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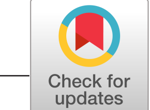

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When a common language is missing: Nurse–mother communication in the NICU. A qualitative study

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Abstract

Aims and objectives: To explore how communication in neonatal intensive care units (NICUs) between immigrant mothers and nurses take place without having a common language, and how these mothers experience their NICU stay.

Background: Admission of infants to NICU affects both parents and infants. Immigrant mothers constitute a vulnerable hospital population in need of culturally, linguistically and individually tailored information.

Design and methods: The study had a qualitative design reported according to the COREQ criteria. Eight mothers who spoke neither Scandinavian nor English went through individual semi-structured interviews. Six mother–nurse interactions were observed, and eight nurses' experiences were explored through focus-group interviews. All interviews were audio recorded and transcribed verbatim. The analysis was thematic and hermeneutic in character.

Results: Interpreters were present during the consultations with the physicians, but rarely during the daily nurse-mother interactions. Nurses focused on daily routines, infant care guidance and mother–infant attachment. The mothers learned through demonstrations and hands-on guidance. Language barriers made it difficult to assess the mothers' understanding, but the mothers expressed that they felt adequately included in the care of their infant and well informed and guided. Even so, both mothers and nurses expressed desire to use interpreters more regularly. The pictorial communication boards available lacked important vocabulary needed in neonatal nursing contexts and their use furthermore interrupted the mother–nurse conversation.

Conclusion: Body language, simple words, guesswork, trial and error characterised the nurse–mother interaction. The nurses adopted various communication strategies to help the mothers understand and give them a voice. Competent interpreters were used during meetings with physicians, but not during daily bedside guidance and information giving by nurses.

Relevance to clinical practice: Knowledge of immigrant mothers' and nurses' communication strategies and how both parties think, feel and act to overcome

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communication problem is necessary to improve clinical practice and reduce communication barriers.

KEYWORDS

communication barriers, cultural competency, infant, intensive care units, language, mother–child relations, neonate, newborn, nonverbal communication, patient education, qualitative research, translation

1 | INTRODUCTION

Focus on the parents as well as the infants is of central importance for the healthcare providers in the neonatal intensive care units (NICUs). Increased immigration leads to demographic changes in most European countries. Subsequently, healthcare personnel take care of an increasing number of culturally and linguistically diverse patients. The number of mothers with no common language with the NICU's healthcare professionals have increased over the last decades.

Of the Norwegian population of about 5.3 million, immigrants and persons with immigrant parents constituted 17.7% primo March 2019 (Statistics Norway, 2019). The overall admittance of newborn infants to NICUs in Norway is about 11% (Roennestad, Stensvold, & Knudsen, 2018).

Limited research has highlighted migrant mothers' experiences in the NICUs (Ardal, Sulman, & Fuller-Thomson, 2011; George, Duran, & Norris, 2014). According to these authors, most health research studies are focused on ethnic majority participants that can speak the majority language fluently. Such a skewed distribution of the research participants may lead to a population echelon with selection of higher education and income. Groups that are more vulnerable tend not to be studied.

2 | BACKGROUND

Globally, birth before gestational age (GA) 37 weeks ranges from 5%–18%. Thus, prematurity is the leading cause of death in children under 5 years of age (World Health Organization [WHO], 2019). Prematurity, sickness and admission to the NICU create serious stress on the parenting role and the family system as a whole. It may affect parental behaviours, responsibilities, everyday routines and cognition. Compared with majority ethnic mothers, immigrant mothers have shown a higher incidence of depressive symptoms when their infants are admitted to the NICU (Ballantyne, Benzies, & Trute, 2013) and increased psychological distress compared with parents of healthy infants (Grunberg, Geller, Bonacquisti, & Patterson, 2019; Woodward et al., 2014). If parents are anxious, depressed, grieving, isolated, suffer from sleep deprivation and/or feelings of inadequacy, this may affect the bonding process and the parent–infant attachment (Al Maghaireh, Abdullah, Chan, Piaw, & Al Kawafha, 2016; Grunberg et al., 2019).

What does this paper contribute to the wider global clinical community?'

- Increased globalisation leads to increased number of mothers in the NICU who are unable to speak the majority language
- This paper adds to understand how mothers and nurses without a common language communicate

Various structured intervention programmes are fully or partly implemented in NICUs. The purposes of these programmes are mainly to promote infant development (Spittle & Treyvaud, 2016), support the parents and bolster the parenting role (Puthussery, Chutiyami, Tseng, Kilby, & Kapadia, 2018). Examples are the Newborn Individualised Developmental Care and Assessment Program (NIDCAP), Kangaroo Mother Care, (KMC), the Mother–Infant Transaction Program (MITP) and Creating Opportunities for Parent Empowerment (COPE). Structured parent–nurse conversations are incorporated in all these programs, which are broadly categorised as parent education and parent support (Puthussery et al., 2018). These interventions may help to reduce the mothers' level of stress, reduce the incidence of depression and promote parent–infant interaction and attachment (Benzies, Magill-Evans, Hayden, & Ballantyne, 2013; Kyno et al., 2013). Lack of a common language may make these interventions difficult to organise.

In Norway, neonatal patients have the legal right to have at least one parent present at all times (Patient's Rights Act, 1999) to promote the infant-parent bonding process and enable the parents to function as advocates for the infant's needs according to family-centred care (FCC).

Additionally, independent of parental health literacy the Norwegian Patient's Rights Act (1999) establishes the right to have equal access to equal quality healthcare services. This legislation also stipulates the rights to tailored information according to the ability to understand the information's content and significance. To fulfil this law, the use of an authorised interpreter is required when a common language is missing or inadequate in this particular context.

The purpose of interpreter-aided conversations is to inform parents about their infants' condition and enable them to ask questions and effectively participate in decision-making concerning their

infants' treatment and care (Ardal et al., 2011). The assistance of an interpreter does not always eliminate all communication barriers. Information may be lost in translation (Hanssen & Alpers, 2010; Miquel-Verges, Donohue, & Boss, 2011). If the interpreter only knows the parents' language but not their culture, there is a danger of serious misunderstandings (Flores, 2005; van Rosse, de Bruijne, Suurmond, Essink-Bot, & Wagner, 2016). In spite of the legal requirement of using interpreters when needed, professional linguistic assistance is not always used (Hanssen & Alpers, 2010). Besides the obvious linguistic problems, this may create uncertainty in both parents and healthcare personnel and may make mothers feel socially isolated in the NICU.

To meet the family's needs in a dignified manner requires culturally congruent care as perceived by the parents. Each family must be respected for its individuality, ethnic, cultural and sociodemographic diversity (Gooding et al., 2011; Wiebe & Young, 2011). It is necessary to build a trusting relationship between the care provider and the parents. Communication barriers may create fragile interactions, which may influence communication and reciprocal understanding negatively (Hendson, Reis, & Nicholas, 2015).

The aim of this study was to explore how communication in a NICU between immigrant mothers and nurses takes place without having a common language, and how these mothers experienced their NICU stay.

The research questions were as follows: How do mothers without a common language with the healthcare personnel experience their stay in the NICU? How do NICU nurses experience caring for mothers and infants without a common language with the mothers?

3 | METHODS

The study has a qualitative design with a hermeneutic semi-structured interview approach and is reported in accordance with Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong, Sainsbury, & Craig, 2007) (Appendix S1). This design has a potential to verbalise what vulnerable populations—here immigrant mothers—convey about their experiences and issues (Braun & Clarke, 2013). A three facets approach was chosen: First mothers were interviewed with a semi-structured interview guide, then mother–nurse interactions were observed and finally nurses' experiences were explored through focus-group interviews.

The purpose of the interviews was to learn about the interviewees' subjective experiences, attitudes, thoughts and motives (Brinkmann & Kvale, 2015). Unstructured, nonparticipant observation was chosen to increase our understanding of the mother–nurse relationship, communication and collaboration (Polit & Beck, 2017).

Recruitment: A purposive recruitment of mothers more than 18 years of age, who spoke neither any Scandinavian languages nor English. Their infants were physiologically stable at the time of the interview as evaluated by the Duty Nurse and the Team Leader. The Team Leader and Duty Nurse selected which mothers could be asked to participate. An important goal was that the interview should not be too much of a burden. Interpreters gave oral information about the study. Recruitment and interviews took place towards the end of the infant's hospital stay.

Participants: Eight mothers and eight nurses were interviewed. All were 18 years or older (mean 28 years). Only mothers who neither spoke a Scandinavian language nor English were included. They hailed from Europe, Asia and Africa and had from none to two children before their present hospitalised infant. Their stay on the ward varied from a few days to 2 weeks.

Five of the interviewed nurses were certified as nurse specialists with postgraduate education in intensive care, paediatric or neonatal nursing. Their ages were between 28 and 59 (mean 44) years. Their NICU work experience varied between 2–34 (mean 16) years.

3.1 | Data collection

The interviews with the mothers were conducted in seven different languages assisted by professional interpreters. These were open-ended questions where the mothers could talk freely about their experiences in the NICU. The purpose was to assess whether they felt that they had received all the information they needed about their infant's illness, treatment and care, the unit's routines etc. We also asked whether being unable to understand what the healthcarers said could make them feel suspicious, and whether they were contented with how the communication and interaction with the healthcarers were facilitated. The interviews lasted for 25–35 min and took place in a quiet room on the ward.

Six mothers agreed to be observed regarding mother–nurse interactions. These observations were completed right after the interviews and highlighted everyday activities by the infant's incubator or cot. We observed what tasks mothers and nurses performed together and how the nurses prepared for these collaborative tasks. We also observed who tended to initiate communication during these tasks and *how* things were communicated. The observations lasted 10–30 (mean 16) minutes creating a total of 100 min of observational data.

After the data collection with the mothers was completed, the nurses were interviewed through two focus-group interviews with four nurses in each group. Each lasted about 40 min and produced rich data through narratives, complementary comments, questions and answers. Field notes were taken during the entire data collection period.

Sixteen interviewees and six nonparticipant observations were conducted. Based on Malterud, Siersma, and Guassoras' (2016) five items for deciding information power: aim: specificity, theory, dialogue and analysis, this sample size was assessed as adequate. The aim of the study was rather broad, but the participant specificity is dense, as they all held the specific characteristics needed to answer the research questions. As presented in the background section, the theory concerning ethnic majority mothers is sound, but meagre

concerning minority mothers. Being three experienced analysts added to the information power.

Conducting interviews through interpreters complicate the dialogue. The researcher–mother dialogue therefore had a different characteristic than the monolingual dialogue in the focus-group interviews. The interviewer being an experienced researcher was very helpful and important for the interview quality.

3.2 | Data analysis

The interviews were audio recorded, transcribed verbatim and checked for accuracy against the recordings. Rigour was obtained through being three analysts with different backgrounds; NMK: Neonatal Nurse Specialist/Senior Lecturer, DF: Physician and Professor of Neonatology, IH: Nursing Professor experienced in intercultural and qualitative research. This furthermore helped to avoid analytic bias, strengthened trustworthiness and depth of reflection and thus added important value to the analyses (Gair, 2012). The second and third authors read the texts without the first author's insider preunderstanding.

The analysis was inductive, thematic and hermeneutic in character. Gadamer (1989) teaches us to be open, curious, communicate authentically and to realise that the fusion of horizons through the reading of texts leads to the creation of something new. The data were read and re-read multiple times. This created a circular investigation of the transcribed interview data and the observational notes as each reading led to greater depth of understanding of the data corpus. Thus, we identified both communalities and variations of perceptions and experiences in the data.

Braun and Clarke (2006) have defined thematic analysis as "a method for identifying, analysing and reporting patterns (themes) within data" (p. 79). They have described thematic analysis in six phases: 1) familiarising oneself with the data and noting down initial ideas, 2) initial coding of interesting features and 3) collation of codes into potential themes. These themes captured important features about the data in relation to our research question. Phases 4) and 5) included reviewing the coded themes and from these develop overarching themes (Figure 1). In phase 6) NMK and IH wrote a preliminary paper text which then was discussed and developed further in collaboration with DF.

3.3 | Ethical considerations

The study was approved by the Scientific Committee at Oslo University Hospital and the Hospital's Data Protection Officer (certificate number 17/16915). All potential interviewees received written and orally information in their home language. They were informed about confidentiality, that participation was voluntary and that they could withdraw from the project at any time. They all signed an informed consent form. All interviews and observations were conducted by NMK. She had no contact with the mothers prior to recruitment but knew some of the nurses. Her co-authors did not know the identity of any of the study participants. No data were collected from mothers or nurses who did not take part in the study.

4 | RESULTS

Two overarching themes came to the fore: (a) information sharing and nursing guidance despite lack of a common language, and (b) communication and caregiving despite lack of a common language. Information and communication are closely related, and the mothers described the two communicative aspects as if they were one and the same. While the nurses did not say much about information, they talked a lot about communication and guidance of the mothers and emphasised the relational aspects of their interaction.

4.1 | Information sharing and nursing guidance despite lack of a common language

Information sharing is a central aspect of FCC. Two sets of information were offered the mothers; information given by the doctors through the use of interpreters, and information and guidance given by the nurses.

4.1.1 | Physicians' information

The physicians' information tended to focus on the infants' condition/illness, medical treatment, prognosis and outcome. In these meetings, the mothers appreciated that interpreters were present. The use of interpreters was reassuring: "When they want to tell me something serious about the child, they have with them an interpreter …. If there is an interpreter, then I ask about things and there is understanding between us" (Mother 3). Although they did not talk to the physician every day, a meeting was arranged whenever "I have questions or say I need to talk." (Mother 3). Even so, for some mothers, it was difficult to remember the questions they had prepared for the physicians: "You have … questions, but just when the doctor is there you might forget it and don't think about it" (Mother 8). They found it easier to talk to the nurses who were with them all day long.

4.1.2 | Nurses' information and guidance

The nurses' information tended to focus on the daily routines in the NICU, caring routines for the child and guidance regarding the infant's care and breastfeeding. Support and practical guidance on nutrition, feeding tubes, bottle and breastfeeding required time and effort by the nurses. The information tended to be communicated primarily through practical guidance and trial and error. Nurses would for instance show the mothers how and where to pump breast milk. The

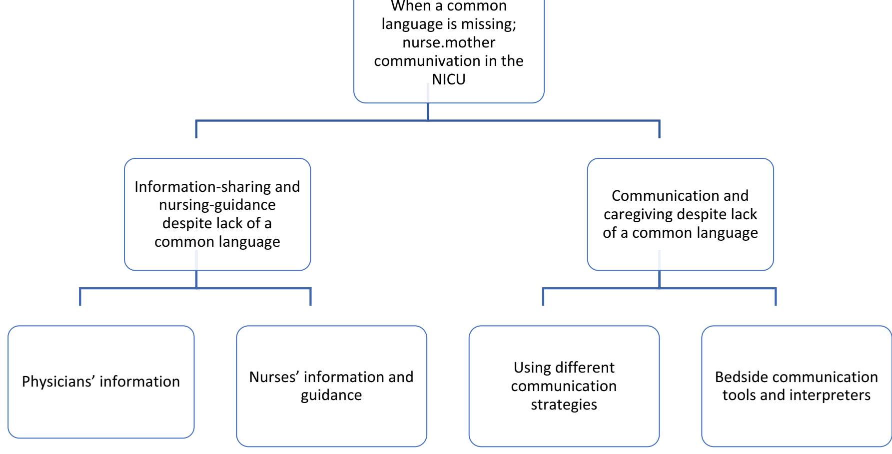

FIGURE 1 Analytic themes and sub-themes [Colour figure can be viewed at wileyonlinelibrary.com]

mothers then tried to practise what the nurses had shown them even if they did not necessarily understand the words:

> *What is it that they have explained to me? For example, what they are going to do … and then they did it. … And then I understood. Then I began to understand after they did. Not after the explanation.*
>
> *(Mother 4)*

Another mother found that,

> *the nurses provide good information, they guide you - don't do that - do like this—and even though I somehow speak less, I can understand quite a few things, so I try to follow their advice.*
>
> *(Mother 2)*

Observations showed that the nurses named their various care actions and offered guidance by showing or doing for the mothers: nesting the baby in bed, to help the child burp, etc. They also spent much time and energy trying to explain things like fluid balance, energy consumption, feeding procedures etc., repeating the message several times. Why and how to do tube feeding seemed to be among the things that was difficult for the mothers to understand. Although the mothers nodded, the nurses were painfully aware of being unable to assess whether and how the mothers understood the information they conveyed as they rarely had interpreters to support them in their daily work. Nurse 7 sighed and said: "Information …, it's problematic!".

Observations also showed that when the mothers nursed or fed their child, the nurses would confirm what the mothers were doing by nodding in a positive and encouraging manner. The mothers followed the nurses' every movement not to miss any detail of what they were doing. Even so, the language barrier made understanding difficult. However, the mothers appreciated that the nurses "try to explain it [information] and simplify it as best they can" (Mother 7).

By repeatedly being shown and guided the mothers gradually learned how to care for their infant. Thus, through the nurses' conscientious repetition of words and most importantly, actions, the mothers gradually were able to understand. Observations revealed that communication improved when the eye contact between nurse and mother was good.

Through their "show and tell" the nurses also communicated a culture of care which tended to be different from the mothers' home culture. Although the mothers were inspired by how the nurses were playing, chatting and babbling with their child, it was also important to them to find their own way of doing things: "It's my child, … I do [things] both [ways] as it is my child …» (Mother 6).

4.2 | Communication and caregiving despite lack of a common language

The mothers experienced the nurses as friendly and kind and that they communicated well even if they did not have a common language. Observations showed that nurses tended to praise the child a lot and the mothers would smile and seem proud. A nurse said that:

> *We talk, and nod and smile and you get some kind of communication and we have the baby in common and you talk to the baby: 'we'll change [your] diaper'.*
>
> *(Nurse 5)*

It was important to the nurses to provide a good and safe atmosphere during procedures and/or collaboration as "one is not dependent on a common language to see that someone cares for your child. The handling of children is quite universal" (Nurse 8). Observations indicated that usually it was the nurses who invited to collaboration and communication, rarely the mother.

4.2.1 | Using different communication strategies

The nurses spontaneously used different tools and methods to illustrate what they wanted to convey. These appeared to be adapted to the situation and the mother's ability to understand. One of the mothers explained that the nurses would,

> *"use hands, hand language, for example. And then if [the nurse] notices that I do not understand …, then she uses her gestures to point and signal so that I can understand. So, she tries more than one way to communicate to me so that I can understand".*
>
> *(Mother 5)*

Despite the fact that the mothers did not speak English or any Scandinavian language, all the nurses used words—mostly Norwegian, some a little English. They seemed to speak intuitively and kept a conversation or monologue going throughout the collaboration with the mother. One nurse explained that she talked "to them as if they [understand], and more specifically show what you do. Eye contact, reading body language, trying to be clearer" (Nurse 6).

The nurses used gestures, whispered, spoke clearly with a low voice and slowly, used simple words and repeated the same message many times. They verbalised what they did, but also what the mother did. It was important not to stress the mother, so "… I don't talk that loud…. that's what many people do, they scream somehow. Stressful!" (Nurse 5).

Even if the depth of the mothers' understanding was questionable, the mothers learned some Norwegian during their stay. When possible, the nurses started the "conversation" with the few words that the mothers knew on arrival. In such cases, they would start with,

> *some words that we knew she could understand, because then we could point [things] out to them. It gets very basic, but one could at least come a step further in everyday [situations].*
>
> *(Nurse 4)*

The mothers tended to be content with this because,

> *there are a number of things that I didn't realise and didn't know about before. [Now] I know a lot about it because this has been repeated again and again by you here.*
>
> *(Mother 5)*

Lack of a common language made it important for the nurses to have "good antennae" and opportunities to "read" as: "you might understand a little intuitively». This, however, was not adequate when «you need to explain [what you do] and then you don't quite know how…." (Nurse 3). This was particularly problematic when the infants were uneasy or some apparatus alarm went off, situations the mothers found stressful as:

> *things that we [as nurses] perceive as trifles may seem like a disaster to the mothers because they do not understand what it is. … Just watching the monitors may be scary. … How are you going to [explain] with body language? [When a monitor alarm goes off] we can be perceived as plunging in on the monitor and Mum gets scared while the nurse is smiling at her! The message changes from sender to recipient and then it becomes completely wrong.*
>
> *(Nurse 8)*

> *It was problematic not knowing the mothers' backgrounds. Were they from urban areas and used to hospitals or from "rural areas where they do not have so much technical equipment?"*
>
> *(Nurse 8)*

The nurses tended to praise the child a lot which made the mothers smile and seem proud. The nurse also smiled and nodded a lot during nurse–mother collaboration. Although the mothers often nodded affirmatively and thus gave the impression that she understood, it often turned out that she did not. This was a two-way problem. Mothers could become frustrated when for instance nurses fed their infants instead of calling on them to do so: "We are here for the child to learn to breastfeed … sometimes they give the baby milk a little too early and then I come to breastfeed the child and the child is sleeping" (Mother 1).

4.2.2 | Bedside communication tools and interpreters

The nurses wished they could have a dedicated interpreter present for practical nursing activities, guidance and information giving. They admitted that,

> *we tend to use interpreters for [meetings] with doctors only. … but you want to be part of the conversation and inform about discharge and so on, too. I, at least, have not experienced that we have used interpreters for guidance and bedside information [and thus reach the same quality of care] as we usually do with majority mothers.*
>
> *(Nurse 4)*

Another said that using interpreters is "really very important", but admitted that until this was discussed in the focus-group interview, she had «never really thought about it» although to order an interpreter for bedside communication is possible «and it is a very good idea!» (Nurse 2). "We do not think as often as we should that, ok, if mother does not speak Norwegian then we will book an interpreter" (Nurse 1).

Also, the mothers believed it would be helpful to have an interpreter bedside together with the nurses and when they were shown around and informed about the ward and its routines. This would have made them less uncertain. Sometimes the husband wanted to function as interpreter. Mothers informed that older siblings occasionally were used to ask the nurses questions, something the nurses did not mention. When family members served as interpreters, the nurses were uncertain whether they translated everything. They

had "experienced that Dad interprets what he thinks mother needs to know. So, mother does not know about the small nuances that may be important to her when she is back home on leave with the sick child" (Nurse 1). The nurses also worried that family interpreters might mistranslate what was being said. An interesting finding was that although the mothers were unable to make themselves linguistically understood without an interpreter present, they said that they felt more or less adequately informed and guided by the nurses.

The nurses also discussed the need of various communication tools. They doubted the usefulness of glossaries or key-word charts. Nurse 4 pointed out that although "glossary tables may have their usefulness they often do not contain the words needed" in their daily communication with the mothers. The nurses thought that although key-word charts or small glossaries could be helpful in very simple collaborative situations, they could also prevent the flow of the communication. They tended towards it being better to "read" the mothers than staring at charts or tables as,

> *One gets a little too focused by having these glossary tables. Personally, I work much freer when I can just do things myself. Because then I can read the family [instead of focusing on] how I should use that chart.*
>
> *(Nurse 1)*

Mothers used Google Translate for short questions and found it helpful. Also, some nurses had tried using Google Translate. They found it to be somewhat helpful but also causing translation errors:

> *I used Google Translate once when trying to explain that the baby was having specific symptoms, but this was not what came up on Google Translate. Mom said in very broken English that it meant something completely different, so I do not think Google Translate is a good tool … … but in the end you use whatever may be helpful.*
>
> *(Nurse 8)*

5 | DISCUSSION

Communication can be seen as "the reciprocal and effective process in which messages are sent and received between two or more people" (Grant, 2019, p. 236). Communication between mother and nurse usually develops as the nurse continuously answers questions and shares her knowledge. This helps the mother familiarise herself with her infant (Aagaard & Hall, 2008). Communication also depends on what method is used and the context in which it occurs. Our study showed that both nurses and mothers emphasised *how* messages were mediated. Although communication boards were available in the NICU the nurses found them difficult to use as they lacked the words or explanations needed in neonatal nursing contexts. They furthermore pointed out that their use interrupted the mother–nurse conversation. Thunberg, Ferm, Blom, Karlsson, and Nilsson (2019) hold that pictorial communication aids may make families more communicative and increase parental involvement in care of the infant.

Some of the interviewees had tried Google Translate. This proved to be a rather untrustworthy linguistic tool as the electronic translation could be erroneous, and it was impossible to ensure the quality of the translated communication. Even so, many parents use it to explain things to healthcare personnel and to learn new words (Patriksson, Nilsson, & Wigert, 2019).

Healthcare professionals are supposed to incorporate the family's values, beliefs and cultural background in their information giving (Gooding et al., 2011; Institute for patient- & family-centred care, 2019). This enables the parents to actively participate in decisions-making and care of their infant. de Wit, Donohue, Shepard, and Boss (2013) found that although both physicians and mothers were satisfied with their meetings and spoke the same language, in nearly half of the cases the mothers rated the infant to be less ill than indicated by the physicians. With such assessment disparity between physicians and mothers from the same ethnic group, we may question to what extent minority mothers agree with ethnic majority physicians. In addition, there is a question of what is truly understood in spite of the use of interpreters. Furthermore, stress or nervousness often caused the mothers to forget the questions they had planned to ask, leaving them silent and inadequately informed.

Not surprisingly Parker, Lopera, Kalluri, and Kistin (2018) found in their study that the mothers felt more reassured and supported when the exchange was in their native language. If healthcare professionals are uncertain whether an interpreter is needed (Jones, Sheeran, Pines, & Saunders, 2019), this is usually a sign that they do need an interpreter. The purpose of interpreting is ideally to mediate a speaker's ideas to the listener as if they were expressed in the listener's own language (Nailon, 2006). To accomplish this, the interpreter needs to possess adequate knowledge about Western biomedicine and its vocabulary and treatment practices as well as the patient's understanding of illness aetiology (Hanssen & Alpers, 2010).

Occasionally, the infant's father stepped in as a linguistic helper. This tended to make the nurses wonder whether the translation was adequate and made them concerned whether lack of adequate language skill or medical insight caused incorrect translations (Hanssen & Alpers, 2010). Some husbands seemed to censor the information to "protect" the mother (Thunberg et al., 2019). Hence, family members as spouses or children should never serve as interpreters except in emergency situations where there is no interpreter available (Nailon, 2006).

In the NICU, mothers tend to be alert to situations that may represent a danger to their infants. The mothers constantly observe the nurses' care actions and vigilantly watch over their infants (Cleveland, 2008). Particularly, immigrant mothers tend to be very sensitive to the nurses' nonverbal language as it is harder for them than for ethnic majority patients—or mothers—to grasp the content of conversations and assess the infant's condition (Patriksson et al., 2019). Explaining all the blips and beeps from the NICU technical equipment which they saw worried the mothers, was for instance

difficult. When explanations were attempted, the nurses never knew whether the message was understood in spite of the mothers' affirmative nodding.

Although the handling of children is rather universal the nurses emphasised that while they communicated through gestures, hands-on guidance and the few words the mothers knew, information in a deeper sense was not possible. The mothers seemed to concur with this as they said that they understood the nurses' information *after* being shown what to do and how to do it. Moreover, structured early intervention programmes to support infant and parents cannot be fully implemented without a common language. These problems also challenge the parents' legal right to equal quality healthcare (Patient's Rights Act, 1999).

Not surprisingly both parties might feel inadequate; the mothers because they were unable to express their feelings and needs, the nurses because they were unable to give the same quality of care as they did to mothers with whom they could fully communicate. Patriksson, Berg, Nilsson, and Wigert (2017) point out that communication without a common language creates an asymmetric power relationship. The observation that the nurses primarily approached the mother, rarely the other way around, may indicate that the mothers did not feel sufficiently comfortable or confident to initiate contact. This in spite the fact that they in the interviews expressed that they experienced the nurses as helpful and kind.

During the hospital stay, the mothers acquired some basic Norwegian words or expanded on an already existing vocabulary. Patriksson et al. (2019) found that parents with children in the NICU want to learn the majority language quickly to better impart and receive information.

In light of what is discussed above, it is interesting that our data also indicated that the immigrant mothers might feel adequately supported even when linguistic communication is more or less missing. This may be caused by the nurses' ability to provide a good and safe atmosphere through their comportment and actions. When unable to explain things that happen on the ward, it was essential that the nurses through nonverbal signs and actions were able to show that they were in control and that the baby was safe. Their tone of voice, their patiently repeating everyday words and naming their nursing actions were also important. A friendly tone of voice transcends language barriers and helps the recipient feel accepted and secure. This may counteract psychological distress and depressive symptoms (Ballantyne et al., 2013). Furthermore, the better the nurses' ability to build a trusting relationship with the mother, the more reassured and able to trust in the nurse's competence and care the mothers will be (Wiebe & Young, 2011). Observations showed that also eye contact was an essential part of the communication which augmented understanding, a finding supported by Cleveland (2008).

As social and interactional beings, humans always communicate (Watzlawick, Bavelas, & Jackson, 1967). Words and silences all convey a message. In the nurse–mother communication experimentation, trial and error, and guessing were primary. This was reflected in how mothers and nurses alike tried to “read” one-other. Thus, both parties used their “antennas” to the fullest to “tune into” each other. Smiles and the use of a low and comfortable voice helped to provide the mothers with emotional support that created a beneficial environment for the infant.

Good will transcends verbal language and makes it possible to create a welcoming environment despite the absence of a shared language. However, smiles and a positive attitude are inadequate to meet all supportive needs. Much of the mother–nurse communication seemed to rely on both parties' best guess even though our observations indicated that the nurses more or less consciously used the communication strategy best suited in a given situation. Body language tends to be more productive when conveying concrete messages than expressions of thoughts and feelings (Thunberg et al., 2019). Even so, when collaboration is based on nonverbal language and the nurses' “antennas,” there will be misunderstandings and problems. Patient–nurse relationships are fragile and require heightened sensitivity and awareness to overcome communication barriers and decipher the patients—or mothers'—needs (Delmar, 2012).

While the physicians' information giving seemed to be well in hand with the help of authorised interpreters, interpreters were rarely called in for nursing information and guidance. Both mothers and nurses expressed a desire for more frequent use of the interpreter service also in the mother–nurse collaboration contexts. The need for increased use of interpreters as expressed by our interviewees is supported by other researchers (Hanssen & Alpers, 2010; Kale & Syed, 2010). This would make it possible for mothers to ask the questions forgotten in the meeting with the physician, make it easier to explain nursing interventions and improve the emotional support so essential for neonatal nursing care (Turner, Chur-Hansen, & Winefield, 2014). While the presence of interpreters was seen as mandatory in meetings with physicians, it was not so in connection with nurse–mother interactions.

5.1 | Strengths and limitations

Highly qualified and authorised interpreters with experience from hospital settings assisted with the interviews with the mothers. Although these interviews were fairly short, they offered rich data and showed a lot of similarities in spite of the mothers' different cultural backgrounds. A limitation was that the transcribed translated interviews were not checked by translating them back to the respective languages used during the talks.

6 | CONCLUSIONS

The immigrant mother–nurse interaction was characterised by the use of body language, simple words and reciprocal guessing of what the other was trying to express. The mothers felt that they had a positive relationship with the nurses and gradually learned to understand what they wanted to say—often by trial and error. The NICU

nurses adopted a wide range of communication strategies to help the mothers understand.

Both this study's interviews and observations clearly indicated that the use of authorised interpreters was as important in the nurse–mother relationship as in meetings with the physicians. The use of competent interpreters is needed to optimise nursing care, information giving and bedside guidance. This will enable non-Norwegian/non-English speaking mothers actively to participate in the caregiving of and decision-making concerning their infant while in the NICU.

7 | RELEVANCE TO CLINICAL PRACTICE

The lack of a common language between healthcarers and immigrant mothers is a serious challenge in the NICU as it significantly limits good communication, information giving and nursing guidance for the mothers. In light of increasing globalisation and migration, knowledge of mothers' and nurses' communication strategies and how both parties think, feel and act to overcome these problems are important to improve clinical practice.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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REFERENCES

Aagaard, H., & Hall, E. O. (2008). Mothers' experiences of having a preterm infant in the neonatal care unit: A meta-synthesis. *Journal of Pediatric Nursing*, *23*(3), e26–e36. https://doi.org/10.1016/j.pedn.2007.02.003

Al Maghaireh, D. F., Abdullah, K. L., Chan, C. M., Piaw, C. Y., & Al Kawafha, M. M. (2016). Systematic review of qualitative studies exploring parental experiences in the Neonatal Intensive Care Unit. *Journal of Clinical Nursing*, *25*, 2745–2756. https://doi.org/10.1111/jocn.13259

Ardal, F., Sulman, J., & Fuller-Thomson, E. (2011). Support like a walking stick: Parent-buddy matching for language and culture in the NICU. *Neonatal Network*, *30*(2), 89–98. https://doi.org/10.1891/0730-0832.30.2.89

Ballantyne, M., Benzies, K. M., & Trute, B. (2013). Depressive symptoms among immigrant and Canadian born mothers of preterm infants at neonatal intensive care discharge: A cross sectional study. *BMC Pregnancy and Childbirth*, *13*(Suppl 1), S11. https://doi.org/10.1186/1471-2393-13-s1-s11

Benzies, K. M., Magill-Evans, J. E., Hayden, K. A., & Ballantyne, M. (2013). Key components of early intervention programs for preterm infants and their parents: A systematic review and meta-analysis. *BMC Pregnancy and Childbirth*, *13*(Suppl 1), S10. https://doi.org/10.1186/1471-2393-13-s1-s10

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Los Angeles, CA: Sage.

Brinkmann, S., & Kvale, S. (2015). *InterViews: Learning the craft of qualitative research interviewing*, (3rd ed.). Thousand Oaks, CA: Sage.

Cleveland, L. M. (2008). Parenting in the neonatal intensive care unit. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, *37*(6), 666–691. https://doi.org/10.1111/j.1552-6909.2008.00288.x

de Wit, S., Donohue, P. K., Shepard, J., & Boss, R. D. (2013). Mother-clinician discussions in the neonatal intensive care unit: Agree to disagree? *Journal of Perinatology*, *33*(4), 278–281. https://doi.org/10.1038/jp.2012.103

Delmar, C. (2012). The excesses of care: A matter of understanding the asymmetry of power. *Nursing Philosophy*, *13*(4), 236–243. https://doi.org/10.1111/j.1466-769X.2012.00537.x

Flores, G. (2005). The impact of medical interpreter services on the quality of health care. A systematic review. *Medical Care Research and Review*, *62*(3), 255–299. https://doi.org/10.1177/1077558705275416

Gadamer, H.-G. (1989). *Truth and method* (2nd rev. ed.). New York, NY: Continuum.

Gair, S. (2012). Feeling their stories: Contemplating empathy, insider/outsider positionings, and enriching qualitative research. *Qualitative Health Research*, *22*(1), 134–143. https://doi.org/10.1177/1049732311420580

George, S., Duran, N., & Norris, K. (2014). A systematic review of barriers and facilitators to minority research participation among African Americans, Latinos, Asian Americans, and Pacific Islanders. *American Journal of Public Health*, *104*(2), e16–e31. https://doi.org/10.2105/AJPH.2013.301706

Gooding, J. S., Cooper, L. G., Blaine, A. I., Franck, L. S., Howse, J. L., & Berns, S. D. (2011). Family support and family-centered care in the neonatal intensive care unit: Origins, advances, impact. *Seminars in Perinatology*, *35*(1), 20–28. https://doi.org/10.1053/j.semperi.2010.10.004

Grant, A., & Goodman, B. (2019). *Communication & interpersonell skills in nursing* (4th ed.). London, UK: Sage Publications.

Grunberg, V. A., Geller, P. A., Bonacquisti, A., & Patterson, C. A. (2019). NICU infant health severity and family outcomes: A systematic review of assessments and findings in psychosocial research. *Journal of Perinatology*, *39*(2), 156–172. https://doi.org/10.1038/s41372-018-0282-9

Hanssen, I., & Alpers, L.-M. (2010). Interpreters in intercultural health care settings: Health professionals' and professional interpreters' cultural knowledge, and their reciprocal perception and collaboration. *Journal of Intercultural*, *23*. http://immi.se/intercultural/nr23/hanssen.htm

Hendson, L., Reis, M. D., & Nicholas, D. B. (2015). Health care providers' perspectives of providing culturally competent care in the NICU. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *44*(1), 17–27. https://doi.org/10.1111/1552-6909.12524

Institute for Patient- and Family Centered Care. (2019). *Institute for patient- and family centered care*. Retrieved from http://www.ipfcc.org/bestpractices/sustainable-partnerships/background/pfcc-defined.html

Jones, L., Sheeran, N., Pines, R., & Saunders, B. (2019). How do health professionals decide whether an interpreter is needed for families in neonatal and pediatric units? *Patient Education and Counseling*, *102*(9), 1629–1635. https://doi.org/10.1016/j.pec.2019.04.004

Kale, E., & Syed, H. R. (2010). Language barriers and the use of interpreters in the public health services. A questionnaire-based survey. *Patient Education and Counseling*, *81*(2), 187–191. https://doi.org/10.1016/j.pec.2010.05.002

Kyno, N. M., Ravn, I. H., Lindemann, R., Smeby, N. A., Torgersen, A. M., & Gundersen, T. (2013). Parents of preterm-born children; sources of stress and worry and experiences with an early intervention programme – A qualitative study. *BMC Nursing*, *12*(1), 28. https://doi.org/10.1186/1472-6955-12-28

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research*, *26*(13), 1753–1760. https://doi.org/10.1177/1049732315617444

Miquel-Verges, F., Donohue, P. K., & Boss, R. D. (2011). Discharge of infants from NICU to Latino families with limited English proficiency. *Journal of Immigrant and Minority Health*, *13*(2), 309–314. https://doi.org/10.1007/s10903-010-9355-3

Nailon, R. E. (2006). Nurses' concerns and practices with using interpreters in the care of Latino patients in the emergency department. *Journal of Transcultural Nursing*, *17*(2), 119–128. https://doi.org/10.1177/1043659605285414

Parker, M. G., Lopera, A. M., Kalluri, N. S., & Kistin, C. J. (2018). "I Felt Like I Was a Part of Trying to Keep My Baby Alive": Perspectives of Hispanic and Non-Hispanic black mothers in providing milk for their very preterm infants. *Breastfeeding Medicine*, *13*(10), 657–665. https://doi.org/10.1089/bfm.2018.0104

Patients' Rights Act. (1999). *Lov om pasient-og brukerrettigheter. Law on Patients' and Users' Rights* [Norwegian]. Retrieved from https://lovdata.no/dokument/NL/lov/1999-07-02-63?q=pasientrettighetsloven

Patriksson, K., Berg, M., Nilsson, S., & Wigert, H. (2017). Communicating with parents who have difficulty understanding and speaking Swedish: An interview study with health care professionals. *Journal of Neonatal Nursing*, *23*(6), 248–252. https://doi.org/10.1016/j.jnn.2017.07.001

Patriksson, K., Nilsson, S., & Wigert, H. (2019). Immigrant parents' experiences of communicating with healthcare professionals at the neonatal unit: An interview study. *Journal of Neonatal Nursing*, *25*(4), 194–199. https://doi.org/10.1016/j.jnn.2019.03.007

Polit, D. F., & Beck, C. T. (2017). *Nursing research : Generating and assessing evidence for nursing practice* (10th ed.) Philadelphia, PA: Wolters Kluwer Health.

Puthussery, S., Chutiyami, M., Tseng, P.-C., Kilby, L., & Kapadia, J. (2018). Effectiveness of early intervention programs for parents of preterm infants: A meta-review of systematic reviews. *BMC Pediatrics*, *18*(1), 223. https://doi.org/10.1186/s12887-018-1205-9

Roennestad, A., Stensvold, H. J., & Knudsen, L. M. M. (2018). *Norwegian Neonatal Network (NNN)*. Retrieved from https://www.kvalitetsregistre.no/sites/default/files/39_arsrapport_2017_nyfodtmedisinsk.pdf

Spittle, A., & Treyvaud, K. (2016). The role of early developmental intervention to influence neurobehavioral outcomes of children born preterm. *Seminars in Perinatology*, *40*(8), 542–548. https://doi.org/10.1053/j.semperi.2016.09.006

Statistics Norway. (2019). *Immigrants and Norwegian-born to immigrant parents*. Retrieved from https://www.ssb.no/en/befolkning/statistikker/innvbef

Thunberg, G., Ferm, U., Blom, Å., Karlsson, M., & Nilsson, S. (2019). Implementation of pictorial support for communication with people who have been forced to flee: Experiences from neonatal care. *Journal of Child Health Care*, *23*(2), 311–336. https://doi.org/10.1177/1367493518819210

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19*(6), 349–357. https://doi.org/10.1093/intqhc/mzm042

Turner, M., Chur-Hansen, A., & Winefield, H. (2014). The neonatal nurses' view of their role in emotional support of parents and its complexities. *Journal of Clinical Nursing*, *23*(21–22), 3156–3165. https://doi.org/10.1111/jocn.12558

van Rosse, F., de Bruijne, M., Suurmond, J., Essink-Bot, M.-L., & Wagner, C. (2016). Language barriers and patient safety risks in hospital care. A mixed methods study. *International Journal of Nursing Studies*, *54*, 45–53. https://doi.org/10.1016/j.ijnurstu.2015.03.012

Watzlawick, P., Bavelas, J. B., & Jackson, D. D. (1967). *Pragmatics of human communication: A study of interactional patterns, pathologies and paradoxes*. New York, NY: WW Norton & Company.

Wiebe, A., & Young, B. (2011). Parent perspectives from a neonatal intensive care unit: A missing piece of the culturally congruent care puzzle. *Journal of Transcultural Nursing*, *22*(1), 77–82. https://doi.org/10.1177/1043659609360850

Woodward, L. J., Bora, S., Clark, C. A., Montgomery-Hönger, A., Pritchard, V. E., Spencer, C., & Austin, N. C. (2014). Very preterm birth: Maternal experiences of the neonatal intensive care environment. *Journal of Perinatology*, *34*(7), 555–561. https://doi.org/10.1016/j.pedn.2018.12.003

World Health Organization (WHO). (2019). *Preterm birth*. Retrieved from http://www.who.int/news-room/fact-sheets/detail/preterm-birth.

SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

AppendixS1

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