

Public health care nurses' views of mothers' mental health in paediatric healthcare services: a qualitative study

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Aim: To investigate public health nurses' perceptions and experiences of mental health and of the prevention of mental ill health among women postpartum, within paediatric healthcare services. **Background:** Although maternal health following childbirth should be a priority within primary care, it is known that women postpartum do not always receive the support they need to adapt to and cope with motherhood. Research implies that postnatal problems lack recognition and are not always acknowledged in routine practice. Few studies have been presented on this topic or from the perspective of nurses. **Methods:** For this study, eight semi-structured interviews were conducted with public health nurses, and the transcribed texts were analysed through a process inspired by Burnard's description of the four-step qualitative content analysis. **Findings:** Three categories – external influences on postpartum mental health, screening for and preventing postpartum mental ill health and paediatric healthcare services as a platform for support – were interpreted to reflect the nurses' perceptions and experiences of mental health among women postpartum and of the prevention of mental ill health among women postpartum. **Conclusion:** We found that public health nurses can have an important role in supporting mothers' mental health postpartum. Although caution is warranted in interpreting our results, the findings concur with those of other studies, highlighting that an equal care emphasis on both the mother and child can be an important aspect of successful support. Implementing person-centred care might be one strategy to create such an emphasis, while also promoting the mental health of new mothers. Public health nurses have a unique opportunity to support mothers' transition into healthy motherhood, especially because they are likely to meet both mothers and children on a regular basis during the first year after birth.

Key words: content analysis; interviews; mental ill health; nursing; qualitative research

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Introduction

Maternal health following childbirth should be an area of priority in primary care, but it has thus far

been relatively sparsely investigated (Hoddinott *et al.*, 2002). It is not rare that women experience emotional instability including worry, anxiety and a general low mood after giving birth. However, postnatal problems are not always acknowledged in routine practice (Hearn *et al.*, 1998) and lack recognition (cf. Gjerdingen and Yawn, 2007). It is also known that some women postpartum do

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not receive the support they need to cope with motherhood (Tarkka *et al.*, 2002). Emerging evidence indicates that untreated mental ill health can be associated with poorer long-term outcomes for children beyond the immediate postnatal period (Lovejoy *et al.*, 2000; Nulman *et al.*, 2002; Grace *et al.*, 2003) – a finding that highlights the importance of the topic. For example, postpartum depression has been shown to be associated with cognitive delay, a range of emotional and behavioural difficulties in young children (cf. Murray *et al.*, 2003) and less favourable parenting behaviours (Turney, 2011). The resulting increased psychological vulnerability of children whose mothers suffer from mental ill health emphasises the need for effective detection and treatment during the postnatal period.

Routine assessment of the mental health of women postpartum and at the primary-care level could potentially facilitate early identification of women experiencing distress (Austin and Priest, 2005). Almond (2009) suggests that service providers should consider routine depression assessments for all postnatal women. Systematic reviews exploring interventions targeting, for example, postpartum depression conclude that interventions focussing on mothers may result in improved mother–infant relationships (Poobalan *et al.*, 2007). Detecting mental ill health and offering treatment are, therefore, vitally important – not only for the mother but also for the infant and the extended family. However, the most effective approach for detecting and supporting mothers at risk and whether screening is the best route to improve the detection of vulnerable mothers have not yet been established. A validated and reliable prediction tool for routine clinical assessment is also still lacking (NICE, 2007). One commonly used instrument is the Edinburgh Postnatal Depression Scale, or EPDS. The EPDS is described as a mood-assessment instrument (Hewitt *et al.*, 2009) that can be used for the early identification of mentally unwell mothers in paediatric healthcare services (PHCSs). Although the EPDS has been shown to be effective in measuring the severity or probability of clinical depression, the Swedish Board of National Health and Welfare (NBHW, 2011) states that there is a need for further evidence-based implementations of PHCS.

In Sweden, as in many other European countries, PHCSs are commonly organised within

primary-care systems. In addition to safeguarding newborn children's well-being, public health nurses and/or health visitors (hereinafter referred to as 'nurses') have a central role in supporting mothers' well-being postpartum. According to the NBHW (2011), more knowledge about how to strengthen mothers in their roles as parents and how to expand their psychological support is warranted. It is vital that nurses understand the importance of establishing good relationships between the mother and child early on (Nelki *et al.*, 2010). Good relationships can assist nurses in offering person-centred care to women postpartum. The effectiveness, or impact, of the above on women's mental health still needs to be investigated in more depth, as existing research provides no clear-cut answers. For instance, Shaw *et al.* (2006) investigated the effectiveness of postpartum support programmes in improving maternal mental health and concluded that there was no evidence to endorse the universal provision of postpartum support. However, evidence did indicate that high-risk populations might benefit from support programmes postpartum. Shaw *et al.* also found that home visit programmes improved parent–infant interaction, whereas high-intensity home visits and less intensive peer support seemed to be equally effective for mothers' mental health (2006). However, few studies have investigated this phenomenon from a nurse's perspective. It is likely that nurses, especially during sensitive times (e.g., postpartum), can play an important role in detecting and supporting women's mental health. Therefore, this study seeks to investigate public health nurses' perceptions and experiences of mental health and of preventing mental ill health among women postpartum within PHCSs.

Design

This study had a qualitative descriptive design. The data were collected through semi-structured interviews, and the transcribed text was analysed through a process inspired by qualitative content analysis.

Sample

Fourteen public health nurses were purposively approached for the interview (i.e., the purposive sampling technique) (Polit and Beck, 2012).

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- How do you perceive the mental health among mothers postpartum who you encounter at the paediatric health care services?
- How do you experience the situation as a nurse when signs of mental ill health are present in a mother postpartum?
- How do you experience the meeting with mothers who show signs of mental ill health?
- What activities/interventions do you use at signs of mental ill health?
- How do you support the mother postpartum to prevent mental ill health?
- How do you draw up the support? Which factors are of importance?

Figure 1 The semi-structured interview questions

However, six nurses declined to participate due to heavy workloads and difficulties in finding time for the study. The final group of participants, therefore, comprised of eight nurses. The following inclusion criteria were used: public health nurses, no <50% duty and no fewer than two years of work experience within PHCSs. The strategy was to recruit a sample with one common denominator (i.e., context), but individual variations (i.e., perceptions and experiences) (Polit and Beck, 2012). Respondents were recruited from five primary-care centres within PHCSs in Southern Sweden through the centres' nurse managers. The respondents' work experiences ranged from 6 to 35 years (mean of 23 years).

Data collection

Semi-structured interviews were conducted, and an interview guide was used (Figure 1). Before the study started, one pilot interview was also conducted to control the suitability of the questions. The pilot study did not result in any changes to the semi-structured questions. Probing questions were used to support the interviewees and to verify understanding. Such questions included: 'What do you mean?', 'Can you tell me more?', 'What did you do then?' and 'Can you exemplify?' The interviews lasted for about 40 min and were recorded on tape and transcribed verbatim.

Data analysis

The transcribed interviews were analysed through a process inspired by the inductive 'four-step' content analysis (Burnard, 1996). In this type of analysis, the investigator identifies, codes and categorises important meanings from the text (Burnard, 1991; 1996). In the first step, the second

author (J.H.) read the transcribed texts to obtain an overall understanding. The texts were then read in greater depth, and we highlighted those parts of the texts that were interpreted as responding to our aim. In the second step, the highlighted parts were condensed, while preserving the central meaning. The third step involved the creation of codes. In the fourth step, the codes were read, compared and contrasted with the text (again) to ensure credibility (Burnard, 1991; 1996). In this final stage, three categories consisting of similar codes were created (Table 1). The second author (J.H.) took the lead in the data analysis, whereas the other authors (G.B. and D.M.B.) served as co-analysers, involved in the interpretation of codes and abstraction. Finally, the first and last authors also read a couple of the interviews to validate this phase of the analysis.

Ethical consideration

This study was conducted in compliance with the established ethical guidelines of the Declaration of Helsinki. Although under the Swedish Ethical Review Act 2003:460 (Ministry of Education and Research: SFS, 2003) this study did not require ethical clearance, we applied for and received ethical guidance from the ethical advisory board in Southeast Sweden (No. 137–2012).

Findings

Three categories – external influences on postpartum mental health, screening for and preventing postpartum mental ill health and PHCSs as a platform for support – were interpreted to reflect nurses' perceptions and experiences of mental

Table 1 Example of the process of analysis

Interview text	Category
<p>'In general, I think that they [mothers postpartum] are feeling worse and worse. As a speculation, I think it is a far too stressed society we inhabit, and we are suffering from immense demands'.</p> <p>'It is not really allowed to just be a mom. You have to be everywhere, join everything, swim, bathe and have some coffee and everything you are supposed to do. Then, you should also renovate the house'.</p> <p>'... to have [own] a lot of stuff and to do a lot of stuff, it seems as if it is not allowed to just be a mum'.</p>	External influences on mental health postpartum
<p>'If they talk to their child, how they handle their child, It can be one thing, how you handle your child – a bit abrupt and with anger... there, you can actually spot it'.</p> <p>'We have to be sort of mini therapists [in relation to screening with EPDS]. Or ears at least. It is not always so much you can do, except to listen, but, sometimes, that is enough'.</p> <p>'Maternity care and paediatric care, a social worker that can work preventative, and an open parent group ... That is how I would like to work. Then, you have several professions to team up with. Alone, there is not much you can do. When you are an alone public health nurse, you really need others working with you'.</p>	Screening for and preventing mental ill health postpartum
<p>'I have to get a sense of where we are at, who is the mother in front of me, what kind of family, and how I can help them. You cannot do it by the book [by following a set of instructions]'.</p> <p>'One, does the home health visits, and then you try to take the temperature of their situation [the mothers]. How is it in your proximity? Do you have support, or are you very alone? If they are very alone, one tries to enrol them into a parenting group'.</p> <p>'It is like you really try to listen to where the needs are. It [the need] can be encouraging, supporting or advisory. But, often, the biggest need among the mothers is for someone to listen – to listen and dare to hear what I am talking about'.</p>	Paediatric healthcare services as a platform for support

health and of preventing mental ill health among women postpartum within the PHCS.

External influences on postpartum mental health

In the category of external influences on postpartum mental health, the nurses shared their experiences and perceptions of postpartum mental health in general and of factors they believed could influence mothers' mental health. The nurses reflected on how our changing society is mirrored in mothers' mental health. Nowadays, increased stress and intensified demands often cause insecurity, blurred expectations and heightened psychological stress for women (Table 1). The nurses particularly experienced that higher levels of stress were caused by the ideal picture of motherhood: being a good mother and wife, not neglecting personal interests or oneself and simultaneously presenting a beautiful appearance and achieving a successful career. The nurses felt that the idea of 'perfect motherhood' caused a great deal of stress and anxiety among certain

mothers, who felt that they were not 'good enough' in comparison with the ideal picture. The nurses also experienced mothers who had not bought the idea of perfect motherhood, and thus relaxed in their role. In relation to this, the nurses also highlighted the stress caused by a society that is more accessible and reachable than ever before, which results in a constant influx of information, particularly for mothers who read the latest discoveries and participated in social media such as Facebook, Twitter and blogs. In some mothers, this stress contributed to a sense of insecurity. The nurses perceived that feeling insecure about the knowledge needed to cope with motherhood could further add on to the distorted picture of motherhood, which the nurses felt had little relevance to real life.

Everything is crazy, so it is not strange if they feel they have missed out on something with all the different pictures showing off mothers with newborn babies. There they are [in the picture], sitting like a Madonna with her little child. They smile and everything is rosy and

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beautiful. But that's not the way it is. So, it becomes a shock landing in this [everyday life after birth]. What it is all about?

(H)

The nurses' opinions were divided opinions regarding whether mental ill health among mothers had increased. Some of the nurses had experienced that mental health was good overall, but with certain exceptions. Others experienced that mental health problems had increased, particularly with regard to the more serious conditions needing pharmacological therapy, such as depression and anxiety. The nurses perceived that they could confirm a distinctive change in the societal climate, which they believed had a negative impact on the mental health of mothers.

Social status and education were also factors mentioned in relation to mental health. In some more affluent neighbourhoods, where the mothers were likely to have university educations, the nurses stated that it was more difficult to identify mothers who were mentally unwell. The same was true for the nurses' ability to detect possible causes, such as addiction problems. From an outsider's perspective, the social status and general mental health of these women appeared to be more stable. As one nurse expressed it:

There is a lot of mental ill health, but they [the women] are better off hiding it in the better-established families.

(C)

The nurses perceived that equality between genders was another important factor influencing the mental health of mothers postpartum. By this, they meant that, in well-educated families, it was likelier that certain responsibilities such as parental leave and household chores were shared between the mother and the father, which could positively influence the women's mental health postpartum. The flipside of the coin could be relationship problems. As one nurse (F) expressed it: *If you have a dysfunctional relationship already before, this is not going to be improved by having a baby because it is going to add on a lot of strain.* The nurses' experience was also that, in the more deprived neighbourhoods, where many mothers lacked college educations, unemployment rates were high and many mothers were single, there were higher levels of mental ill health. These mothers

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were also perceived by the nurses to more commonly suffer from addiction problems and from financial and social difficulties.

Social networks were a further factor experienced by the nurses to have an impact on women's mental health postpartum. Access to a social network could work as both a protection for sustained mental health and a risk factor for mental ill health. For those mothers without relatives or friends to support them in their close vicinity, it often meant vulnerability. Having no one close to assist with practical matters could cause isolation and loneliness.

No one can assist them, and then you are very vulnerable, especially if it is a minor crisis. So there I can feel, I have noticed that then it can fail, and they do not cope.

(B)

This phenomenon was especially visible in neighbourhoods with high levels of immigrants. Here, mothers were often more isolated and, consequently, suffered from higher rates of mental ill health than mothers in other areas. In addition, many of these women were refugees and had arrived in Sweden traumatised, which the nurses perceived was likely to further negatively affect their mental health. Lacking knowledge of the Swedish language and the Swedish context increased their isolation.

Screening for and preventing postpartum mental ill health

The category of screening for and preventing postpartum mental ill health reflected how the nurses experienced the EPDS as very useful. This was particularly true because the nurses' focus shifted from the child to the mother. The EPDS screening was anonymous and was only noted in children's case notes as having occurred. Commonly, an hour was set aside for the screening session, and the nurses' experiences of the session were that many mothers gained confidence in their relationships with the nurses as a result of the session.

It is very positive. Even if there are no problems, you get to know so much. One knows how they think ... how they get along, and from that, I can support them, even if there are no problems.

(E)

Potential mental instabilities in mothers could be detected during this 1-h session, and, at times, the nurses experienced unexpected revelations. Mothers who, from the outside, appeared perfectly happy could reveal feeling mentally unwell during the session. The nurses described how suspicions of mental ill health could sometimes be raised when mothers were subdued and unusually quiet during meetings or be inferred from the interactions occurring between mothers and their babies (Table 1). The 1-h session did not always touch on the mother's mental health; however, regardless of the topic, the nurses perceived that the conversation was individual and sensitive to the needs of the mothers (Table 1). Based on the mothers' scores on the EPDS, nurses could offer a referral to a psychologist; however, the nurses experienced that it was often sufficient to offer the mother additional meetings. The purpose of these meeting was never to get answers to questions, but rather to try to encourage the mother to reflect on what she had expressed and on her available resources.

During a child's first year, the nurse often met with the mother on a regular basis, which made it possible to offer meetings at any point in time. The nurses felt that this offer should be governed by the mothers' needs, or, at times, by the nurses' understanding (e.g., when nurses perceived that a mother needed support, even if this was not explicitly expressed). In the latter cases, the nurses revealed how they might sometimes schedule a covert meeting by booking an extra weighing of the baby. Through such measures, the nurses ensured an extra opportunity to meet with the mother. At times, however, this caused a dilemma, as attending weight control meetings is voluntary – an allowance that had to be respected by the nurses. Thus, in certain cases, it was difficult to know how additional support should be introduced and offered. Nevertheless, in general, the nurses noted that they spent a substantial amount of time on supportive meetings. Some nurses perceived that they had time for only one longer supportive meeting before they had to send a referral to the mental health team.

Sometimes, maybe I don't ask the next question, as I am afraid what the answer might be, as I don't have time to listen to it. It is crap. Before, I could say, 'this is something I want to go further with', and book a new time for an

appointment. I have no new appointments, and it all comes down to nothing.

(F)

Some of the nurses experienced that they did not have time for longer supportive meetings, but expressed that they did not perceive this as a problem, particularly because they informed the mothers in advance about the situation and perceived that this knowledge lowered the women's expectations of the nurses.

PHCSs as a platform for support

In the category of PHCSs as a platform for support, continuity and good communication patterns were considered essential for building up the PHCS as a supportive environment and as a resource for mothers and their babies. One nurse expressed this perspective by saying: *I think it is important that they know they are always welcome and no questions are wrong* (A). The nurses perceived the PHCS as an arena for preventing mental ill health, as well as for supporting mothers suffering from mental ill health. A majority of the mothers with known mental ill health had established contact with a mental health team before their contact with the PHCS. The nurses experienced such contact as furthering their support to the mothers. The nurses also expressed an expectation that the maternity welfare staff would carry over information if any extra support were needed for the mothers. However, the perception was that the co-operation between the maternity welfare staff and the PHCS varied and that the communication between the different services did not always work optimally.

Then, one always hopes that the midwife at the maternity welfare gives a signal if some bells are ringing, and they do it in some cases, but one might think not very often. They are very much into integrity and of sticking to your own areas.

(D)

The nurses had also experienced a lack in collaboration among different authorities with regard to preventing mental ill health. The only times that collaborations were experienced to work well were in cases of severe mental ill health, which usually included the involvement of social services due to

concerns about the child. The reasons given for the problematic collaborations included, among others, the fact that different authorities were regulated by different legislations, which made it very difficult to hand over or speak about certain cases.

The nurses perceived that, even by the time of their first meeting with a mother and her baby (i.e., at the home visit), it was possible to assess the mental health of the mother, as well as the baby's well-being. Home visits were, in general, experienced to be good opportunities to get to know the parents, their influences on the child's well-being and their possible support needs from PHCSs (Table 1). Home visits also meant that the nurses could observe different types of informal conversations, while also sensing the mood in the family by watching the parents' interactions with each other and with the child. As one nurse (D) expressed it, *you sense a lot inside the walls, how it is. Even if you clean and make it nice [the house], you sense it.* The nurses also perceived that home visits gave valuable information about the mothers' mental health. The nurses told about their 'silent knowledge' as one way of detecting when mothers were not well. This silent knowledge was explained either as a gut (or intuitive) feeling suggesting that everything was not quite right or as the result of years of accumulated working experiences.

And then the gut feeling that one you can't explain, but you only feel that something is not right because sometimes you feel it. If someone asks you, 'what is not right?' then I can't say it. I only feel inside that something is kind of not ok.

(H)

In each case, support was offered depending on the nurse's perception of the mother's need. The nurses often suggested that mothers join a family group. Such a group could help mentally unwell mothers to meet others. The nurses perceived that such an experience helped mothers to realise that they were not alone and that others shared their experiences (Table 1).

Discussion

Our findings illuminate the importance of public health nurses and/or health visitors being aware of

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and having knowledge of on-going societal transitions and the influences that social and cultural capital can have on women's mental health postpartum. This is particularly true in light of how the vicissitudes in context, values and views reflected here appear to have influenced the roles of both motherhood and womanhood. As a result, a changed view of motherhood complexity has emerged, reflecting both increased demands and an increased exposure to higher expectations in terms of the ability to multitask. Beyond this was the constant influx of social media. The nurses perceived that these factors have been resulting, recently, in some women postpartum being more anxious, worried and insecure than women have been historically. This changed view of motherhood concurs with that of Perälä-Littunen (2007), who suggested that major changes have taken place in the roles of women and in gender attitudes in the Western world. Others (Koniak-Griffin *et al.*, 2006) have also highlighted how the mothering experience and perceptions of mothers are under the influence of images and myths in today's increasingly diverse society. It is likely that the biggest challenge in the already demanding transition to motherhood could be the prevailing and conflicting discourses of myths and images (cf. Kirkley, 2000; Douglas and Michaels, 2004) reflected by magazines, parenting books and the media. Douglas and Michaels (2004) mirror this theory in their concept of 'the new momism', in which 'decent mothers' of today have to devote all of their beings to their children and enjoy every minute of it. This puts mothers in a situation where they are 'damned if they do (i.e., stay at home) and damned if they don't (i.e., go to work)'.

Our findings also reflect how the nurses perceived that social media could add pressure to and negatively influence women's mental health. However, research into social media and its relationship to maternal well-being is contradictory (McDaniel *et al.*, 2012). Hall and Irvine (2009) have found that social media, such as the Internet, can empower mothers through information exchange and Internet communities, whereas others (Youngs, 2001) have found that it can increase stress and feelings of loneliness. Regardless, it appears to be critically important that nurses are able to support women in their transition into becoming mothers as part of preventing mental ill health. One plausible nursing strategy might be to

help mothers identify their strengths and competencies and to support them in further developing these features, while also helping them navigate through the never-ending deluge of information, myths and images.

With regard to the impact of cultural capital on women's mental health postpartum, it became obvious through the nurses' narrations that the changes Sweden has experienced – that is, its movement from being a relatively homogeneous society to being a heterogeneous society – demand culturally competent nurses. This was especially discernable in the nurses' perceptions that mothers with immigrant backgrounds had higher rates of mental ill health than Swedish women. This partially anecdotal insight is supported by earlier research. For example, Beiser (2005) suggested that immigrants and refugees might be more prone to mental ill health, mainly due to potential stressors such as pre-migration experiences, acculturation and the limiting and marginalising structural characteristics of new contexts. Thus, healthcare professionals need to have knowledge about the impacts that migration-related life experiences can have on the health statuses of immigrants and refugees (i.e., healthcare professionals must be culturally competent). The need for culturally competent nurses is supported by Jirwe *et al.* (2009), who, in her research, identified five core components of cultural competence: cultural sensitivity; cultural understanding; cultural encounters; understanding of health, ill-health and healthcare; and social and cultural context. Consequently, skills in and knowledge about the core of cultural competence can enable nurses to meet the needs of patients from different cultural backgrounds and to support various groups of women postpartum.

For the nurses in our study, screening for mental ill health postpartum and using tools, such as the EPDS, were considered important parts of their clinical practice regarding the detection and prevention of mental ill health. This finding is in line with that of Austin and Priest (2005), who emphasised the importance of brief, user-friendly and validated measures, such as EPDS, which can enable symptoms of distress to be evaluated. Nevertheless, the NBHW (2011) stresses the need for evidence-based interventions in PHCSs and criticises the EPDS screening tool for its lack of qualitative aspects. Larger trials, such as

Shaw *et al.* (2006) systematic review, show that only those suffering from severe mental ill health seem to actually benefit from mandatory screening and interventions. Our findings reflected that, when the nurses actually detect mental ill health, they can, at times, experience a lack of resources and competence to handle the situation. This finding is in line with the NBHW (2011) and Nelki *et al.* (2010), who emphasised the need for greater competence, continuity and individual person-centred care. We suggest that the question of screening should be debated within the nursing community, as it opens up the floor for questions regarding, for example, for what and for whom we should screen. Gjerdingen and Yawn (2007) supported this suggestion, stating that screening is not useful if other systems are not put into place. Our findings imply that, even if low mood can be detected by nurses, the support the nurses offer must be given within the framework of the existing capacity of their primary-care organisations. This reveals that routinely screening for mental ill health without implementing actual care plans or nursing interventions (beyond simply referring mothers to other healthcare agents) as a back-up is a lost nursing opportunity, particularly because, at least in Sweden, the nurse will continue to meet with the mother on a regular basis. It seems appropriate to suggest that more research focussing on the nurses' part in this process and the potential benefits of screening might be warranted before any mandatory screening of postpartum mental ill health is enforced.

Interestingly, PHCSs were viewed as a platform for support targeting not only the newborn child but also the mother. As our study focussed on nurses' perceptions and experiences, we cannot elaborate on whether the mothers also shared this view. However, our results imply that time is generally lacking with regard to caring for the mother. This implication is supported by others (Tarkka *et al.*, 2002; Nelson, 2003), who have stated that mothers tend to experience that the support they receive is directed not towards them but towards their children. If this actually is the case, then it represents a lost opportunity to offer person-centred care (cf. Cronenwett *et al.*, 2007) that, naturally, would include both the mother and child. A person-centred approach would likely make the transition between maternal and postpartum care less noticeable, and thus help in

supporting mental health. The latter is especially important, considering that our findings imply a possible fragmentation in the care pathway between maternity and paediatric care, which is particularly evident for those mothers with known mental health problems. In our study, it appeared that good intent was present among the professionals, but the nurses shared experiences of organisational barriers preventing collaborations across different clinical areas. Research (Xyrichis and Lowton, 2008) has indicated that discontinuity in care is common, particularly within primary healthcare and that, in practice, inter-professional work is not always achieved. Despite evidence that patient outcomes are improved through organised practice systems, the best ways to accomplish the key elements of good patient care in routine practice remain unclear (Von Korff and Tiemens, 2000).

Home visits were reflected in the interviews as important support tools, and the nurses perceived that this type of intervention allowed them to gain insight into the full picture of the mother and the child – an insight that made it easier for them to support the mothers. It is worth noting that in the Swedish context only one home visit is generally conducted, and the main contacts between mother and nurse take place at the clinic. Others (e.g., Ciliska *et al.*, 2001) have verified the beneficial effects of home visits. However, in a systematic review by Dennis (2005), the findings suggested that if the goal of home visits is to improve the mother's or child's health outcomes four or more home visits are required. Considering these contradictory (Ciliska *et al.*, 2001; Dennis, 2005) findings, and despite the perception of the nurses in this study of home visits as a useful support tool, it seems that further in-depth enquiries are required before firm guidance about the number of visits and/or the mothers who would gain most from this type of support can be issued.

Methodological considerations

The trustworthiness of a qualitative study can partly be evaluated within the framework of the study's credibility (Guba, 1981). Our sampling technique allowed us to capture differences. However, we did not succeed in recruiting all of the contacted nurses ($n = 14$); thus, a limitation of

this study may be that its findings are based on a small number of informants (i.e., eight). Nevertheless, there is little consensus regarding the most appropriate sample size (McLafferty, 2004). In this context, a potential advantage of our study may be that the interviews provided relatively rich material (i.e., about 68 pages of transcribed text). Although the sampling was purposively conducted, it was uniform with regard to gender (female); nevertheless, it was considered representative of the nursing profession, as in Sweden only ~17% of nurses are male. This, together with the informants' heterogeneous education and work experience, might increase the transferability of our findings to similar contexts. The qualitative content analysis (Burnard, 1996) made it possible to justify the texts by structuring and presenting categories. The risk of subjectivity was limited (Hutchinson and Wilson, 1994), and the credibility of the study was enhanced by all three authors working together throughout the analysis phases to supplement and contest each other's readings. By presenting quotations both within the text and in a table (Table 1), we have, hopefully, enabled readers to independently validate our interpretations (Benner, 1985) and their trustworthiness. Although this study highlights some valuable learning points, it is important to note that it is a small-scale study performed in a specific setting and context. These characteristics should be taken into account when evaluating the study and its results.

Conclusion

Our findings indicate that public health nurses might play an important role in supporting mothers' mental health postpartum. Future research can help in establishing nurses' roles in healthcare organisations concerning, for example, the development of more a person-centred care approach to include equal emphasis on both the mother and child. Our findings also suggested the possible importance of nurses being aware of and having knowledge about the influences that social and cultural capital seem to have on women's mental health postpartum. Public health nurses are likely to meet both mothers and children regularly during the first year, and thus to have a unique opportunity to support mothers' transitions into a healthy motherhood. Efforts by primary healthcare

organisations to factor such needs into nurses' daily work could allow nurses to more strategically promote women's mental health postpartum.

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Conflicts of Interest

None.

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