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Abstract

In multicultural societies, health care professionals encounter immigrant families of children with asthma. They play an important role in supporting these families, but few studies have focused on this phenomenon. The aim of the present study is to gain a broader understanding of the challenges health care professionals face in their encounters with non-Western immigrant parents of children with asthma. Seventeen professional caregivers were interviewed, and their narratives were analyzed using qualitative content analysis. The results show that health care professionals' main challenges when encountering immigrant parents can be described by the theme, "Turning oneself inside out." This theme is characterized by five categories: gender and professional issues, impact on professional relationships, communication challenges, unfamiliar disease and treatment perceptions, and time issues. The results highlight the importance of providing health care professionals with support and organizational conditions that increase opportunities to understand the unique situation of these families.

Keywords

asthma, health care settings, speciality clinics, pediatrics

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Introduction

In a multicultural society like Sweden, as in many other countries, health care professionals encounter immigrant families. Having left their country of origin, immigrants may experience numerous changes in their new country. Some individuals adapt well, while others experience many difficulties (Berry, 1997). In Sweden, almost 1.8 million individuals (total population 9.4 million) have an immigrant background, if second-generation immigrants are included, and about 200 nationalities are represented (Statistics Sweden [SCB], 2010).

Asthma is one of the most common chronic diseases among children worldwide, causing recurring episodes of wheezing, breathlessness, chest tightness and coughing. Asthma symptoms can be effectively treated, and with adequate treatment most children with asthma can achieve good control of the disease. The prevalence of symptoms varies from 1% to 30% in different populations, and the prevalence is increasing in many countries, especially among children (Global Initiative for Asthma [GINA], 2010). Studies in the United States and the United Kingdom have shown that asthma prevalence, morbidity, and mortality differ across ethnic groups (Boudreaux, Emond, Clark, & Camargo, 2003; Netuveli et al., 2005). Gupta, Carrión-Carire, and Weiss (2006) found a widening gap in asthma hospitalizations and mortality between Black and White children in the United States. During a 20-year period beginning in 1980, the rate of asthma hospitalizations for White children decreased from 11.5 to 8.1, while it increased slightly for Black children, from 34.3 to 36.5 discharges per 10,000 inhabitants. During the same time period, childhood asthma mortality per 1,000,000 inhabitants increased from 1.6 to 1.8 for White children and from 7.2 to 9.8 for Black children.

As asthma is a disease that can be effectively controlled, and as most of the care is managed by the parents at home, it is important to develop a partnership between the family and health care professionals (GINA, 2010). Chini et al. (2011) investigated whether an active partnership can improve the management of asthma and quality of life and found that an asthma program based on a strong family–physician–school partnership resulted in increased quality of life among the participating parents and children. It also minimized the socioeconomic burden of asthma disease. The program involves educational interventions and additional activities to improve respiratory and psychological conditions.

Families of children with asthma live in uncertainty because asthma affects their children's ability to breathe and asthma can rapidly worsen (Dalheim-Englund, Rydström, & Norberg, 2001; Rydström, Dalheim-Englund, Segesten,

& Rasmussen, 2004). Wu, Smith, Bokhour, Hohman, and Lieu (2008) showed that if families also have an immigrant background, parents report higher levels of worry about their children's asthma. Many immigrant mothers lack knowledge about the course and self-management of asthma and mistakenly believe that asthma is an acute rather than a chronic condition (van Dellen et al., 2008).

An ethnically diverse population might pose a challenge to professionals dealing with immigrant families with a chronically ill child. When families encounter health care professionals who differ in cultural background they do not always experience the health care provided as caring (Berggren, Bergström, & Edberg, 2006; Cortis & Kendrick, 2003), and patients' expectations are not always considered (Cortis & Kendrick, 2003). Good communication is essential for effective transcultural care that attends to patients' beliefs and promotes shared decision making (Carl & Partridge, 2004). To perform transcultural care, cultural competence is necessary (Leininger & McFarland, 2002).

There is no single, universally accepted definition of cultural competence. Most definitions of cultural competence indicate the need to adjust and recognize your own culture to understand the culture of the patient/family. Leininger (2002) defined cultural competence as the ability "... to assess and understand culture, care, and health factors and use this knowledge in creative ways with people of diverse or similar lifeways" (p. 117). The U.S. Department of Health and Human Services (2011) has developed guidelines for health care professionals to improve health and quality of life in culturally diverse communities. It builds on the recommendations derived from the consensus-based discussions of the National Consensus Panel on Emergency Preparedness and Cultural Diversity and integrates programs, resources, and tools from leading public and private research and sources. As such, the toolkit is meant to provide content and guidance that may assist agencies in working with communities to address a broad set of priorities to improve health and quality of life that are central to effective emergency event strategies and actions.

At present, there are an inadequate number of health care professionals worldwide who are skilled in providing culturally competent care (Miller et al., 2008). Stereotyping exists among health care professionals (van Ryn & Burke, 2000), and the cultural orientation provided by the medical care system is often narrowly limited to specific cultural groups (Taylor, 2003). It was found that Swedish nurses' problematic encounters with immigrants are related to immigrants' different behavior, language barriers, difficulties related to contact with relatives, and reliance on authorities (Ozolins & Hjelm, 2003).

In an Australian health care context, it was found that language proficiency and skin color were used as social markers to classify and negatively evaluate people of non-English-speaking backgrounds (Johnstone & Kanitsaki, 2008). The consequence of this was that language and skin color were used to justify exclusion from health care relationships and resources. The results of one study conducted in the United Kingdom showed that the nursing care provided to a sample of Pakistani patients lacked a holistic approach and failed to meet the care needs of this patient population (Cortis, 2004). By contrast, another study conducted in the United Kingdom showed that nurses conceptualize and practice individualized care individuality, thus having a holistic approach, focusing on nursing needs and promoting independence, partnership, and negotiation as well as equity and fairness (Gerrish, 2000).

Asthma is a common condition affecting children worldwide. It can have a profound impact on the well-being of the whole family. Feelings of uncertainty arise, and families of immigrant compared to nonimmigrant background report higher levels of worry about their children's asthma. It has also been shown that ethnicity and migration have effects on asthma prevalence, morbidity, and mortality. Cultural competence is an important factor in nursing care, but studies also show that professionals sometimes lack this competence when dealing with immigrant families. Because asthma influences these families' daily life, requires a high degree of self-care, and can be effectively controlled, health care professionals have an important role to play in supporting these families. However, to date there are no reports of investigations exploring health care professionals' views on working with immigrant families of children with asthma. Therefore the aim of the present study was to gain a broader understanding of the challenges health care professionals face in their encounters with non-Western immigrant parents of children with asthma.

Method

Selection and Description of Participants

Eighteen health care professionals participated in the study; 14 women and four men. Fifteen participants were Swedes by birth; the other 3 participants came from Italy, Iran, and Kosovo. They ranged in age from 32 to 59 years and they all had more than 5 years of professional experience in caring for children with asthma. The group included 11 female nurses, 2 female and 3 male physicians, and 1 female dietician. Participant selection was made to represent the mixture of staff working in asthmatic child care teams. The work setting was a hospital for 10 participants and a noninstitutional setting for 7 participants. All study participants had at least 5 years of experience

caring for immigrant families who were predominantly from the Middle East. The study was undertaken in one large city and in one medium-sized town in the south of Sweden. None of the approached health care professionals declined to participate in the study.

Data Collection

Open interviews were conducted at the health care professionals' workplaces. Both authors were present at all interviews. All but two of the health care professionals were interviewed separately. The interviews lasted 20 to 90 min. The health care professionals were initially asked, "Please, tell us what it is like to meet and care for immigrant families of children with asthma." During the interviews the researchers used probes to clarify meaning, including "What happened?" "How did you feel?" All interviews were audio-recorded and transcribed verbatim.

Data Analysis

The transcribed interviews were analyzed using qualitative content analysis, as described by Graneheim and Lundman (2004). Such a process includes several steps. The analysis started with an open reading of the text to acquire a sense of the whole, in relation to the study aim. Expressions about the challenges health care professionals face in their encounters were extracted and combined in one text, which is the unit of analysis. This text was then read through several times and divided into meaning units, which were in turn condensed and labeled with a code. A condensed meaning unit is characterized by a process of shortening while preserving the core of the text. The codes were compared, based on similarities and differences, and sorted into categories, which constitute the manifest content. Finally, the underlying meaning, that is, the latent content of the categories, was formulated into a theme, which represents the challenges that health care professionals face in their encounters with non-Western immigrant parents of children with asthma. To increase trustworthiness, the two authors participated in the whole process, from the data collection to the writing of the manuscript. Quotes representing each of the meaning units, their codes, and categories are presented in Table 1.

Ethical Considerations

Permission was sought from health care managers to approach health care professionals at the hospital and at the noninstitutional care centers. The

Table 1. Examples of Condensed Meaning Units, Codes, and Category Under the Theme, Turning Oneself Inside Out

Meaning units	Condensed meaning units	Codes	Category
They think that you get a cold just by sitting in the rain or going out in cold weather.	The parents think that disease is caused by weather, the evil eye, or by God.	Unrealistic views of what causes the disease.	Unfamiliar disease and treatment perceptions.
Some of the parents think that asthma is caused by the evil eye, and some think that they are punished by God.			
... some (of the parents) don't want to give their child cortisone by an inhaler. Instead they want injections or pills.	The parents have a blind faith in drugs administered in the form of injections or tablets.	Refusing to accept common treatment.	
If the doctor doesn't write out a prescription of pills, the parents will not be satisfied.			
They just come to the medical center, don't bother to call, just sit there for the smallest trifle.	The parents often seek care unnecessarily and prematurely.	Not accepting common routines.	
Just a little fever means that they seek care directly.			

health care professionals were informed about the study by mail and all of them gave their informed consent. They were also informed by one of the authors when the interviews were scheduled. This information included the aim of the study, stressing that participation was voluntary and that the

participants could interrupt their participation at any moment. The participants were also informed that the study would be reported in such a way that they could not be recognized by others reading the report. Conducted during 2007, the study conforms to the principles outlined in the Declaration of Helsinki (World Medical Association Declaration, 2005). According to Swedish law at the time of the study, there was no need for a review by the ethics board if written consent had been obtained from the participants and if the study did not involve physical interventions (SFS, 2003:460; update 2004:198).

Results

The challenges that health care professionals face in their encounters with non-Western immigrant parents are described by one theme, “Turning oneself inside out,” and five categories, *Gender and professional issues*, *Impact on professional relationships*, *Communication challenges*, *Unfamiliar disease and treatment perceptions*, and *Time issues*.

Turning Oneself Inside Out

The health care professionals main perception when meeting immigrant parents of asthmatic children is that they need to open their minds, find new solutions, and reevaluate old ones, as these families come from unfamiliar cultures with culture-specific perceptions, traditions, and practices; one professional states, “I have to turn myself inside out.” They report that encounters with immigrant parents require strong personal commitment and empathic ability and that although such encounters put increased demands on professionals, they also contribute to an increased understanding of life in general. According to one participant, “On the whole, you become more open and respectful in your encounter with all patients.” The professionals express that they have to be tactful/gentle when they meet immigrants to avoid misunderstandings; one says, “You have to use kid gloves (when you meet immigrants), but if it’s a Swedish family you can use rubber gloves.” However, their work can become too much of a burden; the demands are too high, the working conditions are too stressful, and the professionals may lack the strength to provide care in the way they wish to provide it. One of them says, “When you don’t have the strength, you don’t listen properly and send them away with a note. You don’t make an effort. You choose the easy way out, that’s the way it is.”

Gender and professional issues refer to the status of women and female health care professionals. Such issues often bring about feelings of powerlessness. In immigrant families from the Middle East the fathers have a dominant position. The mothers remain in the background even though they may have the greatest knowledge of and main responsibility for the child's well-being. According to the health care professionals, one reason the fathers act as the main conversation partner is that they are the official spokesperson for the family. Furthermore, in some families, women are not allowed to leave the house unless accompanied by their husband or another male relative. Such gender issues sometimes mean an asthmatic child arriving at the hospital with serious breathing problems. According to one nurse, "The mother must wait until the father comes home from work before bringing the child to hospital, and therefore these children can be very ill when they arrive here."

Gender issues also refer to immigrant families' insistence on seeing a male doctor when their child is ill. They often believe that only a doctor can solve their problems, and they refuse to take other team members seriously. Nurses express that male family members only listen to nurses out of politeness; one of them says,

Nurses are not good enough. She is merely another person. This is most annoying, especially in cases when nurses have more experience than the physician, but it can also happen to female doctors. You have to put up with it.

Another nurse says,

They (the fathers) stand there with their arms folded across their chests, and you can't help feeling you're not good enough; it's obvious from the whole atmosphere that they're only listening to you out of duty, in spite of the fact that we give them exactly the same advice as the doctor does.

Many immigrant families only accept personal contact with a physician when their child needs attention. According to the health care professionals, these families are unaccustomed to nurse-led telephone advice, so instead of calling they bring their child directly to the emergency department to see a doctor. This is considered challenging, because the Swedish health care system also consists of telephone advice and nurse consultations as well as physician contacts. According to the nurses, such situations cause feelings of powerlessness.

Impact on professional relationships is linked to being too involved in the immigrant parents' life situation. The professionals express that immigrant parents often want to be more personal than they are used to. This is experienced as both enriching and frustrating. In their work they sometimes pay a visit to the patient's home. To pay a visit is perceived as enriching in the sense that such meetings allow health care professionals to gain a greater understanding of the immigrant family's life situation. According to one professional, "By meeting people from different cultures in their everyday lives you get new perspectives, find new approaches, yes it's so enriching."

A home visit as well as meetings in other caring contexts are sometimes perceived as too informal. Some participants reported incidents of immigrant families violating their sense of professional boundaries. For example, one physician says, "They are interested in my private affairs, want to exchange services with me, comment on my hairstyle. Sometimes it feels too informal. I want a physician-patient relationship." The professionals feel it is necessary to avoid a personal bond that could be difficult to cope with. Many of them mention that they try to be personal without entering the immigrants' private spheres. If the relationship becomes too personal, the fear is that the parents' demands will increase and that the situation will become untenable. One physician says, "If you have a personal relationship it can become a burden that is difficult to manage."

Communication challenges refer to language difficulties. Some of the parents do not speak Swedish at all or not particularly well. Such issues lead to feelings of uncertainty. Health care professionals cannot be sure their instructions about the child's treatment have been understood correctly, and they are concerned the child may not receive the care and treatment required. At times the language difficulties are obvious, but on other occasions it is hard to determine whether the parents have really understood.

Communication challenges are particularly obvious when health care professionals assess the child's care needs over the phone. They cannot see the child and there may be uncertainties as to whether they have understood the parents' descriptions correctly. It is also difficult to be certain that they have provided clear information to the parents: "I don't know how to explain what a teaspoon is; you have to show it to them. Otherwise we're not talking about the same thing." They also describe sometimes getting the impression that the parents only pretend to understand.

I explain to them and inform them and make great efforts to ensure that they have understood. I also pose questions that I believe will indicate

whether they have understood or not, for example, in relation to which medication they should administer to their child. At the follow-up visit, I ask if the child has received that medication and they say “yes.” But the Spiro meter tells another story, hmmm

In addition, it is not unusual for the sick child’s siblings to contact the health care services, as they may understand the Swedish language better than their parents do.

It takes so much energy to mind the telephone helpline, and at times a sibling phones and when you ask what’s wrong with the asthmatic child, the sibling has no idea. In such cases, our advice is to take the child to hospital, you don’t dare to wait.

According to the health care professionals, the families are not always keen on using a professional interpreter. Instead they employ a relative as an interpreter or believe that their own language skills are sufficient. This may lead to concerns that the professionals’ message has not been translated correctly or has been misunderstood. The conversation can reveal the necessity of an interpreter, but at that stage, contacting an interpreter might be considered a sensitive issue, because such a recommendation could cause the family to lose face. Some professionals also experience use of an interpreter as tiring, and one of them expresses this as follows: “You have to be sooo clear, no small talk, and you have to make an effort the whole time to look at the person whose words are being interpreted instead of looking at the interpreter.”

Unfamiliar disease and treatment perceptions refer to immigrant parents’ views about the causes and treatment of their child’s disease. According to the health care professionals, some immigrant parents believe that the cause of disease is “the evil eye,” while others are convinced that it was sent by God. Such beliefs can have consequences for the child’s treatment.

They have their own ideas, and they care for their child in their own way, even if they are given other instructions from the medical centre. They listen politely to what I’m saying, but then they do it their own way. This is very annoying and frustrating. You try again and repeat the instructions.

Another source of frustration is that immigrant families often seek care at an early stage and very frequently. Caregivers believe this is based on a different approach to illness and treatment. The professionals do not feel this is

connected to country of birth, but instead to personal knowledge of illness and treatment. They report that, owing to lack of knowledge about asthma, some parents hesitate to bring their child to the day care center or to allow him or her to spend time outdoors, as they believe such activities would make the child worse.

To some of the immigrant parents, receiving medication for their child is very important. The professionals describe how parents perceive the visit to the physician as pointless and unnecessary if the physician fails to prescribe medication. It is often easier for these immigrants to obtain potent medication in their native countries, even without a prescription. If the child is not prescribed antibiotics, the immigrant parents may become disappointed, even if the physician explains to them that a cold is caused by a viral infection, on which antibiotics will have no effect. The parents often prefer medication in tablet form, in spite of the fact that the most appropriate asthma drug treatments are often preparations for inhalation. The professionals say that many of the families do not have the necessary respect for the medication prescribed, and as an initial form of treatment the parents sometimes give the child cortisone in tablet form instead of a bronchodilator, in spite of the risk for serious side effects. One health care professional states, "It's better that they come to the emergency department than trying to deal with the situation themselves." In that way, the professionals can meet the parents and their child face-to-face and develop alternative teaching methods to help parents understand their child's prescribed medication.

Time issues are linked to time-consuming activities and time perceptions. Such issues give rise to feelings of irritation. The health care professionals state that they often feel forced to give these families time for personal meetings, because they are uncertain as to whether they can assess the child's condition over the phone. They are unclear about whether or not the parents have understood their advice. Therefore, according to the professionals, it is preferable to arrange consultations at the clinic, so that they can see the child and, for example, demonstrate how to give the child inhalers in the most effective way. Many immigrant parents are unfamiliar with the concept of self-care and are used to personal encounters with health care professionals. Appointments with immigrant families require more time, and one doctor says that

As a foreign doctor myself, I give them more time, you have to take the time, they've had problems and it's natural that they need more attention. They need a little more time while Swedish people need a little less."

In addition to this, the parents themselves might demand more time; the foreign doctor continues, "Sometimes immigrants think they are discriminated against by the health care services and therefore might demand a thousand times more care than they would do in their native countries."

According to the health care professionals, some cultures do not speak in terms of "half past two" or "a quarter to three" but only in full hours. This means that sometimes immigrant families are not on time. Moreover, some parents find it difficult to understand the Western system of canceling appointments. Having a different time perception to that of the professionals can lead to problems in following standard care procedures. Different time perceptions are difficult and could be perceived as impossible to change, as a person's sense of time is often culturally conditioned and thereby deeply rooted.

Discussion

The main challenge for health care professionals when they meet immigrant parents of children with asthma is describe by the theme, Turning oneself inside out. This theme is characterized by five categories: Gender and professional issues, Impact on professional relationships, Communication challenges, Unfamiliar disease and treatment perceptions, and Time issues.

Turning oneself inside out shows that the health care professionals feel they are exerting themselves to the utmost to provide adequate care even if the parents' expectations are perceived as being different or unfamiliar. Other studies have also indicated that immigrants' expectations regarding the health care system are occasionally perceived as unknown and thereby put great demands on professionals, which contributes to uncertainty (Boi, 2000; Halligan, 2006; Lundberg, Bäckström, & Widén, 2005; Ozolins & Hjelm, 2003). It has also been found that health care professionals sometimes have prejudices against patients with different cultural backgrounds (Hultsjö & Hjelm, 2005; Vydelingum, 2006) and that these prejudices can be an obstacle to the provision of high quality care (Baldonado et al., 1998; Cortis, 2004; Johnstone & Kanitsaki, 2008). When meeting with patients from an ethnic minority, health care professionals sometimes judge them on the basis of their cultural background (Diver, Molassiotis, & Weeks, 2003). In such situations, health care professionals' priorities may conflict with patients' wishes. With regard to preventing prejudices, Lundberg et al. (2005) showed that nurses find it important to have the opportunity to participate in courses, lectures, and seminars that illuminate perspectives on health, illness, and death in various cultures. However, Diver et al. (2003) concluded that education about cultural encounters in health care is pointless, as every patient is an

individual and cannot be generalized in terms of culture. On the other hand, Leininger and McFarland (2002) claimed that health care professionals should have culture-specific knowledge when dealing with people from different cultures. These conclusions, taken together, show that a nurse should always meet a patient as a unique individual and that it is important to listen to what the patient wishes to say about his or her life situation. Such an attitude does not exclude the importance of culture-specific knowledge, but increases the opportunity for patients to feel involved in their own care. This has been described as meaning "... that patients and health care professionals should play the same pitch" (Björk Brämberg, 2008, p. 121).

Gender and professional issues are related to a sense of frustration among health care professionals, as male doctors are more respected than female doctors, and doctors are more respected than other health care professionals. Similar findings have emerged in other Swedish studies (Hultsjö & Hjelm, 2005; Ozolins & Hjelm, 2003), where nurses expressed feeling frustrated when immigrants did not respect their professional competence. Moreover, in certain cultures it is deemed impolite to question a doctor's authority (Greenhalgh, Helman, & Chowdhury, 1998), but to use health care resources effectively, it is important that nurses and physicians work together to raise the status of nurses' efforts. Our study reveals that the man is often the authority figure of the family, which can be compared to a study by Hultsjö and Hjelm (2005), where nurses reported that many foreign women are prevented from acting independently due to the culture's prevailing view of women. This may be a problem that must be solved. Should health care professionals remain passive when confronted with this attitude toward women? Or should we act, and, if so, in what way? It is important to strive toward openness in encounters with these families to avoid passing judgment. But it is equally important to keep the debate alive to create the best possible situation for these families. Otherwise there is a risk that such an attitude toward women will be accepted even though Swedish law stipulates equality between men and women.

Communication challenges reveal that having to deal with different native languages can make health care professionals feel uncertain. This is in accordance with the findings of Cortis (2004), Lundberg et al. (2005), and Halligan (2006). Our results indicate that parents sometimes use relatives as interpreters, which can be problematic. Fatahi, Mattsson, Lundgren, and Hellström (2010) found that nurse radiographers did not consider friends, relatives, particularly children, and staff to be ideal alternatives to professional interpreters. According to Gerrish (2001), using siblings to children as interpreters probably has negative effects on quality of care, as siblings often have

insufficient knowledge of the language, particularly medical terminology, and lack impartiality. Furthermore, Cortis (2004) maintained that siblings' interpretations can be filled with emotions, misunderstandings, and mistakes. For that reason, it is essential for health professionals to employ professional interpreters when a foreign language becomes an obstacle to high quality care.

Unfamiliar disease and treatment perceptions arise from the differences between immigrant parents' and professionals' views on illness and treatment. When different cultures meet, there may be a seed of conflict, as some immigrants believe that illness is caused by "the evil eye," or the curse of God. According to Almahzoomy (2005), the view of Arab women with diabetes is that one cannot foresee the future and that the human ability to influence illness is limited, because Allah governs both health and illness. Perhaps this is why Ezeobele, Malecha, Landrum, and Symes (2010) found that Nigerian-born immigrant women living in the United States preferred the clergy to health care professionals when suffering from depression. Such views can be difficult for Western health professionals to deal with, as a Western view of illness and treatment usually is based on a scientific explanation. Nevertheless, both immigrant parents and health care professionals have the same goal when they meet, and that is a healthy child. To achieve this goal, it is essential to communicate and to respect each others' different views on disease and its treatment. But it is also essential that health care professionals inform immigrant parents about the treatment that Western health care can offer in a clear and respectful way, as no benefit can be gained from an excellent treatment if these treatments are not used by the patients.

The health care professionals in our study experience that some immigrant parents have different perceptions of time, which are addressed in *time issues*. Such issues can arouse feelings of irritation among professionals. Not turning up on time for an appointment means that schedules have to be rearranged, which can have an impact on other patients' appointments. Hanssen (2007) claimed that other cultures may have a different sense of time, arguing that such patients may find it difficult to accept that the attitude toward time is stricter than they are accustomed to. Nevertheless, when human beings get to know each other, cultural differences can be experienced as exiting and trigger a desire to learn more about these differences. In that way, we can improve our attitudes toward each other and use this knowledge in creative ways.

Methodological Considerations

The trustworthiness of the present study is strengthened by the fact that the authors tried to stay true to the research process described by Graneheim and

Lundman (2004). To ensure trustworthiness, all interviews in the study were conducted by the two authors together, and afterwards the material was continuously analyzed, discussed, and reflected on. For the data analyses, we considered content analysis to be a suitable approach, as we investigated a phenomenon that could be expected to contain distinct experiences. The categories that emerged from our data should be viewed as manifest content, which describes as “what the text says” (Graneheim & Lundman, 2004, p. 106), while the theme is considered to be a latent content, as it originates from “interpretation of the underlying meaning of the text” (p. 106). One limitation of the present study is the unequal gender distribution among the participants. It is possible that the results would have been different if more men had participated. The fact that two researchers participated in all interviews may also have been a limitation. This may have blocked the participants’ free associations, but the researchers were aware of this and tried to remain open and responsive to what the interviewees wished to talk about. Although we do not claim that the study has captured all the various aspects of the phenomenon, we do consider that our findings provide a broader understanding of the challenges health care professionals face in their encounters with non-Western immigrant parents of children with asthma. To capture other gaps in our knowledge about this phenomenon, further research is needed. As communities in the Western world are becoming increasingly multicultural, further research also must include the perspectives of immigrant families. Such an approach can promote care provision that meets the needs of everyone involved.

Conclusion and Concluding Remarks

In conclusion, the result shows that professionals who meet immigrant parents of children with asthma “have to turn themselves inside out.” These great efforts on the part of health care professionals may reflect the existence of a gap between the professionals’ ability to provide culturally competent care and the immigrant parents’ expectations. Such a gap may lead to children not receiving the care they need, an increase in emergency visits, and thus higher health care costs. A gap between parents and professionals may also decrease professionals’ work satisfaction, leading to higher staff turnover.

Consequently, the result highlights the importance of providing professionals with support and organizational conditions that facilitate working with immigrant parents of children with asthma. They need time for reflection with colleagues and professional guidance when challenges arise. In this way, they may be able to meet these parents as unique individuals with unique histories and therefore unique needs. This requires openness, willingness,

and the courage to stop and consider what others want to say. In this regard, professionals must bear in mind that their preunderstandings, based on their ideas about culture- or religion-specific needs, might be misleading. This would increase professionals' opportunities to understand the unique situation of these parents and help them view such encounters as a positive challenge. However, professionals also need the courage to tell these families about new expectations that may arise, for example, to talk about how different cultures view time. Meeting a patient in this way not only indicates a willingness to help but also demonstrates a belief in the individual's ability to cope with life in a new country.

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