mammor med högre initial depressionsskattning tenderade att få fler terapisessioner. Ensamlevande mammor hade initialt mer depression. Ju högre utbildningsnivå, desto snabbare sjönk mammornas depressionsnivå. Barnfunktionsskattningen var associerad till om barnet hade en medicinsk diagnos eller ej. Pappornas depressionsutfall var oansenligt, kanske för att det mestadels var mammorna som deltog i terapierna. Däremot indikerade deras barn-skattning att de blev mindre oroliga efterhand. **Slutsatser:** SPIPIC tycks bidra till att minska mammors depression samt båda föräldrars oro kring barnets social-emotionella fungerande. BVC-placerade terapeuter kan lättare identifiera och behandla föräldrar med emotionell problematik. BVC-sjuksköterskor bör få regelbunden handledning av psykoterapeut för att lättare identifiera föräldrar och barn med emotionell problematik och för att gynna ett gott interprofessionellt samarbete.

**Nyckelord:** Barnhälsovård, barn-förälder psykoterapi, interprofessionellt samarbete, postpartum emotionella svårigheter

## LIST OF SCIENTIFIC PAPERS

I. Kornaros, K., Zwedberg, S., Nissen, E., & Salomonsson, B. (2018). A hermeneutic study of integrating psychotherapist competence in postnatal child health care: nurses' perspectives. *BMC Nursing*., 17. https://doi.org/10.1186/s12912-018-0311-1

II. Kornaros, K., Zwedberg, S., Nissen, E., & Salomonsson, B. (2019). A hermeneutic study of integrating psychotherapist competence in postnatal Child Health Care: Parents' perspectives. *Infant Mental Health Journal*., 41(1), 108–125. https://doi.org/10.1002/imhj.21828

III. Kornaros, K., Zwedberg, S., & Nissen, E. A hermeneutic study of integrating psychotherapist competence in postnatal Child Health Care: Psychotherapists' perspectives. (In Ms)

IV. Salomonsson, B., Kornaros, K., Sandell, R., Nissen, E., & Lilliengren, P. Short-term psychodynamic infant-parent interventions at child health centers: Outcomes on parental depression and infant social-emotional functioning. (Submitted 2019)

# CONTENTS


1 **PREFACE** ..... 1

2 **BACKGROUND** ..... 3

2.1 PRENATAL EMOTIONAL ADJUSTMENT PROBLEMS ..... 4
2.2 POSTNATAL EMOTIONAL ADJUSTMENT PROBLEMS ..... 4
2.3 BABY WORRIES AND THE CRISIS PERSPECTIVE ..... 5
2.4 PSYCHOLOGICAL TREATMENTS OF BABY WORRIES ..... 7
2.4.1 Parent-infant psychotherapy methods ..... 7
2.4.2 Short term Psychodynamic Infant-Parent Intervention at Child Health Centers (SPIPIC) ..... 9
2.5 PERINATAL MENTAL HEALTH: ISSUES ON ORGANIZATION ..... 10
2.6 THE CLINICAL PROJECT ..... 12

3 **AIMS** ..... 13

4 **DESIGN AND METHODOLOGY** ..... 14

4.1 Table 1. Overview of the design of all studies. ..... 14
4.2 THE QUALITATIVE STUDIES ..... 15
4.2.1 Setting ..... 15
4.2.2 Recruitment procedures and samples ..... 15
4.2.3 The theory of hermeneutic analysis ..... 16
4.2.4 Data analysis: strategy ..... 17
4.3 THE QUANTITATIVE STUDY ..... 19
4.3.1 Setting ..... 19
4.3.2 Recruitment and sample ..... 19
4.3.3 Inclusion and exclusion criteria ..... 21
4.3.4 Instruments ..... 21
4.3.4.1 *Parent-reported depression* ..... 21
4.3.4.2 *Parent-reported infant social-emotional functioning* ..... 21
4.3.4.3 *Background factors and therapeutic setting* ..... 22
4.3.5 Statistics ..... 22
4.4 ETHICS ..... 22

5 **RESULTS** ..... 24

5.1 Study I ..... 24
5.2 Study II ..... 25
5.3 Study III ..... 26
5.4 Study IV ..... 27

6 **DISCUSSION** ..... 33

6.1 METHODOLOGICAL CONSIDERATIONS ..... 33
6.1.1 Qualitative method ..... 33
6.1.2 Quantitative method ..... 34
6.2 Discussion of results ..... 35
6.2.1 Paradigm shift at the CHC: from “soma” to “psyche” ..... 35
6.2.2 Child or Family health center care? ..... 36
6.2.3 In-service PMH training for CHC nurses ..... 38
6.2.4 Supervision as the nave in interprofessional collaboration ..... 39
6.2.5 The need of an oscillating therapeutic technique ..... 40
6.2.6 Outcomes of SPIPIC and their relations with the results of the qualitative studies and other studies ..... 42

7 **CONCLUSIONS AND CLINICAL IMPLICATIONS** ..... 45

8 **FUTURE RESEARCH** ..... 46

9 **ACKNOWLEDGEMENTS** ..... 47

10 **APPENDIX** ..... 50

10.1 Appendix 1. Questionnaire Study IV: background data parents.....50
10.2 Appendix II. Questionnaire Study IV: Psychotherapist's assessment .....53
11 **REFERENCES** .....56

# LIST OF ABBREVIATIONS

| | |
|---|---|
| ASQ:SE | The Ages and Stages Questionnaire: Social Emotional |
| BUMM | Child and adolescent medical center |
| BUP | Child and adolescent psychiatry |
| CBT | Cognitive behavioral therapy |
| CCb | Clinically significant change b |
| CHC | Child health center (in Swedish BVC) |
| CHCC | Child health center care |
| CPP | Child-parent psychotherapy |
| EPDS | The Edinburgh Postnatal Depression Scale |
| GAD | Generalized anxiety disorder |
| MDD | Major depressive disorder |
| MIP | Mother-infant psychoanalytic treatment |
| MLM | Multilevel growth modelling |
| OCD | Obsessive compulsive disorder |
| PIP | Parent-infant psychotherapy |
| PMH | Perinatal mental health |
| PMHC | Perinatal mental health care |
| PMAD | Perinatal mood and anxiety disorders |
| PPD | Postnatal/postpartum depression |
| PTSD | Posttraumatic stress disorder |
| RCT | Randomized controlled trial |
| SPIPIC | Short-term psychodynamic infant-parent intervention at child health centers |
| SSI | Strange situation intervention/procedure |
| SSRI | Selective serotonin reuptake inhibitors |
| WWW | Watch, wait and wonder |

# 1 PREFACE

I was six years old when I first visited the excavation of the temple Asclepius, dedicated to the God of medicine. As usual, it was a hot summer day, in Lendas my home village, on the island of Crete. I was walking around land that had been inhabited by the Minoans since the Neolithic time, around 7000 B.C. The temple was built in the 4th century B.C, on a cliff overviewing the breathtaking Mediterranean Sea. Asclepius' followers sought such invigorating, salubrious landscapes when establishing their hospital-like sanctuaries.

As I walked among the antique pillars, I heard my parents talk about "dream healing", "the Goddess of motherhood", and that the center was renowned in antiquity as a sanctuary for also providing hydrotherapy and physiotherapy. They described how people from the Levant and northern Africa travelled across the sea to be healed. Women also came to the temple to get help with infertility and depression. They worshiped Leto, who was the mother of Artemis and Apollo and the goddess of motherhood.

Priests guided them through rituals of physical and mental purification, special diets and incubation, during which they spent the night in one of the buildings of the sanctuary and waited for Asclepius to enter their dreams with a therapy. Such dream healing represents the ancient forerunner of modern psychotherapy. Later, with the increasing emphasis on real-world and medical treatments, the sanctuary started employing physicians who could supplement their priests' spiritual curatives by application of medicinal plants. According to ancient stelae, many ill visitors were healed by this holistic course of action.

This day is etched into my memory. I wanted to share it with you as this thesis captures both motherhood and psychotherapy approximately 2500 years later. It is fascinating how, in this epoch, the first philosophers reasoning steered toward an integrative medicine. The myths could not satisfy them, they still wondered and reasoned, admitting that they did not know. Unlike our time, they believed in the balance between soma, psyche and pneuma. The latter term can be described as a form of circulating air necessary for the systemic functioning of vital organs which sustains consciousness in a body. Human health depended upon balancing these three elements.

After my Bachelor's degree in Social Work, I went through the rite of passage of giving birth and entering motherhood, which stimulated me to deepen my knowledge in parent-infant interaction. I completed a two-year Master program in Psychology and also met my supervisors, Associate Professor Björn Salomonsson and Professor Eva Nissen. We were all astonished by the absence of psychological treatment at Child Health Centers in Stockholm, not least because of the increasing prevalence of mental illness in our society today. We assumed that this would lead to increased postpartum mental distress and non-optimal parent-infant interactions. Could health care perhaps work more preventatively and holistically and not only alleviate the symptoms of illness? Such were our deliberations that lead up to this thesis.

# 2 BACKGROUND

In Sweden today, the majority of new parents with their children visit a Child Health Center (CHC). The organization has the assignment of reviewing the child's somatic and emotional development as well as providing parents with the emotional support needed to optimize the child's development. The nurses are either specialized in public health nursing, or pediatric nursing. Salomonsson (2010) conceptualized the term "baby worries", which is based on clinical observations of mother-infant relationships at CHCs. This term describes a parent's worries about their baby's functioning, themselves as parents, and/or about their relationship with the child. Importantly, I argue that it is not self-evident where to draw the line between baby worries and mental illness, and which efforts are needed to approach each problem.

Previous research has focused on describing the various forms of perinatal mental distress (Howard, Piot & Stein, 2014; O'Hara & Wisner, 2014), its effects on fetus and child and on early interactions between parent and child (Barker, Jaffee, Uher & Maughan, 2011; Field, 2010; Fredriksen, von Soest, Smith & Moe, 2019; Goodman et al., 2011; Grigoriadis et al., 2013; Stein et al., 2014). Fewer studies have been published about how to identify families with baby worries within primary health care and to investigate what kind of treatment they need. One systematic review from US showed that counseling interventions can be effective in preventing perinatal depression (O'Connor, Senger, Henninger, Coppola, Gaynes, 2019).

Patients within primary health care have often fallen into a temporary crisis, and help needs to be deployed rapidly to prevent the onset of major depression (Cuijpers, Quero, Dowrick & Arroll, 2019). The majority of patients within primary health seem to prefer psychological treatments (McHugh, Whitton, Peckham, Welge & Otto, 2013; Van Schaik et al, 2004). To what extent CHC nurses feel they can handle psychological counseling at CHCs has not been investigated. Clinical experiences suggest that referrals to other health care facilities may be perceived as stigmatizing. In addition, since parents visit the local CHC regularly, they seem to feel secure there which, perhaps, would make such units suitable for detecting and treating baby worries. Overall, there is also a lack of knowledge about interprofessional collaboration between CHC nurses and psychotherapists within primary health care.

## 2.1 PRENATAL EMOTIONAL ADJUSTMENT PROBLEMS

Already during pregnancy, the mother's emotional distress may be associated with adverse pregnancy outcomes, such as perceived stress years after delivery (Monk et al., 2019), negative effects on the child's emotional, behavioral and cognitive development (Glover, 2011; Monk, Lugo-Candelas & Trumpff, 2019). Parents' own adverse childhood experiences and attachment style are related to anxiety, depression and stress in the perinatal period (Moe et al., 2019). Rubertsson, Pallant, Sydsjö, Haines & Hildingsson (2015) found that women with elevated levels of depression during pregnancy recorded lower attachment scores to their fetus. Rossen et al. (2017) showed that stronger antenatal bonding predicted stronger postnatal bonding. Mothers with emotional distress during pregnancy have an increased risk of postpartum depression (PPD) (Heron et al., 2004; Kirkan et al., 2014). These factors have been shown to also influence the quality of care and parent-infant interactions later in the child's life (Dubber, Reck, Müller & Gawlik, 2015).

## 2.2 POSTNATAL EMOTIONAL ADJUSTMENT PROBLEMS

Already Hippocrates (460 - 370 B.C.) recognized that some women after childbirth experienced "puerperal fever" which produced "agitation, delirium and attacks of mania" (Penn Medicine, 2020). Possibly, his description corresponds to today's diagnosis of postpartum psychosis. As for postnatal depression, as long as written text has existed, there have been descriptions of it (Barre, 2001; Klerman & Weissman, 1980; Kruger, 2005 in Greaves, 2009, p 40-41). However, as we view things today, the range of postpartum emotional distress is much wider in their character and they affect women around the world (Wesselhoeft et al., 2019).

Today's term Perinatal Mood and Anxiety Disorders (PMAD) comprises various emotional adjustment problems, such as GAD (Generalized anxiety disorder), OCD (Obsessive Compulsive Disorder), Panic Disorder, PTSD (Posttraumatic Stress Disorder), MDD (Major Depressive Disorder) and PPD (Fleischman, 2019; Jarvis et al., 2019). One advantage at categorizing mental problems is that they enable us to investigate their prevalence. For example, PPD has a prevalence of around 15% (Gaynes et al., 2005; O'Hara & Swain, 1996; Wickberg & Hwang, 1997). This has led the general public and the medical profession towards an increased attention to these conditions and their treatment. Rubertsson, Waldenström, Wickberg, Rådestad and Hildingsson (2005) investigated the prevalence of

perinatal depressive mood in a national Swedish sample. About 12 percent scored above the cut-off level 11/12 for postpartum depressed mood on the Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden, Sagovsky, 1987). Half of them were depressed already during early pregnancy. Similar results have been found in many other studies (Alhammadi et al., 2017; Park, Karmaus & Zhang, 2015).

One possible disadvantage to such categorizing is that it may restrict our perspective on the individual woman's suffering. No two women are identical and thus, no two cases of PPD are identical, which was also suggested by Moe et al. (2019). I speculate that clinging to disease categories may stifle the health care staff's personal judgement and life experience when meeting the individual parent. The CHC nurse may perhaps also be more inclined towards asking about symptoms than about the patient's personal life experiences.

If we focus on PPD, Beck (2002) looks at it from five theoretical perspectives and I will describe three of them. The "medical" or "illness model" is dominating in the literature. It indicates that PPD is caused by perinatal hormonal changes and should be treated with biological methods. In contrast, the "feminist model" focuses on social, political, and economic contexts of the mother's life. It views the underlying problem as a social construction. Thirdly, the "attachment model" sees the underlying problem as the mother's attachment needs not being met by her partner. Interventions focus on marital therapy, de-escalating negative interactive cycles, and promoting individual attachment security.

## 2.3 BABY WORRIES AND THE CRISIS PERSPECTIVE

Beck's perspectives highlight that the theoretical lens through which a clinician views postpartum depression has ramifications on the treatment prescribed. Salomonsson (2010) coined the term baby worries since he felt that the traditional categories of perinatal psychopathology did not cover the baby's possible maladjustment, which is also reflected in the absence of baby questions in the EPDS (Cox et al.,1987). He also noted a great variability of many parental symptoms. Hence, he chose the somewhat vague term "baby worries" to illustrate the difficulty in distinguishing between distress in parent(s) and baby, and between transitory and persistent distress. This led to a model of care that makes it incumbent on the healthcare professional to identify the parent's concern, explore with him/her the problem, include both partner and baby in treatment, and focus on subjective experiences of suffering. Below are some examples of "baby worries", which I have collected from observation visits at Dr Salomonsson's CHC and from the parent interviews (study II):


**Figure 1.** Description of "baby worries" as I have observed them.

The word *crisis* comes from the Greek *krisis,* which means "turning point". It indicates recovery from, or death of, for example, a disease (Etymonline, 2020). The vignettes above can be viewed from a crisis perspective, that is, as dramatic periods in the parent's life that can either recede or aggravate into various forms of PMAD. The latter alternative implies an extra burden for the depressed parent who is suffering from an emotional pain while simultaneously taking care of a baby.

Concerning treatment for "baby worries", Dennis' & Dowswell's (2013) review shows that psychosocial and psychological individually customized treatments, in late pregnancy or within six weeks after delivery, were more effective than conventional healthcare in reducing the risk of PPD. It also concluded that home visits by health care professionals after childbirth reduced depressive symptoms.

Another burden in a family with a depressed parent is that this state is often associated with a non-optimal child development. Studies have demonstrated how the postnatally depressed women's emotional illness may affect the family (Holopainen & Hakulinen, 2019; O' Hara, 1999) and the child's well-being (Chronis et al., 2007; Edhborg, Lundh, Seimyr, & Widström, 2003; Hammen & Brennan, 2003; Olson, Bates, Sandy, & Schilling, 2002; Weissman et al., 2006). Such effects may even extend into adolescence with fewer social competencies, lower levels of self-esteem and higher levels of behavioral problems (Murray, et al., 2010). This growing body of evidence highlights the importance of early interventions and strategies to improve parental and child health.

## 2.4 PSYCHOLOGICAL TREATMENTS OF BABY WORRIES

Today, medication such as Selective Serotonin Reuptake Inhibitors (SSRI) are prescribed to many women with PPD to improve their psychological health (Scrandis, 2018). I will not summarize such treatments, since my thesis evaluates a psychological therapy method. I will therefore concentrate on reviewing other parent-infant psychotherapeutic methods.

### 2.4.1 Parent-infant psychotherapy methods

The psychotherapy methods that evolved during the last 50 years differ in emphasis on support or insight, which roles they attribute to the family members, to what extent they focus on unconscious influences in mother and baby, and to what extent their theories rely on

psychoanalytic theory, attachment theory, developmental psychology, and infant research. Most methods contain tacit assumptions of which clients they are suited for. In all the methods below, the therapist pays attention to the parents' and the baby's emotional state. In contrast, as for Cognitive Behavioral Therapy (CBT) we have not found studies with an explicit infant focus.

Parent–infant psychotherapy was introduced by Fraiberg (1980) and Dolto (1982, 1985) half a century ago. Another technique influenced by psychoanalytic and attachment theory is Parent–Infant Psychotherapy (PIP; Baradon, Biseo, Broughton, James & Joyce, 2016). It views the baby as propelled by a need to engage a caregiver to help him/her with building up attachment and emotional regulation. The therapist also observes the infant's contact with her.

Psychodynamic Mother-Infant Psychotherapy (Robert-Tissot et al, 1996) follows the technique of the "Geneva school" (Cramer & Palacio Espasa, 1993), and resembles Fraiberg's (1980) method but focuses more on how the mother's projections onto the child can contribute to a disturbed parent–infant relationship. It was compared with the Video-feedback Interaction Guidance method (McDonough, 2004) in a Randomized Controlled Trial (RCT; Robert-Tissot, 1996).

In the Watch, Wait and Wonder (WWW) (Cohen et al., 1999) treatment, the therapist observes mother and infant playing while encouraging the mother to reflect on her baby and their relationship. An RCT compared it with Fraiberg's method (Cohen, Lojkasek, Muir, Muir & Parker, 2002). Some results favored the WWW.

Norman's (2001) Mother–Infant Psychoanalytic treatment (MIP) assumes, like Fraiberg, that the baby may contribute to parent-infant pathology. He therefore addressed the baby and established a relationship with him/her to offer containment. An RCT (Salomonsson & Sandell, 2011, I, II) compared MIP and CHC care. MIP effects were found on mother-reported depression and stress, as well as expert-rated mother-infant relationship qualities and maternal sensitivity. At 4½ years (Winberg Salomonsson, Sorjonen, & Salomonsson, 2015), the MIP children had better results on global functioning and were more often classified as "OK" compared with the Child Health Center Care (CHCC) group.

In the Marte Meo technique (Hedenbro, 1997; Høivik et al., 2015), video-clips help the mother perceive her interaction with the child. It may strengthen the relationship between

infants and vulnerable first-time mothers (Kristensen, Simonsen, Trillingsgaard and Kronborg, 2017).

In Stockholm today, distressed families with infants are offered psychotherapy at mid-level care units at BUP (Child and Adolescent Psychiatry). Parents seek help (Skagerberg, 2010) because of "mommy problems", worries about the child's development, and defiance and aggressiveness. Treatments offered are parental support, child neuro-psychiatric investigations, PIP and family interventions. On a national level, psychological support and treatment for parents and infants are unequally distributed (Furmark & Neander, 2018).

### 2.4.2 Short term Psychodynamic Infant-Parent Intervention at Child Health Centers (SPIPIC)

The psychotherapeutic studies referred to above did not specifically discuss how to integrate them in public infant health care. In contrast, SPIPIC was developed to be integrated with health care at CHCs. Salomonsson (2018) combined Norman's MIP method with his experiences as a consultant psychiatrist and psychoanalyst at a CHC. He realized that treatments needed to be briefer and performed in collaboration between the CHC nurses and the psychotherapist. Public funding by the Swedish Inheritance Fund enabled it to be offered at no charge during a clinical project lasting three years.

**Characteristics of SPIPIC can be summarized as follows:**

- The SPIPIC therapist's major perspective on the parents' distress is psychodynamic. Symptoms are thought to express internal, psychological conflicts of which the individual is unconscious. They emerge as distress in the baby's and/or the parent's well-being.
- The conflicts concern ambivalence about the child or partner, unresolved issues with significant persons in childhood ("ghosts in the nursery", Fraiberg, 1980), clashes between the parent's ideals and achievements, etc. The therapist helps him/her become aware of the conflicts and how they link with the symptoms.
- Another aim is to contain (Bion, 1962) the patient's anxieties. She/he may feel helpless, shameful, fearful of herself/himself, confused about feelings vis-à-vis the baby, etc. The therapist empathizes with these feelings, processes them internally, and provides a comment or stance that the patient finds sympathetic and helpful.
- The therapist may also apply a supportive technique. One may also discuss medication though, preferably, only after insight work and containment have not initiated

progress. The therapist is more focused on helping the patient understand her symptoms as a comprehensible reaction to a life crisis than as an indication of a psychiatric disorder.

- The SPIPIC therapist pays close attention to the baby's state. If relevant, she/he brings up a symptom in the baby, such as a depressive appearance, gaze avoidance, hyper- or hypo-arousal, etc. Addressing baby symptoms can be done both directly with the baby and indirectly via the parent.
- The setting varies according to the most immediate focus. For example, one may start with a session with the mother alone, followed by a session with the parents and then one with mother and baby only, etc.
- The number and frequency of sessions is decided in cooperation with the parent(s), for example, one session every second week for two months. This should be gauged according to the therapist's assessment of the case and the parent's preferences.
- The therapist cooperates with the CHC nurse. If the parent addresses something that the therapist deems the nurse should know of, she/he talks with the nurse with due discretion and after consulting with the patient. Another aim with reporting to the nurse is to convey whether her worries about the family were well founded, and if the therapist and the parent(s) have made a viable contact.
- The therapist meets the group of nurses regularly for reflective group supervision. The nurse, with her colleagues and under the therapist's guidance, works towards understanding and relieving her problematic relationship with the family. The aim is to increase her reflective function on perinatal psychological challenges.

## 2.5 PERINATAL MENTAL HEALTH: ISSUES ON ORGANIZATION

Child Health Care in Sweden has developed remarkably during the previous century. CHCs offer check-ups from birth to five years of age and handle both somatic and psychological issues. Check-ups comprise weighing and measuring the baby, providing inoculations, nutritional advice, and pediatric examinations according to child health care's national program (Reuter, 2018). CHC nurses are often the first health personnel to encounter parents with baby worries.

The guidelines recommend that nurses are trained in EPDS-screening, which is a 3-day course, and apply it at 6 - 8 weeks postpartum. Depending on the results, further counseling with the nurse should be offered (Wickberg, 2019). EPDS-screening does not guarantee a

complete detection of depressed mothers (Magnusson, Lagerberg & Sundelin, 2011), Thus, "complementary methods for detecting mothers at risk of stress and depression need to be developed" (p. 39). The EPDS founders were explicit "The EPDS is not a substitute for this clinical assessment, and a score just below the cut-off should not be taken to indicate the absence of depression" (Cox et al., 1987, p. 785). Mothers' attitudes can also contribute to concealing their distress (Liberto, 2012).

Previous studies suggest that CHC nurses feel that it is their obligation to take care of maternal distress (Belle & Willis, 2013), expressed as "seeing, hearing, thinking and having a sixth sense" (Rollans, Schmied, Kemp & Meade 2013). Still, many nurses felt that they lacked educational knowledge (Higgins et al., 2017), skills regarding PMH, particularly in women with mild/moderate depression, and with another cultural background (Berlin, 2010; Edge, 2010), and options for referral (Griep, Noordman & Van Dulmen, 2016; Noonan, Doody, Jomeen & Galvin, 2017). The latter authors found that important variables to influence midwives' confidence were the availability of appropriate resources and referral pathways. We could thus speak of a *treatment gap*; midwives and nurses are ideally placed to detect the parents' emotional problems - yet, they do not succeed often enough. The question is why the gap exists and what could be done to remedy it.

A logical question is if psychotherapists could help minimize the treatment gap. The Swedish National Board of Health and Welfare distributed means in 2009-2012 to support the development of psychotherapeutic skills for healthcare professionals to increase access to psychological treatment within the first primary line care (Socialstyrelsen, 2013). Nevertheless, the National Board of Health and Welfare (Socialstyrelsen, 2019) noted that the need for psychological competence still was high, with a lack of psychologists in 18 out of 20 county councils.

One organization that could help improve the accessibility and quality of parent-infant psychological care is BUP. In Stockholm, 2005, it underwent a major reorganization. Specialized psychologists, who formerly worked in collaboration with CHC nurses, were now relocated to mid-level care units or to BUP units that were not specifically addressing PMH issues. Concern was expressed that the needs of babies would not be met adequately (Rydelius, 2011; Skagerberg, 2009). Skagerberg (2006) found that BUP prioritized infant and toddler cases with neuropsychiatric concerns or parents' worries about their children's

symptoms such as fussiness, colic, weight-stagnation or problems with dysregulation. The latter group forms part of the concept “baby worries” but excludes parents’ worries about their own emotional state and/or their partner relationships. Skagerberg questioned if babies with attachment problems were paid enough attention and given adequate treatment.

An alternative suggestion is that no single profession can assume the entire responsibility of PMH care. Consequently, Forler & Åhlund Lundell (in Skagerberg, 2010) advocate for an interprofessional team, which could promote a collaborative atmosphere. Child psychiatric work with young children requires good diagnostic knowledge and clinical experiences, where the skills of a team could be useful. A recent report (Åhlund, 2019) investigated how care can be improved for young children 0-5 years within the primary health care (first line psychiatry). The report suggests that BUMM (Child and adolescent medical centers) are given the assignment, to be responsible for children 0-5 years of age, both within first line and the consultation assignment with CHC. According to the report, psychologists and possibly other professions need supervision, training and skills development. This requires that CHCs has centrally placed psychologist(s).

## 2.6 THE CLINICAL PROJECT

To facilitate an integration of postnatal health care with psychological therapy, a clinical project was launched in Stockholm January 2013 - January 2017. It was set up in collaboration with the CHC steering group of the Region Stockholm. The idea was to improve health care nurses’ capacity to detect postnatal distress in parents and babies, and to facilitate referral. This was achieved by placing ten psychotherapists at CHC units once a week, where they treated parents and children in SPIPIC and supervised the CHC nurses’ group. The therapists were psychoanalysts with experience in working with adults and parent-infant dyads. They had peer group supervisions, every second week, with the SPIPIC developer.

# 3 AIMS

The objective of this thesis is to evaluate a Short-term Psychodynamic Infant-Parent Intervention at Child health centers (SPIPIC) in Stockholm and to understand how the interprofessional collaboration between CHC nurses and psychotherapists influence the patient(s) and their treatment. Proceeding from the results, I also aim to discuss how Perinatal Mental Health Care (PMHC) can be improved in the future (see section 6).

The aims of the research project were to evaluate the clinical project, specifically:
1. to qualitatively explore nurses' (study I), parents' (study II) and psychotherapists' (study III) perspectives of receiving/providing SPIPIC at CHCs, and nurses' and therapists' experiences of receiving/providing supervision at the premises (study I and III).

2. to quantitatively evaluate SPIPIC outcomes on parent-reported depression and infant social-emotional functioning (study IV).

# 4 DESIGN AND METHODOLOGY

## 4.1 TABLE 1. OVERVIEW OF THE DESIGN OF ALL STUDIES.

| Study | Aim | Design | Participants | Analysis |
|---|---|---|---|---|
| I | To analyze CHC nurses' previous experiences of taking care of families with baby worries. Now that a professional psychotherapist was introduced, how did they experience being supervised, referring cases and collaborate | Fifteen in depth interviews | Fifteen female nurses | Hermeneutic analysis |
| II | To analyze parents' experiences of nursing care and psychotherapy of emotional problems during the perinatal period at the CHC and to explore which emotional problems the parents perceived in themselves, their babies, and their spousal relationship | Thirteen in depth interviews | Thirteen parents | Hermeneutic analysis |
| III | To analyze the psychotherapists' experiences of handling SPIPIC and to examine how they perceived the interprofessional collaboration | Twelve in depth interviews | Eight psycho-therapists | Hermeneutic analysis |
| IV | To evaluate the effectiveness of SPIPIC provided at CHC on parent-reported depression and infant social-emotional functioning. A second aim was to investigate associations between outcomes and pre-treatment adversity factors reported by parents and therapists | Quantitative longitudinal data collected in a naturalistic setting | Index<br>N= 100<br>Norm group<br>N= 80 | Multilevel growth modelling, indices of clinically significant, and reliable, change |

## 4.2 THE QUALITATIVE STUDIES

### 4.2.1 Setting

Interviews were conducted at CHCs in the inner city and suburbs of Stockholm that were chosen to yield an acceptable geographical and socioeconomic variability of the sample. The interviews were conducted by me and held in an office room at the CHC, although in study III, some were conducted at the psychotherapist's private office. During the interviews, I first went through the study aims with the respondents and clarified routines of confidentiality. To gain insight into their experiences, I let them talk freely but within a subject frame. I had set up an interview guide for each study which was based on open-ended questions (see the respective articles). When relevant, I probed further into undeveloped answers. Interviews lasted approximately 1 hour, and they were audio-recorded and transcribed verbatim.

### 4.2.2 Recruitment procedures and samples

In study I, all head nurses at six CHCs where asked if they wanted to participate and if they could supply names of colleagues with varying professional experiences and positions. Fifteen nurses, including the six head nurses, with an average age of 53 (35-65) years, participated in the study. They were all female and their mother tongue was Swedish. Interviews took place January–May 2016.

In study II, I asked each psychotherapist to suggest candidate parents of varying age, gender, country of origin, educational level, emotional problems, treatment durations, and therapy outcomes as assessed by the therapist, with the intention of gaining a heterogeneous sample. Of the 28 proposed parents, 7 were unavailable, and 5 declined to be interviewed. Of the 16 remaining participants, we stopped at 13 since we concluded we had reached a sufficient magnitude of material. Nine mothers and four fathers with a mean age of 34 years and educational mean of 14.2 years were interviewed. The infants included 7 girls and 6 boys, with a mean age of 6.4 months when therapy started. Interviews took place December 2015 to January 2017.

In study III, I invited all psychotherapists to be interviewed. Eight out of ten therapists in the clinical project accepted to participate, of which two were men. Their mean age was 63.5 (42-78) years and their average experience with psychotherapy was 34.6 years. One was a physician and another both a social worker and a psychologist, while the remainder were

psychologists. Half of them had previously worked at child psychiatry units, where they had treated parents and children. Some had worked with couples in therapy. They had been exposed to patients of various socioeconomic status and backgrounds. Interviews were conducted from January 2014 to May 2016.

### 4.2.3 The theory of hermeneutic analysis

Hermeneutics (Greek word meaning "translate, interpret") is both a theory and a methodology of interpretation. Its study object was originally written texts, later also oral and non-verbal communication. It originated in biblical studies and was extended into philosophical hermeneutics by such philosophers as Dilthey, Husserl, Heidegger, and Gadamer (Ödman, 2007). We chose Gadamer's principles in our analyses of details that we had identified in the interview texts, as well as themes that we created on the basis of our analyses of these details and their interconnections.

A hermeneutic approach acknowledges that "understanding" is actually an ongoing process of interpretation. Indeed, understanding is not "a subjective process of man over and against an object but *the way of being of man himself* (Palmer, 1969, loc. 2820, italics added). Gadamer specifies that one's interpretation of reality, whether of an immediate experience or a written text, involves one's pre-understanding and personal background (Ödman, 2007). To differentiate this procedure from the natural scientist's "objective" method, hermeneutical philosophers apply, since Dilthey (1989), the term "*verstehen*" (understand) to describe how we grasp the mind (*Geist*) of another person. This is essentially different from "*erklären*" (explaining) a phenomenon, as is done in the natural sciences. One may seek to "verstehen" why and how mother Jane X-son is depressed right now – and one may seek to "*erklären*" why many mothers become depressed after childbirth. These are two radically different study objectives and study methods.

To "*verstehen"* implies using one's subjectivity, empathy, and fantasy (Alvesson & Sköldberg, 1994) to grasp - or guess - deeper meanings of the respondent's communications. The hermeneutic researcher admits and clarifies that subjectivity always influences an interpretation. Here, no isolated subject is analyzing an object beyond some barrier. The interpretive situation is not one of "a questioner and an object, with the questioner having to construct 'methods'" (Palmer, 1969, loc. 2858) to understand the object. Instead, the questioner finds "himself the being who is being interrogated by the 'subject matter' (idem).

Hermeneutic analysis thus dissolves the subject-object polarity (Alvesson & Sköldberg, 1994, p. 131), and hence its emphasis on dialogue with the other. The question how I set up a dialogue with interview texts will be approached in the next section.

Since hermeneutic interpretations are always interrelated, Gadamer (1975/1989) uses the term *hermeneutic circle or spiral* to describe the process where one's understanding is expanded through a back-and-forth movement. Gadamer claims that no interpretation is universally true or complete, because no interpretation can escape further analysis. Furthermore, understanding needs to take into account both the whole and the parts of a text or any other communication. Especially, we are interested in knowledge about matters of which the other is unaware, that is, we seek to grasp hidden meanings in a communication. To this end, the analyst is especially perceptive as to contradictions in the informant's communications, since they may open up cracks in a previous interpretation.

### 4.2.4 Data analysis: strategy

The analyses were conducted by four members; me, two midwives, of which one is also a Gestalt psychotherapist, and a psychoanalyst (who did not co-author in study III). The hermeneutic method, is well-represented in midwifery research (Berg, Ólafsdóttir, & Lundgren, 2012; Bergbom, Modh, Lundgren, & Lindwall, 2017; Crowther & Smythe, 2016; Lundgren, Morano, Nilsson, Sinclair & Begley (2019), nursing research (Palmér, Carlsson, Brunt & Nyström, 2015; Norberg Boysen, Nyström, Christensson, Herlitz & Wireklint Sundström, 2017), and studies of perinatal experiences (Crowther, Smythe & Spence, 2014; Lundgren, 2010; Thomson & Downe, 2008; Ramsayer, Fleming, Robb, Deery & Cattell, 2019).

I chose the Gadamerian method since I thought the text material included a lot of contradictions and non-verbal communications. I assumed that such varying messages called upon us to broaden the horizons of understanding and yield alternative readings. I chose to interpret the material in junction with researcher colleagues specialized in the field of PMH. The background was the insight that although the hermeneutic researcher is called upon to ask questions to the text, this is easier said than done. But, I hoped that four professionals' background and approaches would yield a question/answer polylogue that deepened our analysis. I also saw the importance of raising the reflections above the common-sense level,

something that Plato described as going from the visible world to the intelligible world (Garefalakis, 2004).

In practical terms, I first went through the transcripts while listening to the recordings to adjust incorrect or incomplete notations. I added my memories of non-verbal communications such as sighs, laughter and expressions of fatigue or sadness. Interviews were primarily analyzed by each co-author individually, who sought to understand the entire text and its parts. This included making us aware of our pre-understanding of various fields of the research domain. In the next phase, all of us met to discuss our interpretations. When we encountered a paradoxical statement, our interpretations relied on a combination of what the informant objectively said and what each one of us subjectively thought was a fruitful interpretation. This process builds a standard for trustworthiness. Through feedback and dialogue about the phenomena we analyzed, our individual *horizons fused* into a shared understanding. This resulted in preliminary themes, whose coherence with the entire text was checked in the next step. Thus, the sense of the text as a whole was expanded and the finally themes were set. Finally, I summarized our results into a running text, with the themes functioning as captions.

In an effort at balancing nomothetic/generalizing and idiographic/specifying descriptions of the respondents' communications, we complemented our analyses by creating "Ideal types" (Kloesel & Houser, 1998; Weber, 1904). Their purpose is to give "shape and sense to disparate, empirically observable attributes" (Wachholz & Stuhr, 1999, p. 330). The Ideal type pertains to "an archetype or model," which can be related to Plato's Theory of forms (Garefalakis, 2004). Neither do such forms nor Ideal types exist in reality, but they provide some comprehensible and brief catchwords encompassing observed phenomena. They emerge through alternate steps of inductive, deductive, and abductive approaches to the material, as shown in Figure 2, The end result is an Ideal type, a cluster that subsumes a "particular constellation of properties" (Kluge, 2000, p. 1) in participants or other phenomena. This methodology has also been used in psychotherapy research (Kächele, Schachele & Thomä, 2009; Wachholz & Stuhr, 1999).

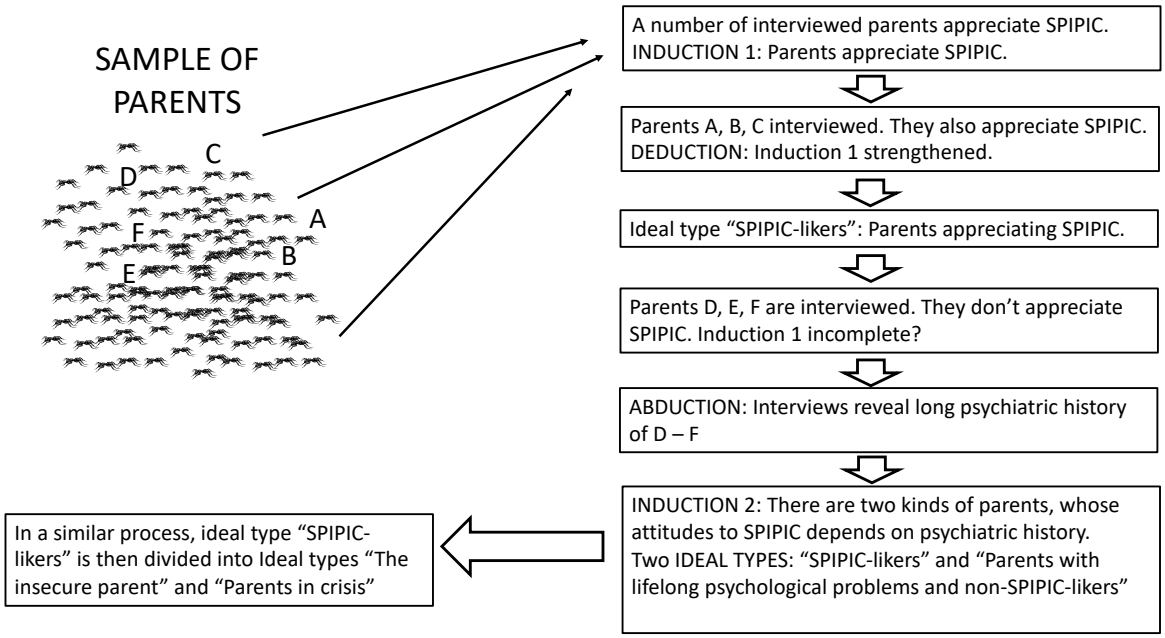


**Figure 2.** Graphical illustration of the creation of Ideal types.

## 4.3 THE QUANTITATIVE STUDY

We decided to set up a quantitative study to assess its outcomes on parent-reported depression and infant social-emotional functioning. These two areas are known to be associated with each other, and they may affect future health of the parent and the child. We hypothesized that if nurses got help with improving their clinical skills in detecting and addressing baby worries and if therapists collaborated with the nurses and offered treatment at the premises, SPIPIC would be beneficial.

### 4.3.1 Setting

The six CHCs were the same as in Study I and II. They were placed in the inner city and suburbs of Stockholm. Their catchment areas had an acceptable geographical and socioeconomic variability.

### 4.3.2 Recruitment and sample

Recruitments were based on the nurse's clinical assessment of the family members, thus reflecting her everyday practice. I assigned a nurse at each CHC to carry them out with the help of her colleagues. Two subsamples were recruited; (1) Families meeting the inclusion criteria (see 4.3.3) and signaling perinatal emotional distress. They constituted the "SPIPIC

group". (2) Families indicating no distress at recruitment. They were recruited right after the nurse had recruited a family to the SPIPIC group and constituted the "norm group".

The norm group had one purpose; to generate cutoff levels from non-distressed families registered at the same CHC as the SPIPIC group. The levels concerned the questionnaires on depression and infant functioning. We preferred a sample from the same CHCs rather than from a nation-wide population. This way, both subgroups were recruited from the same local population and by the same nurses' clinical assessments. Comparing the SPIPIC group's data with the norm group's cut-off levels enabled us to calculate the SPIPIC group's clinically significant change (CCb). Based on power calculations, we recruited 100 parental couples from the SPIPIC group and 80 couples from the norm group.

If parents consented to participate, the nurse administered paper questionnaires at Timepoint 0, before treatment start. If only one parent was present, he or she was asked to suggest the partner to also fill in questionnaires. Three and nine months later (Timepoint 1 and 2), follow-up questionnaires were submitted on a project webpage safeguarding confidentiality. Figure 3 shows this process in graphical detail.

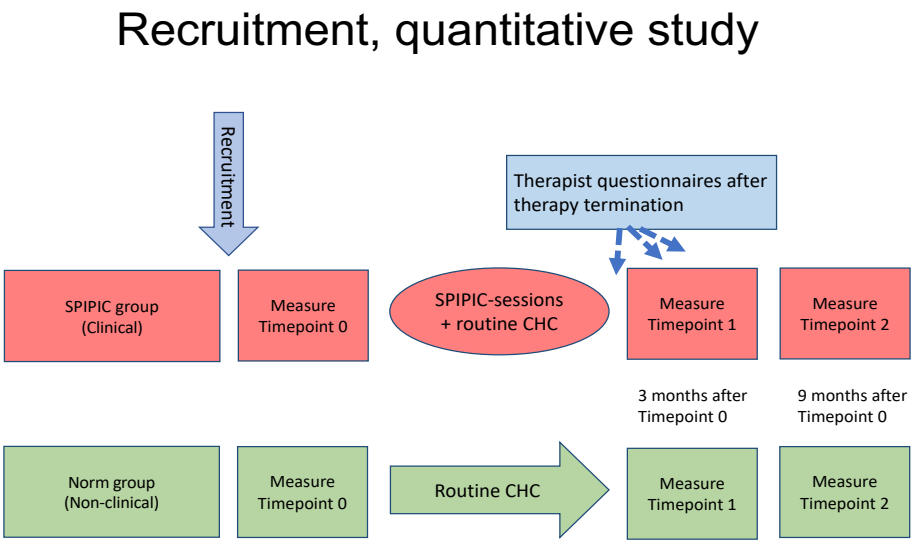


**Figure 3.** Design of study IV. CHC = Child Health Center. SPIPIC = Short-term psychodynamic infant-parent intervention at Child Health Centers.

### 4.3.3 Inclusion and exclusion criteria

Inclusion criteria were parents with an index non-twin child below 2 years. At regular check-ups, either or both parents had signaled to the nurse difficulties with parenting, marriage, personal well-being, contact with the child, or baby problems such as feeding, sleep and affect regulation. A reasonable mastery of Swedish language was required. The screening selection was made by the nurse as she suggested the parents a contact with the psychotherapist. The final decision if SPIPIC was suitable was made by the therapist and upon parental consent.

Exclusion criteria were parental mental disorder of such severity, for example, postpartum psychosis or substance abuse, that the nurse or therapist considered immediate psychiatric care indicated, alternatively mental disorder of the child of such severity, such as developmental inhibition or neuropsychiatric problems, that they assessed that specialist child psychiatric care was indicated.

### 4.3.4 Instruments

#### *4.3.4.1 Parent-reported depression*

The Edinburgh Postnatal Depression Scale (Cox et al., 1987) is a widely used ten-item questionnaire. Cox et al. (1987) and Murray and Carothers (1990) found adequate sensitivity (.86 and .96) and specificity (.78 and .81) for major depression compared with a standardized interview. We used an authorized Swedish translation (Lundh & Gyllang, 1993), which has been validated (Wickberg & Hwang, 1996). In our sample, internal consistency (Cronbach's α) was .896 for mothers and .826 for fathers.

#### *4.3.4.2 Parent-reported infant social-emotional functioning*

The Ages and Stages Questionnaire: Social-Emotional (ASQ:SE; Squires, Bricker, Heo, & Twombly, 2001) contains items rated on a four-step scale, except for four items on a two-step scale. Test-retest reliability is reported at .94, and Cronbach's α for internal consistency for babies of 3 to 14 months at .69 and .67. Three age ranges are relevant to this study: 3 – 8, 9 – 14, and 15 – 20 months, each with a different number of questions. To enable comparison across age groups, we calculated mean scores across all items. We used a Swedish translation authorized by the constructor. Our Cronbach's α for 3 – 8 months was .704 for mothers and .549 for fathers. For 9 – 14 months, it was .754 and .747.

#### *4.3.4.3 Background factors and therapeutic setting*

To assess how parents estimated the influence on their present situation by previous life events, health, and socioeconomic factors, we created 20 questions that they answered at Time point 0. They covered age, education, immigrant status, adoption of parents and child, psychiatric and medical history, the family constellation, and data on delivery and breastfeeding.

The therapists reported in a free-text questionnaire on the parents' histories, symptoms, treatment duration and which family members participated in SPIPIC sessions. They could mark pre-suggested variables and/or write down themes brought up in treatment. We coded their answers into binary categories, such as presence/absence of depression, anxiety, loneliness, relationship difficulties, etc.

### 4.3.5 Statistics

SPSS 25.0 was used for t-, McNemar-, and $\chi^2$- tests and multilevel modelling. Outcomes were calculated using three methods. The first was a multilevel growth modelling (MLM; Gueorguieva & Krystal, 2004; Singer & Willett, 2003). MLM handles nested data and utilizes all available information, which provides accurate estimates under fairly unrestrictive missing data assumptions. We used data collected in three waves on patients from six CHCs. EPDS and ASQ: SE scores were nested within patients, who were nested within CHCs.
The second method assessed how many individuals' change could be considered reliable (Edwards, Yarvis, Mueller, Zingale, & Wagman, 1978; Nunnally, 1975). The third method was to calculate how many individuals had moved from a dysfunctional to a functional population. We calculated the *clinically significant change b* (Jacobson & Truax, 1991), abbreviated CCb. The functional population is defined as M +/- 2 *SD*, where M and *SD* refers to our norm group's values.

## 4.4 ETHICS

The project was approved by the Swedish Central Ethical Vetting Board (Centrala Etikprövningsnämnden), Dnr 2013/1311-31/3.

According to the ethical guidelines of the Declaration of Helsinki (World Medical Association, 2013), four main ethical principles must be adopted and followed during research; respect for autonomy, beneficence, non-malfeasance, and justice. To achieve *respect for autonomy*, participants were free to participate in the studies and to withdraw at any time.

They were given oral and written information about the studies. Further information was provided on the project's homepage, where they gave their consent to participate. Parents who declined research participation were free to continue SPIPIC and/or CHC care. Some of the parents in the quantitative study (IV) also took part in the qualitative study II after their psychotherapies were terminated.

The ethical principle of *beneficence* implies that the research should be useful for the families. This research was important since experiences and outcomes of psychodynamic therapy integrated at CHC has not been systematically evaluated previously. The term *non-malfeasance* implies that a researcher should not cause any harm. Building on previous research on similar methods, we had good grounds to assume that SPIPIC would not cause harm and/or be beneficial, especially since it was provided by well-trained therapists. Participants' identities were carefully concealed. The principle of *justice* was also considered as participants were asked to participate without consideration of ethnicity, socioeconomic class or sexual orientation.

# 5 RESULTS

## 5.1 STUDY I

The aim of study I was to qualitatively explore nurses' perspectives of SPIPIC at CHCs and explore their experiences of receiving supervision at the premises. The hermeneutic analysis created four main themes; "The nurses' conceptions of their psychosocial work", "Trespassing on another professional role", "Interprofessional collaboration at the CHC", and "The nurses' conceptions of the psychotherapist's function". In a second step, an analysis that clustered the nurses' attitudes towards handling mental health problems yielded three Ideal types; nurses who expressed "I don't want to", "I want to but I cannot", and "I want to and I can" (take care of families' emotional problems at the CHC).

When assessing psychosocial perspectives of the different centers, we found them to be heterogeneous, whereas each center's perspective was more homogeneous. The head nurse's attitudes to psychological work and supervision influenced the center. Nurses tended to value skills that Aristotle (1999) subsumed under the terms "episteme" and "techne". In contrast, they were more modest in evaluating their tacit knowledge or "phronesis". In our interpretation, nurses who managed to combine these three perspectives were conversant with detecting and addressing baby worries with the parents. These nurses did not feel that counseling sessions with the parent implied trespassing on the therapist's work, and they valued collaborating with her in patient work and supervision.

Many aspects of SPIPIC were appreciated by the nurses, such as easy referral and access to the psychotherapists. Also, the intervention helped them to learn more about emotional problems in the families. The nurses wished that the therapist should be a team member, be transparent about his/her work, and give feedback about cases in treatment. Their criticism included that sometimes, there was no transparency on the part of the psychotherapists. Nurses wanted to know more about the content of therapies, because this would have helped them decide which kind of patients were best suited for therapy. Also, some nurses felt that the framework concerning supervision was not clearly expressed. Nurses asked for clearer guidelines from the CHCC organization regarding how and to what extent they should work with psychosocial problems.

## 5.2 STUDY II

This study qualitatively explored parents' experiences of postpartum emotional distress and of receiving help by nurses and therapists in the project. Three main themes were formulated; "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 Ideal types: "The insecure parent", "Parents in crisis", and "Parents with lifelong psychological problems". The insecure parent included primiparous mothers who had difficulties with their transition to motherhood. Parents in crisis felt like they had been tossed into shocking responsibilities and/or due to their partner's factual or emotional absence. Parents with lifelong psychological problems reported feeling like outsiders and being exploited since childhood.

Previously, parents had experienced that it was impossible to access psychological care within primary healthcare. When finally reaching a CHC within the project, some still felt that there was a long "take-off" to opening up to the nurse about their emotional distress. In general, they very much appreciated talking to the psychotherapist, though some were critical.

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.

Parents' account of their therapies helped us differentiate the therapists' insight-promoting and supportive efforts, as well as their receptive (listening) and proactive (active and prescribing) styles. To explain the varying therapy experiences among the Ideal types, we emphasized the parents' *characterological differences*. Some seemed more "anaclitic" or dependent on the nurse's immediate help and approval. For them, it was difficult to switch to a therapist, especially one who used an insight-promoting technique. In contrast, the introjective parent was more influenced by her internal judgements of self-worth, failure and guilt. Such parents seemed to appreciate an insight-promoting experience in therapy. Since the perinatal emotional balance is precarious, the therapist sometimes needed to switch between insight-promotion and support. Some parents recalled such experiences and appreciated them. We also concluded that psychotherapists who had a holistic family

perspective and could grasp complex social-cultural situations were experienced as particularly helpful.

## 5.3 STUDY III

This study qualitatively explored eight psychotherapists' experiences of supervising nurses and providing short-term treatment to parents at the Centers. Three themes were created: "Working on commission by the nurse", "Client issues and therapists' approach", and "The therapist's experience of supervising, and her trust in the nurses influenced the quality of supervision". The analysis expanded the understanding of the therapist-nurse collaboration. Two Ideal types were constructed: "Therapists with an adaptive approach" and "Therapists with a maladaptive approach".

Attitudes that characterized the psychotherapist with an "adaptive approach" were a positive perception of oneself as a therapist, a readiness to be transparent about one's work, had the courage to lift uncomfortable questions with the nurses and courage to insist on supervision. At the same time, the therapist needed to be aware that she was working on the nurses' commission. Therapists who could work on the nurses' commission considered it crucial to be transparent and involve the team in viewing the patient from a psychodynamic perspective. This seemed to influence the nurses to work through interpersonal relations in nursing which made them better understand the patient's existential situation. Therapists corresponding to the adaptive pattern found ways of collaborating with the nurses and were well integrated in the CHC paradigm. Their supervisions helped the nurses to bridge somatic and psychological perspectives.

The therapist with a "maladaptive approach" was either too controlling or/and too reserved in relation to the nurses, which led to a distance from the nurses. If there were any supervisions with such therapists, they kept their patients' stories in secrecy. The therapist's experience of supervising and her trust in the nurses influenced the quality of supervision. We concluded that some psychotherapists needed more theoretical and practical knowledge of group supervision at workplaces.

Many times, various problems appeared simultaneously, such as baby worries, anxiety and depression, delivery traumas and loneliness. If the client, in addition, came from a culture and

class background other than the therapist, this posed a further difficulty for some therapists. Their way of working with fathers varied. Some welcomed his participation and emphasized his positive influence in therapy while others mainly focused on the mothers' distress. Some therapists reported paying extensive attention to the baby's signals and trying to address him/her. Others directed interventions mostly to the parent(s), which they sometimes explained by referring to the limited timeframe for therapy.

## 5.4 STUDY IV

The aim of this study was to quantitatively evaluate SPIPIC outcomes on parent-reported depression and infant social-emotional functioning. Figure 4 shows the number of respondents in the two groups at the three time-points.

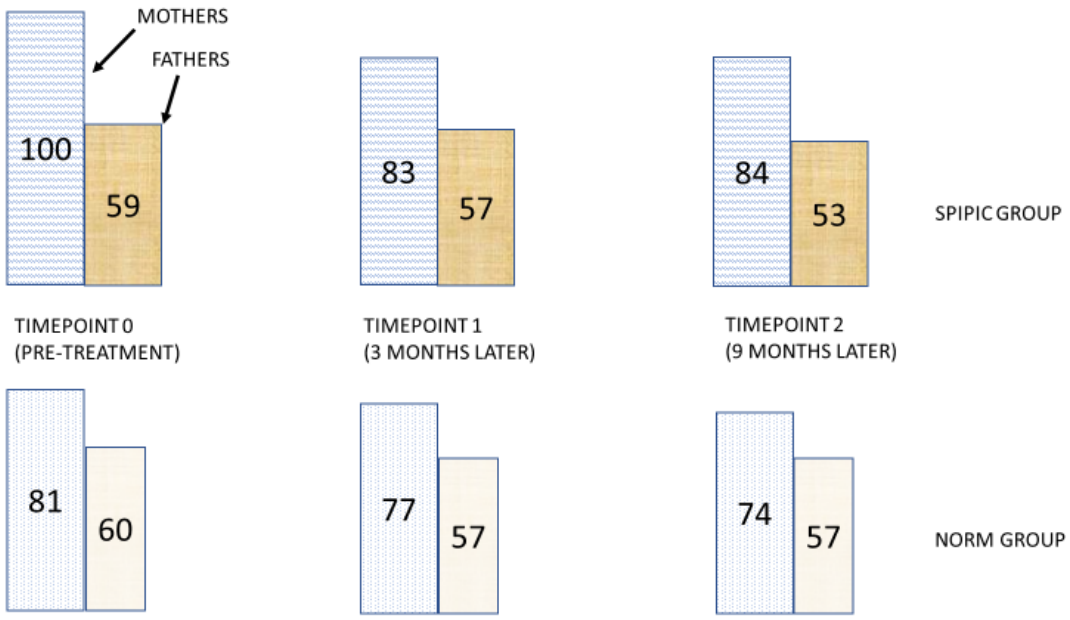


**Figure 4.** Number of participants at time-points 0 - 2.

Regarding the characteristics of the participants and their responses to the background questions, SPIPIC mothers were more stressed during pregnancy and also had more complicated labor experiences. They also had a tendency to having received psychiatric care or psychotherapy before pregnancy, a finding that was even more salient for fathers. Finally, SPIPIC infants had more often a medical diagnosis (see table 2).

**Table 2.** Background data. Only available, non-imputed data are presented. Bracketed numbers refer to standard deviations or, when indicated, percent. Complicated labor exp. = Complicated labor as experienced by parent. Skin to skin < 1h = Skin-to-skin contact with baby initiated less than one hour after delivery. */ Two SPIPIC babies were born in gestational week (GW) 32 and 37, and two norm group babies were born in GW 34 and 35.

| Variable | SPIPIC | NORM GROUP | $\chi^2$ | t-test | df | p |
|---|---|---|---|---|---|---|
| MOTHERS | | | | | | |
| Age | 32 (4.7) | 33 (5.1) | | -1.690 | 177 | .093 |
| Education (years) | 15 (2.8) | 15 (2.5) | | 0.117 | 176 | .907 |
| Immigrant | 14/99 (14 %) | 5/77 (6%) | 2.631 | | 1 | .105 |
| Medical diagnosis | 24/98 (25%) | 14/81 (17%) | 1.377 | | 1 | .241 |
| Psychiatric care before pregn. | 38/100 (38 %) | 21/80 (26%) | 2.785 | | 1 | .095 |
| Psychotherapy before pregn. | 45/96 (47%) | 27/80 (34 %) | 3.110 | | 1 | .078 |
| Stressed during pregnancy | 64/100 (64%) | 24/80 (30%) | 20.561 | | 1 | <.001 |
| Liked pregnancy | 70/96 (73 %) | 61/76 (80%) | 1.261 | | 1 | .261 |
| Caesarian section | 23/99 (23%) | 23/80 (29%) | 0,705 | | 1 | .401 |
| Ventouse delivery | 10/97 (10%) | 4/77 (5%) | 1.518 | | 1 | .218 |
| Complicated labour exp. | 26/98 (27%) | 11/79 (14%) | 4.204 | | 1 | .040 |
| Skin to skin < 1h | 92/99 (93%) | 73/81 (90%) | 0.459 | | 1 | .498 |
| FATHERS | | | | | | |
| Age | 35 (5.3) | 35 (6.5) | | 0.167 | 117 | .433 |
| Education (yrs) | 15 (2.6) | 15 (2.9) | | 1.174 | 117 | .976 |
| Immigrant | 5/59 (9%) | 8/60 (13%) | 0.722 | | 1 | .396 |
| Medical diagnosis | 6/59 (10%) | 3/60 (5 %) | 1.137 | | 1 | .286 |
| Psychiatric care before pregn. | 13/61 (21%) | 2/60 (3 %) | 9.002 | | 1 | .003 |
| Psychotherapy before pregn. | 27/61 (44%) | 4/60 (7 %) | 22.436 | | 1 | <.001 |
| Stressed during pregnancy | 17/61(28 %) | 9/60 (15 %) | 2.969 | | 1 | .085 |
| Liked pregnancy | 57/61 (93%) | 57/60 (95%) | 0.135 | | 1 | .713 |
| Skin-to-skin <1h | 43/61 (71%) | 38/60 (63%) | 2.406 | | 1 | .300 |

| | | | | | | |
|---|---|---|---|---|---|---|
| INFANTS | | | | | | |
| Age (months) | 4.8 | 5.2 | | 0.477 | 175 | .634 |
| Boy | 48/100 (48%) | 44/81 (54%) | 0.715 | | 1 | .398 |
| Prematurity* | 2/93(2%) | 2/78 (3%) | 0.032 | | 1 | .859 |
| Breastfeeding | 97/98(99%) | 77/81(95%) | 2.507 | | 1 | .177 |
| Breastfeeding start delayed | 13/95(14%) | 6/75(8%) | 1.364 | | 1 | .243 |
| Living with 1 parent at a time | 7/102 (7%) | 2/80 (3%) | 1.815 | | 1 | .178 |
| Medical diagnosis | 12/98 (12%) | 2/80 (3%) | 5.772 | | 1 | .016 |

The average number of therapy sessions was 4.3. The mean duration of SPIPIC was 8.6 weeks (*SD* = 8.0), ranging 1 – 32 weeks. The most common setting was a mother in therapy (94%). Both parents participated in only 9%. In 83% of the cases, the baby was present in one or more sessions. As shown in table 3, multilevel growth modeling analyses showed a significant decrease in mother-reported depression (EPDS) and infant socioemotional functioning (ASQ:SE).

**Table 3.** Multi-level growth models estimating change in symptoms over time. ** p < .01, * p < .05. ASQ:SE = the Ages and Stages Questionnaire: Social-Emotional. EPDS = the Edinburgh Postnatal Depression Scale.

| | **Mothers (n = 100)** | | **Fathers (n = 59)** | |
|---|---|---|---|---|
| | EPDS | ASQ:SE | EPDS | ASQ:SE |
| Baseline score | | | | |
| Intercept | 12.21** | 1.56** | 6.43** | 1.59** |
| Rate of change | | | | |
| Monthly | - 1.20** | - 0.20** | 0.05 | - 0.04** |
| Month x Month | 0.09** | 0.02** | - | - |
| Variance components | | | | |
| Residual | 17.37** | 0.58** | 6.72** | 0.35** |
| Intercept | 9.40** | 0.36** | 12.27** | 0.50** |

Referring to table 4, two thirds of the mothers entered SPIPIC as clinically, significantly depressed. After treatment, half of them had left that area. A reliable improvement was found among 1/2 of the mothers, whereas 1/10 became reliably impaired. Furthermore, 1/4 worried about their infants' social-emotional functioning before SPIPIC, a proportion reduced to 1/11 after therapy. Since so few fathers took part in SPIPIC, we were cautious making any conclusions about their scores. Their depression outcomes were inconspicuous, which to some degree might be explained by the fact that in general, only the mothers participated in the therapies, with or without the baby. On the other hand, the proportion of fathers who worried about their infant's functioning decreased from 15% to 3% which, we assume, contributed to diminishing their distress.

**Table 4.** Summary of questionnaire scores in both groups. Only available, non-imputed data are presented.

| Instruments | SPIPIC 0 | SPIPIC 1 | SPIPIC 2 | Norm 0 | Norm 1 | Norm 2 |
|---|---|---|---|---|---|---|
| **MOTHERS** | | | | | | |
| EPDS | 12.21 (5.31) | 9.52 (5.33) | 8.60 (4.99) | 3.79 (3.15) | 4.44 (3.65) | 4.87 (4.20) |
| EPDS Cohen's d | | | 0.70 | | | |
| EPDS RCEN+ | | | 42/81 (52%) | | | |
| EPDS RCEN- | | | 8/81 (10%) | | | |
| EPDS CCb | 64/100 (64%) | 32/86 (37%) | 27/81 (33%) | 2/81 (2%) | 4/77 (5%) | 10/74 (14%) |
| EPDS McN | | | t =18.27, p<.001 | | | |
| ASQ:SE | 1.54 (1.18) | 1.12 (0.80) | 1.12 (0.88) | 0.98 (0.63) | 0.81 (0.65) | 0.99 (0.64) |
| ASQ:SE Cohen's d | | | 0.40 | | | |
| ASQ:SE RCEN + | | | 10/74 (14%) | | | |
| ASQ:SE RCEN - | | | 0/74 | | | |
| ASQ:SE CCb | 22/90 (24%) | 9/86 (10%) | 7/81 (9%) | 1/69 (1%) | 2/77 (3%) | 3/73 (4%) |
| ASQ:SE McN | | | p <.001 | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **FATHERS** | | | | | | |
| EPDS | 6.54 (4.42) | 6.35 (4.24) | 6.70 (4.57) | 3.83 (3.43) | 4.65 (3.79) | 3.82 (3.79) |
| EPDS Cohen's d | | | -0.04 | | | |
| EPDS RCEN + | | | 7/53 (13%) | | | |
| EPDS RCEN - | | | 12/53 (23%) | | | |
| EPDS CCb | 11/59 (19%) | 11/57 (19%) | 13/53 (25%) | 5/58 (9%) | 5/57 (9%) | 4/57 (7%) |
| EPDS McN | | | p = 1.000 | | | |
| ASQ:SE | 1.62 (1.05) | 1.43 (0.92) | 1.21 (0.78) | 1.25 (0.81) | 1.13 (0.92) | 1.14 (0.65) |
| ASQ:SE Cohen's d | | | 0.44 | | | |
| ASQ:SE RCEN + | | | 2/53 (4%) | | | |
| ASQ:SE RCEN - | | | 0/53 | | | |
| ASQ:SE CCb | 9/59 (15%) | 5/57 (9%) | 2/53 (3%) | 3/58 (5%) | 3/57 (5%) | 1/57 2%) |
| ASQ:SE McN | | | p = .063 | | | |

The predictor analyses showed that mothers with higher initial depression scores tended to receive more therapy sessions. Single mothers initially had higher rates of depression than those living with the child's father. Furthermore, the higher the mother's level of education, the faster her depression scores decreased. Both parents' assessments of infant functioning were associated with whether or not the child had a medical diagnosis.

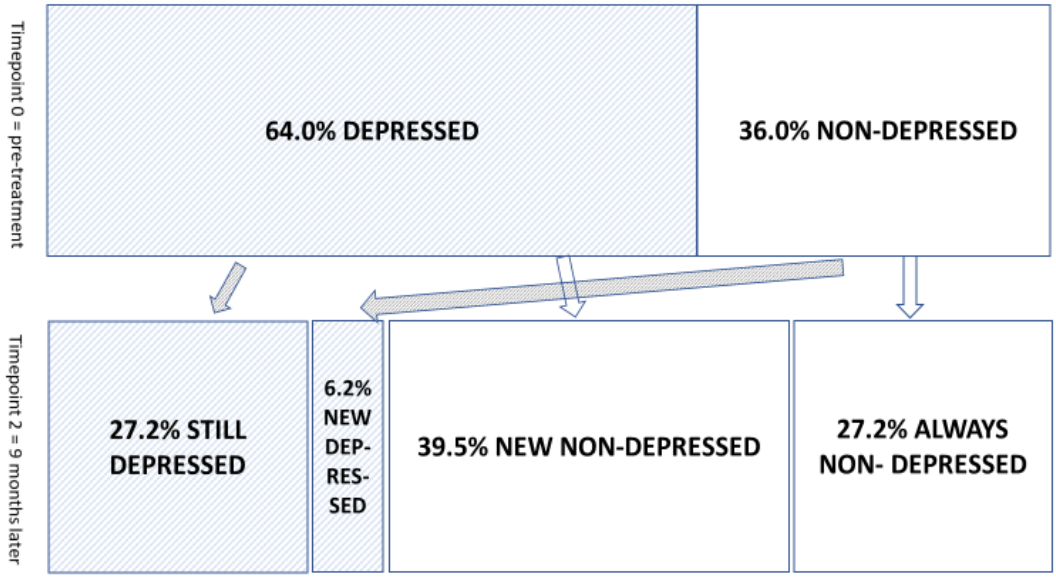


**Figure 5.** Development of SPIPIC mother's EPDS scores. "Depressed" implies EPDS > 11, that is, the level of clinically significant change b, as explained in the article text.

# 6 DISCUSSION

The aim of the thesis was two-headed; 1) to qualitatively explore nurses', parents' and psychotherapists' experiences of Short-term Psychodynamic Infant-Parent Interventions at Child health centers (SPIPIC), as well as nurses' and therapists' experiences of supervision and 2) to quantitatively evaluate SPIPIC outcomes on parent-reported depression and infant social-emotional functioning. Firstly, I will go through various aspects of methodological considerations and results. Thereafter, the results will be discussed in the light of clinical usefulness, in the hope of suggesting improvements of psychological health care within the CHC organisation.

## 6.1 METHODOLOGICAL CONSIDERATIONS

### 6.1.1 Qualitative method

There are several qualitative methods, for example, content analysis (Elo & Kyngäs, 2008; Graneheim & Lundman, 2004), reflexive thematic analysis (Braun & Clarke, 2006; 2019), phenomenological analysis (Van Manen, 2017; 2017; Lindgren, Nässén, Lundgren, 2017), phenomenological reflective lifeworld approach (Dahlberg, Nyström & Dahlberg, 2007; Wessberg, Lundgren, Elden, 2017) and hermeneutic analysis (Fleming, Gaidys and Robb, 2003). One's choice of method depends much on the character of the research questions. My focus was on the informants' experiences, for example, how the nurses felt about collaborating with the therapist, the parents experienced emotional distress, and the therapists experienced working in a new environment. Since such experiences may be difficult or even embarrassing to express explicitly, I assumed that valuable information might be concealed in what was expressed implicitly, particularly through non-verbal communication. Since our group of interpreters wanted to fuse interpretations into a common understanding of horizon we discarded both content analysis and a descriptive phenomenological approach (Patton, 2019).

Hermeneutics and reflexive thematic analysis (Braun & Clarke, 2019) are similar in that both focus on interpretations of the data and both are suitable for generating theory. Our analyses contained themes, which might give the impression that we used reflexive thematic analysis. However, we saw a risk that this method would tempt us to formulate themes without having

exhausted the possibilities of reaching a deeper understanding of the respondents' experiences. In contrast, the hermeneutic method focuses on a wider research context and considers the entire background environment of the research, including the researchers' personal background and pre-understanding (Ödman, 2007). While analyzing according to the hermeneutic method, we subsumed the individuals' experiences under larger entities, for example, common patterns among the nurses' implicit and explicit attitudes towards working with perinatal psychological problems or baby worries. For example, no nurse said, "I don't want to handle emotional problems" and no therapist said, "I am maladaptive", to quote two Ideal types. Instead, the types were formulated in a recursive process to denote what we interpreted, "between the lines", were some informants' implicit attitudes. Once such themes and types had been created, we sought to unravel contradictions between various parts of the interview text, or between seeming contradictions between explicit and implicit, or conscious, and unconscious values, feelings, and attitudes. This way, we hoped to strengthen the trustworthiness of the analysis and that our analyses of the interviewee's experiences would become as wide and deep as possible and be comprehensible to other readers.

### 6.1.2 Quantitative method

We know that parent-infant psychotherapy has a good efficacy in RCT studies (Cohen et al., 2002; Lieberman et al., 1991; Robert-Tissot et al., 1996) compared with other methods. However, these studies were carried out at special infant centers where parents had been recruited or infants had been assessed by a parent-infant expert. We wanted to investigate how a psychodynamic method functioned in public infant health care. Therefore, we designed a naturalistic study to discern if SPIPIC would be an efficient way of working with parents with baby worries.

In fact, we included a second subgroup in our recruitment; parents who, according to the nurse's assessment, were not worried about themselves or the baby. This was not a control group in the ordinary sense. Rather, it served one purpose of providing norm data for calculating clinically significant change. True, we could have used norm data from population studies. However, we thought it more appropriate to compare two subsamples from one and the same population to get a better notion of what differentiated families with and without baby worries.

No matter how large the outcomes of a naturalistic study may be, they cannot be labelled irrefutable effects of the index treatment. In an RCT, such inter-group differences are supposed to be equalized by the randomization procedure. Consequently, outcomes in favor of any treatment can be said to reflect its effects. This is not the case in a naturalistic study, where significance means "compared with coincidence". To determine, reasonably well, whether our outcomes could be said to reflect the influence of SPIPIC, we must go about in other ways, that are summarized on 6.2.6.

Concerning our choice of measurement methods, parental depression and infant functioning are two key candidates for assessing risks regarding parental and child mental health. In an infant mental health context, it would have been adequate to measure video-recorded parent-infant interaction qualities. One might also have measured stress hormone levels in parents and infants. However, since we wanted to include, in the interest of power, a large number of participants, such procedures were practically unfeasible.

## 6.2 DISCUSSION OF RESULTS

### 6.2.1 Paradigm shift at the CHC: from "soma" to "psyche"

The analysis of the nurse interviews captured a paradigm shift; nurses' duties and parents' demands are moving from medical to psychosocial complaints. The question is to what extent nurses and their health organization are well-equipped to meet these demands. A tipping point occurred with the family doctor reform in 1994, which resulted in the nurses performing fewer medical tasks and more of providing parental support. Parallel to this shift, the prevalence of mental illness in society increased (Kosidou et al., 2017). This rise is reflected in study I, where the CHC nurses described that families were complaining increasingly about psychological distress. Also, the nurses lamented that they did not have enough training of meeting such challenges. It seems that today, CHC nurses are shouldering a greater burden of providing psychological support to young families. I also suggest that they are bound to function as "grandparent substitutes" since today, fewer Swedish parents live in the same municipality as their own parents (Statistikmyndigheten, 2017). In one study by Parkes, Sweeting and Wight (2015) less-frequent grandparental support mediated the association between socioeconomic characteristics and parenting stress, particularly among migrants who

might not have direct access to their grandparents. Both nurses and parents in study I and II used the word "grandmother" to describe their relationship. Interestingly, in study IV the therapists claimed that ⅓ of the treated families suffered from loneliness. Study I concluded that CHC nurses were willing to work with postnatally depressed parents, though to various extent. For example, Ideal type "I don't want to" was not willing to do so, results that are similar to Wickberg-Johansson, Erlandsson and Hwang (1996).

The scarcity of psychological support was mentioned by many parents in study II which also has been shown in other studies (Darwin et al., 2017; Hadfield & Wittkowski, 2017). It was "a long take-off" to receive help, they felt like being "in a middle-land" and receiving SPIPIC was described as "luck". These comments by nurses and parents make me conclude that the CHC organization has not caught up with the paradigm shift. *To put it briefly, in the future the organization needs to focus equally on providing medical and psychological care at CHCs*.

### 6.2.2 Child or Family health center care?

Psychotherapists, as reported in study III, expressed that the most common problems addressed in SPIPIC were parenthood, depression, anxiety, spousal relationship, loneliness, and bonding with the child. All these areas have a relational component and involve two or more people in distress. This makes the term "CHC care" deceptive, as it stands out as merely having a child focus. Many parents requested that nurses and therapists should care about "the whole package", to quote one parent in study II. That is, they wanted a family-centered care. One could say that they requested "FHC", that is, Family Health Center care, rather than CHC care as it is often performed today. Indeed, some CHCs had a clearer family profile than others, and the results indicate that SPIPIC might contribute to such a profile by involving all family members in therapy. Evidently, this would presuppose that fathers were invited more often, as will soon be argued. To exemplify, study IV indicated that 83% of the infants took part in one or more sessions. Therapists in study III emphasized the importance of having a "360 degrees' perspective", that is, observing all family members in whatever mode of expression, verbal or non-verbal, they showed their distress.

In contrast, fathers were present in one or more sessions in only 9% of the therapies, a surprisingly low figure since psychotherapists today express an increased interest in the father's predicament (Baradon, 2019). A recent initiative to increase nurses' focus on

fathers/non-birthing parents is to provide individual counseling with them at the CHC at 3-5 months postpartum (Wettergren, Blennow, Hjern, Söder & Ludvigsson, 2016; Bergström, 2019). Study II showed that some fathers/non-birthing parents requested psychological help even earlier. Ståhl, Kristensson Hallström, Skoog and Vilhelmsson (2019) described how CHC nurses welcomed a family-oriented perspective and that the newly established individual counseling with the non-birthing parent at CHC (Wettergren et al., 2016) has deepened their family perspective. Yet, like in study I, these nurses felt uncomfortable with handling psychosocial issues that they were not educated for, such as gambling addiction, marital difficulties, and domestic violence.

Nurses in study I requested a health care model where they were not obliged to refer depressed mothers to a GP or a psychiatry specialist placed at another unit. They expressed that it was time-consuming and the doctors did not always have the necessary qualifications, and they felt that many parents resisted such a transfer because it was "too much psychiatry and a harder step to go somewhere else", as quoted from one nurse. Dumesnil, Apostolidis and Verger (2018) found that physicians vary in their treatment strategies for depression, for example, pro-pharmacological treatment or pro-psychotherapy. They suggest that collaborative care and interdisciplinary training integrate these diverging perspectives, which would increase quick referrals to the appropriate profession. If such care is provided at one and the same unit, I speculate that it would diminish the parents' feelings of stigmatization.

Sometimes, it is also hard to distinguish the child's symptoms from the parents', as described in paper I and III. I argue that this would be facilitated by a changed attitude to postpartum emotional problems, where the family is seen as a unit and not only as a set of individuals. It would also require a move from today's vertical organization with referrals to external specialist resources. I argue that a horizontal organisation, where various professionals collaborate and are accessible to the family on the premises would better meet the parents' need of an integrated somatic and psychological health care. This argument was supported by the parents/nurses who appreciated having both nurse and therapist at the CHC. Millett et al. (2018) made similar findings. *I conclude that it is reasonable to widen the focus of CHC care to a family-centered care covering both somatic and psychological distress.*

### 6.2.3 In-service PMH training for CHC nurses

Nurses at Swedish CHCs are, most often, specialist nurses in pediatrics or health visitors. Their education is primarily founded on nursing and not specifically on reproductive and perinatal health. Study I described how the nurses perceived women having increased demands qua mothers than a decade ago. In line with Borglin, Hentzel and Bohman (2015), there is a changed view of motherhood in modern society. Women have become more anxious, worried and insecure. This filled the nurses with agony at not being educated enough in this area. Interviews with the nurses showed that supervision was important to build up the skills and attitudes that have been subsumed under the concept phronesis. It conveys a general sense of knowing to do the right thing, at the right time, and in the right way (Aristotle, 1999).

On the basis of the National target description for nursing within CHC care (Almqvist-Tangen, Hedman, Nygren & Olsson Kristiansson, 2019), nurses should know about attachment and parent-child interaction. Yet, the text does not specify how PMH knowledge should be promoted. According to that study, the CHC nurse should have education and skills in the EPDS. In Study I, it was perceived as a user-friendly instrument. Nevertheless, many nurses felt uncomfortable handling the ensuing EPDS counseling sessions. Sometimes, their apprehension of emotional distress even made them avoid talking about mental illness with the parents.

According to a new report on Specialist Nursing Education and other health education programs (Utbildningsdepartementet, 2018), there is a need for more psychology and psychiatry being taught already in basic nursing education. In section 6.2.1 and 6.2.2, we mentioned problems in today's health care organization and parents' bewilderment when seeking help for their emotional distress. Possibly, if nurses receive more psychological training in their basic education, this can make them better equipped to perceive emotional distress and to talk with the parent about it. Åhlund (2019) highlights that if BUMM becomes responsible for psychological care of the target group 0 – 5 years within first line psychiatry in Stockholm, this will demand building up specialist psychologist resources for assessment, early detection and triaging of patients – and I add, for psychotherapy. Study I described, for example, that a nurse found it hard to distinguish a mother's paranoid thoughts from ordinary anxiety. Similar topics were often brought up during EPDS counseling and therefore feared by the nurses, results that are in line with other studies (Rush, 2012; Borglin, Hentzel &

Bohman, 2015). To be true, nurses in this project, who were facing such dilemmas could refer to the SPIPIC psychotherapist, who was better educated to distinguish between severe and mild psychopathology. On the other hand, if nurses received a deeper education in psychology, they would probably feel more comfortable meeting psychological distress among parents and know more about which help to recommend. *This requires access to well-trained nurses in PMH, who can both coordinate care and provide the right information about patients' conditions.*

### 6.2.4 Supervision as the nave in interprofessional collaboration

The practice of supervision is varied (Lyth, 2000). It can be used either with mental health nurses (Arvidsson, Löfgren & Fridlund, 2001), nursing students (Holm, Lantz & Severinsson, 1998; Lindgren, Brulin, Holmlund, Athlin, 2005), hospital nurses (Bégat, Ellefsen, Severinsson, 2005) nurses in health care (Hyrkäs, Appelqvist-Schmidlechner & Haataja, 2006) and with caregivers drawn from different professions (Carlsson, Hantilsson & Nyström, 2014). Sessions can be led by a co-worker, as in peer-group supervision (Cutcliffe, Hyrkäs & Fowler, 2011), or by an expert and directed toward less-trained professionals (Fernández-Alvarez, 2016; Salomonsson, 2019). One such format is reflective group supervision with nurses (Weatherston, Weigand & Weigand, 2010), which was used in this project. Its aim is to help nurses to achieve greater self-knowledge about their emotional difficulties with patient(s).

In consistency with other studies (Arvidsson et al, 2001; Hyrkäs et al., 2006), the nurses interviewed in study I often appreciated and agreed on the importance of supervision. They appreciated ventilating emotional challenges within themselves, grasping new perspectives on demanding cases, and learning to cope with them. This concurs with other studies on reflective supervision (Frosch, Mitchell, Hardgraves, Funk, 2019; Heffron, Reynolds & Talbot, 2016; Larrieu & Dickson, 2009; Shea, Goldberg & Weatherston, 2016; Tomlin, Weatherston & Pavkov, 2014). Yet, CHC nurses in study I revealed that it was lowly prioritized. One may ask why such an appreciated part of nurses' work is not an integral part of every-day nursing at the CHC.

Study I and III revealed that the head nurse's and/or the management's attitudes to supervision played a crucial role for its continuation or abolishment. Some CHCs did not have regular supervisions or none at all. Psychotherapists who did not ask why this was the case indicated

that they viewed supervision as an unpleasant duty. Interestingly, such attitudes among head nurses and psychotherapists were associated with a non-optimal interprofessional collaboration. An appreciated supervision depended partly on the psychotherapist's ability to assume a leading role and to be transparent with cases and give feedback from treatment sessions. Carlsson et al. (2014) made a clinical intervention for sustainable care improvement and also described that a supportive leadership during the sessions are found to be extremely significant.

The nurses' reflective attitude was also a prerequisite for the psychotherapist to feel important as a leader. Nurses wanted to join a permissive collegial climate that could allow them to challenge generally accepted norms and ideas. These results are in line with Jonasson, Carlsson and Nyström (2014), who also emphasize that the success of a reflective team presupposes that the management also needs to set a frame for the activity. Time allocated for supervision has to be organized so that it is not the first thing to be dropped when the workload increases. The results show that some CHCs had a management that did not encourage supervisions.

Other factors that affected the supervision was the psychotherapist's ability to understand what the nursing group perceived as important topics and if she could embrace and bring up situations when a supervisee generated insight for her as a supervisor (Fernández-Alvarez, 2016). The author calls this a "bottom-up" approach, whereas I prefer to call it a bidirectional traffic between the two professions. In a climate where such traffic is highlighted and welcomed, the group seems more prone to build up mutual trust and develop further. Based on these results, *I suggest that supervision should be seen more as a nave for a successful interprofessional collaboration at the CHC.*

### 6.2.5 The need of an oscillating therapeutic technique

This section is based on study II and III, since the nurses in study I did not have much information about what went on in sessions. In particular, study II revealed two major dialectics in the therapist's technique; supportive vs. insight promoting technique, and receptive vs. proactive style. 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 to decrease guilt and feelings of being abnormal. 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. The receptive style implied listening

and reflecting on the interaction between all participants in the room. In the proactive style the therapist interacted more actively with the parent and was more prescribing.

No therapist belonged to one single category, but some seemed more prone to oscillate between the two. Parents in study II appreciated such oscillation. They felt that the therapist was empathic with their needs and did not feel that she had to apply only the technique that she had been trained in. I argue that this compliance was of value, since the parents had not sought a specific therapeutic method. They just wanted help in a crisis situation. To some of them, an insight-promoting mode could even be perceived as threatening. There is a kinship between this mode and the receptive style. An example of the latter is one father who said the therapist was listening and asked few questions. He did not feel that she was "fishing" for something special or towards a specific goal. In contrast, in the proactive style the therapist seemed intent on breaking a maladaptive pattern in the parent. Especially those parents who felt helpless in their crisis appreciated this style because it offered them advice and guidance.

Some parents requested that the therapist should clarify the frame; how many and how frequent the sessions should be. It was hard for some to "cross the barrier" and "open-up" to the therapist. They thought it would have been easier if the frame had been clarified to them. Some expressed, especially in the therapy's beginning, that its goal should be defined. Later in the therapy such wishes diminished, either because they had developed more trust in the therapist or that they had come to understand what therapy was all about.

The therapists' technique seemed influenced by the fact that they had left their private practice to work in a public health care setting. Factors that facilitated this transfer was that the psychotherapist had a positive perception of herself as a therapist, offered a high transparency of her work, had the courage to lift uncomfortable questions with the nurses, and who accepted to work on the nurses' commission. These factors constituted what we clustered into the Ideal type of the therapist with an "adaptive approach". Those who did not work according to this approach, in our terms, a "maladaptive approach", for example, by communicating with the nurses via the parent or difficulties in talking with the nurses about the progress of the therapy.

I had assumed the therapists' psychological perspective would get in conflict by a more medical perspective among nurses. However, the interviews with the nurses and therapists did not confirm this. In contrast, the nurses expressed gratitude for having a psychotherapist at the

CHC, she was "a godsend", as one nurse expressed it. When a therapist expressed not feeling welcome at the CHC this was not, in our interpretation, due to such a clash between a medical and psychological perspective. Rather, it seemed related to unsolved conflicts among the staff and to the therapist's problems with transparency with the nurses. *This make me conclude that therapists at the CHC need to be transparent about their work, to the extent that this does not violate their ethical commitment to the patient.*

### 6.2.6 Outcomes of SPIPIC and their relations with the results of the qualitative studies and other studies

To further understand the results of the four studies, I will begin with applying a triangulation procedure (Elliot, Fischer & Rennie, 1999) on the qualitative and quantitative studies. Study IV showed that, compared with scores at treatment start, the SPIPIC mothers became less depressed, and SPIPIC mothers and fathers worried less about their children nine months later on. In a naturalistic study without a control group, it is difficult to know whether the outcomes depend on the intervention or the passing of time, regression to the mean, or other factors. I will now posit arguments from the qualitative studies that support the conclusion that the outcomes were, at least partly, true effects of SPIPIC.

Study I described the psychotherapist as a much appreciated and necessary resource, even by those nurses who questioned the collaboration with her. In general, they appreciated that the psychotherapist added a unique competence in treating parents whom the nurses found it hard to help. In Study II, parents gave a clear and detailed description of the therapist's technique, recalled individual sessions surprisingly well, and were able to quote the therapist's expressions. In turn, the psychotherapists in study III could formulate their ideas about the working mechanisms in therapy and which perspectives were facilitative, for example, seeing all the family members, taking in both explicit and implicit communications, and paying attention to the countertransference, that is, her emotions in the contact with the patient. They also had a diverse perspective on the clients; whom they could treat and whom should be suggested another kind of treatment. *To sum up, I argue that we have sufficient support from the qualitative studies to claim that the outcomes in the quantitative study IV were, to a substantial extent, due to the SPIPIC psychotherapies and the nurse-therapist collaboration. These results also gave us an understanding of which factors might be crucial for improving SPIPIC outcomes in the future.* We will return to this point in the conclusion section 7.

I will now see if other studies can yield a deeper understanding of SPIPIC, for example, for which kind of patients it is suitable, if there is any risk group that is not suited for SPIPIC, and finally, the policy regarding treatment duration. To begin with the fathers, it was striking that they were less depressed than their partners, and the depression outcomes were inconspicuous. The EPDS questionnaire was constructed to screen mothers for PPD. Since many men do not express depression by a depressive affect but rather with somatization or externalizing symptoms, and the EPDS lacks such items, it seems less sensitive in detecting depression in fathers. Psouni, Agebjörn and Linder (2017) recommend that to assess depression in fathers, an instrument should include all these symptoms. Other studies have found validity problems with the EPDS applied to fathers (Carlberg, Edhborg and Lindberg, 2018; Massoudi, Hwang, Wickberg, 2013; Matthey, Barnett, Kavanagh, Howie, 2001). In study IV, fathers' low EPDS scores thus cannot be said to ascertain their "real" depression level.

Setting aside these reservations about EPDS validity, it was noteworthy that fathers' outcomes were much lower than their partners'. One reason could be that they took part in SPIPIC sessions much more rarely and were thus exposed to therapeutic influence only indirectly, via their spouse. Or, they benefited from SPIPIC, though not by becoming less depressed but by becoming less worried about their babies' functioning. It is interesting that while mothers had twice the initial score levels on the EPDS compared with their partners, score levels on the ASQ:SE were almost identical. The third explanation could be a floor effect; the fathers' initial EPDS score levels were already low, which made it difficult to lower them even more. Finally, conclusions on outcomes on fathers must be cautionary, since their n was much less than the mothers'.

Yet, I argue that one conclusion is well-supported by the quantitative study; fathers' low response rate and participation in SPIPIC, plus their indication of worries about their children, poses a challenge to CHC nurses; to be trained in how to bring up sensitive topics with fathers at an early stage. Similar results were shown by Darwin et al. (2017). Likewise, psychotherapists should be more alert as to fathers' emotional distress and include them in therapy. There were fathers in study II and psychotherapists in study III who emphasized this point.

Regarding the question which kind of patients that SPIPIC is most suited for, I suggest, based on study II, Ideal types "the insecure parent" and "parent in crisis". In contrast, Ideal type

“parents with lifelong psychological problems” is a risk group and may need specialized treatment, not the least because of their dependency on immediate help. Nurses easily identify type 3 due to their distinct emotional distress but, as described in study III, they were harder to treat in therapy because of their dependent or anaclitic traits.

Another risk group is immigrants. Twelve percent of SPIPIC parents were immigrants, a lower proportion than the Swedish average (Statistikmyndigheten, 2019). Study I indicated that immigrant families challenged some nurses; they felt a lack of cultural competence and often did not carry out an EPDS screening. Other studies have shown that CHC nurses, despite long professional experience, perceived that they occasionally lacked cultural knowledge (Berlin, Johansson & Törnkvist, 2006; Skoog, Hallström & Berggren, 2017). Thus, some of the nurses can be said to correspond, in this respect, to the Ideal type “I want to but I cannot”. That is, they perceived their cultural “blindness” but did not know how to deal with it. Accordingly, they experienced it harder to deepen their relationship with non-Swedish-speaking immigrant mothers and perceived such cases as more time- and effort-consuming. As for psychotherapists, some were less comfortable with handling patients from other cultures, which emphasizes the need to raise the question on how to work with these risk groups in the future.

Data from study IV enabled us to further identify parents at risk for higher depression scores. If the mother was not living with the father, or if she had experienced psychological distress earlier, she was predisposed to higher initial EPDS scores. The first association concurs with other studies that stress the importance of the other parent’s presence and support (Dennis & Ross, 2006; Gremigni, Mariani, Marracino, Tranquilli & Turi, 2011; Iles, Slade & Spiby, 2011). Similarly, fathers who had felt discomfort during pregnancy were also predisposed to higher EPDS scores. As for infants with a medical diagnosis, this predisposed to higher initial ASQ:SE scores for both parents.

# 7 CONCLUSIONS AND CLINICAL IMPLICATIONS

SPIPIC may reduce depressive symptoms in the mother and reduce both parents' concerns about the child's social-emotional functioning. Insecure parents and parents in crisis seem to be helped by SPIPIC. Five risk groups were identified:

1) Parents with lifelong psychological problems
2) Immigrant parents
3) Mothers not living with the child's other caregiver or who had experienced psychological distress earlier
4) Fathers who had felt discomfort during pregnancy
5) Families having an infant with a medical diagnosis

These groups need special attention by nurses and psychotherapists. To conclude, I suggest improvements in the following areas:

- A powerful implementation plan regarding parent-infant treatment is needed within the CHCC organization to handle today's unequal availability of evidence-based psychological treatment

- I suggest that a family-oriented organization is more appropriate to identify parents with postpartum emotional distress and to offer adequate resources and treatment at the premises

- To train and supervise CHC nurses in becoming more skilled and confident in handling perinatal emotional distress. This applies also to families coming from other cultures than that of the nurse

- Psychotherapists need to work with an oscillating technique that is both insight-promoting and supportive and that focuses on both parents' and the infant's emotional states and on their interaction

- Supervision needs to be seen as the nave for interprofessional collaboration at the CHC. Psychotherapists need to be trained in reflective supervision

These suggestions pose challenges to the two professions as well as health care organizers. They need to allocate time and training for the professions, place therapy expertise on the premises, and provide economical preconditions. I hope that if these points are taken into account, a propitious and accessible perinatal health care can be developed. If this can diminish the prevalence of postpartum distress and depression, marital discord, and infant distress, it will not only decrease the present suffering of the family members. It will also increase their possibilities of a positive emotional development in the future.

# 8 FUTURE RESEARCH

The therapists in this study constituted a homogenously trained group with very long professional experiences. It would be interesting to conduct a similar naturalistic study with professionals having varying length of training, not the least to check SPIPIC's external validity. Another study could investigate how SPIPIC works, in a modified form, on samples with a graver psychopathology or with an immigrant background.

It would also be interesting to study a sample of mothers, fathers and infants, which focused on the psychotherapeutic alliance between the family members and the therapist. Such a study could also evaluate the development in therapy of parent-infant interactions assessed through video-recorded sessions.

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# 10 APPENDIX

## 10.1 APPENDIX 1. QUESTIONNAIRE STUDY IV: BACKGROUND DATA PARENTS

## Studien ”Tryggare kan flera vara” Löp nr: _____

**BAKGRUNDSFRÅGOR:**

Ålder:…….....

Hur många års utbildning har du totalt från första klass till högsta utbildning?.....år

Är hela din familj född i Sverige?: Ja Nej

Är du adopterad?: Ja Nej

Har du invandrat till Sverige? Ja Nej

Om ja, från vilket land?..... vilket år var det?.....

Har du någon medicinsk diagnos? Ja Nej

Om ja; Vilken/vilka?

.....

Barnet är: Pojke ○ Flicka ○

Hur många månader är barnet nu ……..

Är barnet adopterat?: Ja Nej

Om ja, från vilket land?.....

Barnet adopterades vid ..... månader

Barnet bor hos:

Båda föräldrarna Ja Nej

Hos mamma Ja Nej

Hos pappa Ja Nej

| | | |
|---|---|---|
| Växelvis hos mamma och pappa | Ja | Nej |
| Annan vårdnadshavare | Ja | Nej |
| I ”regnbågsfamilj” | Ja | Nej |

**HÄR KOMMER NÅGRA FRÅGOR OM DIN SITUATION FÖRE FÖRLOSSNINGEN:**

| | | |
|---|---|---|
| Har du innan/under graviditeten sökt psykiatrisk vård? | Ja | Nej |
| Har du någon gång gått i psykoterapi? | Ja | Nej |
| Var du stressad under graviditeten? | Ja | Nej |

Om ja: Varför var du stressad?

.....

.....

.....

Tyckte du mestadels om att vara gravid? Ja Nej

Hur var din psykiska hälsa under graviditeten?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Mycket dålig | 1 | 2 | 3 | 4 | 5 | 6 | 7 Mycket god |

Hur var din fysiska hälsa under graviditeten?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Mycket dålig | 1 | 2 | 3 | 4 | 5 | 6 | 7 Mycket god |

**HÄR KOMMER NÅGRA FRÅGOR OM FÖRLOSSNINGEN:**

| | | |
|---|---|---|
| Födde du med kejsarsnitt? | Ja | Nej |
| Födde du med sugklocka? | Ja | Nej |
| Upplevde du att din förlossning var komplicerad? | Ja | Nej |

Om ja: På vilket sätt var den komplicerad? .....

.....

.....

**HÄR KOMMER NÅGRA FRÅGOR OM BARNET:**

Prematurfödsel (föddes före v 37) Ja Nej

Om ja: i vilken vecka föddes barnet? .....

Hade du barnet naket mot din nakna hud direkt efter födseln? Ja Nej

Ammar du/har du ammat? Ja Nej

Om ja: När skedde första amningen? Välj nedan på timmar eller dagar.

Barnet var ..... timmar gammalt

Barnet var…….dagar gammalt

Om du ammat: Hur länge har du ammat (skriv också dgr/mån/år)……..

Ammar du nu? Ja Nej

Beskriv med tre ord hur du upplever/upplevt amningen?

1. .....

2. .....

3. .....

Har ditt barn fått någon medicinsk diagnos? Ja Nej

Om ja; vilken/vilka?

.....

## TACK FÖR ATT DU VALT ATT DELTA I DENNA STUDIE!

## 10.2 APPENDIX II. QUESTIONNAIRE STUDY IV: PSYCHOTHERAPIST'S ASSESSMENT

# Formulär som fylls i av respektive psykoterapeut. Löp nr: _____

**DEN PERINATALA PERIODEN**

**1. Graviditeten var oönskad av mamma:**

Stämmer ☐

Stämmer inte ☐

Vet inte ☐

**2. Graviditeten var oönskad av pappa:**

Stämmer ☐

Stämmer inte ☐

Vet inte ☐

**3. Mamman övervägde abort:**

Stämmer ☐

Stämmer inte ☐

Vet inte ☐

**MAMMANS SKÄL ATT SÖKA HJÄLP FÖR BARNET**

**4. Varför söker mamman hjälp för barnet? (Skriv tydligt!)**

(Anknytningssvårigheter hos barnet (gentemot vem?), oro kring utvecklingen, matsvårigheter, skrikighet,/kolik, kontaktvårogheter, koncentrationssvårigheter, sömnproblem, psykosomatiska symtom, bråkighet, hyperaktivitet, nedstämdhet, annan anledning**)**

_____

_____

_____

**MAMMANS SKÄL ATT SÖKA HJÄLP FÖR SIG SJÄLV**

**5. Vad har mamman för skäl för sig själv att söka vård? (Skriv tydligt!)**

(Bindningssvårigheter, amningssvårigheter, traumatisk förlossning, svårigheter med föräldrarollen, relationsproblem, psykosomatiska symtom, nedstämdhet, oro, ångest, psykotiska problem, tvångssymtom, fobier, självskadebeteende, suicidtankar, sexuella övergrepp, misshandel, krisreaktion, problem med alkohol och droger, pågående skilsmässa annan anledning.)

_____

_____

_____

**PSYKOSOCIALA PÅFRESTNINGAR**

**6. Vad för slags psykosocial påfrestning upplevs? (Skriv tydligt!)**
(Arbete, bostad, ekonomi, bristande nätverk, upplever ensamhet, vårdnadstvist, barnet är/har varit separerat från förälder, dödsfall i familjekretsen, hälsoproblem i familjen, flyttningar, misshandel av barnet, katastrofupplevelse, kultur, migrations och språkproblem, flyktingbakgrund, annat.)

_____

_____

_____

**7. Samtalen har oftast skett i närvaro av:**

Barnet ☐

Mamma ☐

Pappa ☐

Tolk ☐

Annan ☐

(Du kan ange flera alternativ)

**8. Samtalens fokus har legat på det emotionella tillståndet hos:**

Hela familjen ☐

Barnet ☐

Syskon ☐

Mamman ☐

Pappan ☐

(Du kan ange flera alternativ)

**9. Antal avbokade samtal_____**

**Antal utförda samtal_____**

**10. Behandlingen påbörjades_____och avslutades_____(skriv datum ex 150506)**

**11. Patienten/patienterna har remitterats vidare:**

Ja ☐

Nej ☐

**12. Ytterligare kommentarer:**

_____

_____

_____

_____

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