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Patient-centered innovation

Midwives' perceived barriers in communicating about depression with ethnic minority clients

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ABSTRACT

Objective: This study aimed to assess the most influential barriers midwives perceive in communicating about depression-related symptoms with ethnic minority clients.
Methods: In-depth interviews were held with midwives (N = 8) and Moroccan-Dutch women (N = 6) suffering from perinatal depression to identify the most salient communication barriers. Subsequently, an online survey among midwives (N = 60) assessing their perceived barriers and the occurrence of these barriers in practice was administered. Composite scores using the QUOTE methodology were calculated to determine influential barriers.
Results: Three types of barriers emerged from the interviews. Educational-related barriers, client-related barriers and midwife-related barriers. Results of the survey showed that the most influential barriers were educational-related barriers (e.g. lack of culturally sensitive depression screening instruments) and client-related barriers (e.g. cultural taboo about talking about depression).
Conclusion: Culturally sensitive screening instruments for depression and patient education materials should be developed to mitigate the educational-related barriers to communicating about depression. Patient education materials should also target the clients' social environment (e.g. husbands) to help break the cultural taboo about depression.
Practice implications: Based on this study's results, communication strategies to empower both midwives and ethnic minority clients with depression can be developed in a collaborative approach.
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1. Introduction

During pregnancy and in the transition to parenthood, women are at increased risk of developing depression [1]. Although average prevalence rates of postnatal depression have been reported to be around 13% [2], a huge variability in prevalence rates has been found across studies carried out in different countries and healthcare settings, with percentages ranging from 4% till over 60% [3], indicating that the average reported prevalence rate may be an underestimation of this mental health disorder worldwide. Among the risk factors for developing postnatal depression are having low quality social and marital relations, a history of previous mental illness and belonging to socially and economically disadvantaged groups [4].

Previous Dutch research has indeed indicated that the prevalence of depression-related symptoms, such as feeling sad and lonely, among Dutch pregnant women with a Turkish and Moroccan ethnic minority background is 55% and 42% respectively, compared to 22% among pregnant women with a native Dutch background [5]. These higher percentages among Dutch ethnic minority women are in alignment with findings from a literature review showing that migrant women living in developed countries run a threefold risk of developing postnatal depression compared to non-migrant women [6]. As depression during pregnancy is not only associated with a host of immediate negative physical outcomes, such as an increased chance of impaired development of the (unborn) child, preterm delivery and low birth weight [7], but also with a higher likelihood of the child developing long term developmental and psychosocial problems, among which lower communication and social skills [8,9],

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timely interventions are urgently needed for pregnant ethnic minority women suffering from depression-related symptoms [10].

To enable detection of depression-related symptoms in a timely manner and refer ethnic minority clients to appropriate further care, adequate communication between midwives and their clients is a prerequisite [11]. Because maternity care in the Netherlands is based on a predominantly midwife-led model, centered around the idea that women with uncomplicated pregnancies are best taken care of by a midwife, the large majority of Dutch women are accompanied during their pregnancy by midwives, and not, as might be the case in other countries, by gynecologists and obstetricians. However, previous research has indicated that non-Western ethnic minority women may be reluctant to openly communicate about depression, due to a combination of culture-related and language-related factors. For instance, presenting mental health problems to healthcare providers may be seen as a weakness due to the stigma attached to it in some cultures, and may conflict with the desire to fulfill traditional gender roles such as being a good mother and protecting the family's reputation [12,13]. In addition, in non-Western cultures the expression of depression may be different from its expression in Western cultures, because of cultural differences in display rules of emotions [14], different explanatory models of mental health illnesses [15], or the concept of depression not always having a direct equivalent translation into another language [16]. Combined, these factors may partly explain the often-reported somatization of symptoms of depression [17] and the voicing of emotional distress in implicit manners by non-Western ethnic minority patients [18].

Because of the above-mentioned culture- and language-related barriers to communicating about depression, midwives may face numerous obstacles in detecting depression-related symptoms among their ethnic minority clients, thereby failing to refer them to appropriate further care. Scarce qualitative research among healthcare professionals has indeed indicated that they perceive similar culture- and language-related factors as barriers for migrant women suffering from postnatal depression to seek care. Furthermore, they indicated to fear having insufficient cultural competencies to provide adequate care and reported lacking assessment tools to screen for depression in a culturally sensitive manner [19]. As it is known that pregnant women with depression-related symptoms who do receive psychological or psychosocial interventions are less likely to develop postnatal depression [10], barriers to communicating about depression-related symptoms during pregnancy, thereby failing to detect and refer ethnic minority women with depression for further treatment, may pose a significant threat to their and their children's (mental) health.

Although previous research within this field has yielded valuable insights regarding barriers to communicating about depression from migrant and ethnic minority patients' perspective, there is a dearth of research with regard to the barriers midwives perceive in communicating about depression-related symptoms with their ethnic minority clients. Hence, a crucial step in enhancing mental healthcare for pregnant ethnic minority women suffering from depression-related symptoms, is to identify the most influential barriers midwives perceive in the communication process. Having more understanding of which barriers impede communication about depression may help developing effective communication strategies for midwives to support their ethnic minority clients in seeking mental healthcare. As existing Dutch interventions have not been successful in either reaching or retaining ethnic minority women suffering from perinatal depression in mental care treatment programs [20,21], this may indeed suggest that more effort should be given to developing more effective provider communication strategies. Hence, the aim of this study was to assess the most influential barriers midwives perceive in communicating about depression-related symptoms with their ethnic minority clients. In assessing midwives' perceived barriers, we focused specifically on Turkish-Dutch and Moroccan-Dutch women as these represent not only the two biggest ethnic minority populations in the Netherlands [22], but also exhibit high prevalence rates of depression-related symptoms [5].

2. Methods

2.1. Procedure

This mixed-method study consisted of two phases. Because no Dutch research has been done on this topic and the scarce international research findings may not be entirely applicable to the Dutch healthcare context, in the first phase, qualitative in-depth interviews were conducted among midwives and Moroccan-Dutch clients suffering from perinatal depression-related symptoms in order to explore their perceived communication barriers. In the second phase, an online survey, based on the barriers that emerged from the interviews, was administered to midwives to examine the most influential barriers. The study was approved by the ethical committee of our research school (ASCoR) of the University of Amsterdam (nr. 2018-PC-8789).

2.2. Participants and procedure of the interview-study

8 Midwives and 6 Moroccan-Dutch clients were recruited through our personal networks and through snowball sampling. We did not include Turkish-Dutch women in our interview study for two reasons. First, we did not expect to identify additional barriers by including Turkish-Dutch women, because they are quite similar in some respects to Moroccan-Dutch women, such as their migration history and religious background. Second, the midwives, who were interviewed before the clients did not indicate fundamental differences between these two client groups. For the recruitment of Moroccan-Dutch clients, flyers were distributed at midwifery practices and midwives were asked to ask their eligible clients if they would want to participate in this research. In addition, flyers were distributed in supermarkets in migrant-dense areas and we used our personal networks and snowballing techniques to find additional Moroccan-Dutch clients. A few Moroccan-Dutch clients were clients of the 8 midwives included in our study. Sample sizes were based on the saturation principle as outlined in the grounded theory approach [23] as well as recommendations based on previous research indicating that 6 interviews are sufficient to identify the main themes around a topic [24]. Inclusion criteria were 1) having had at least 20% Moroccan-Dutch and Turkish-Dutch clients during the previous year for midwives, 2) being pregnant or having given birth, and having either self-reported feelings of depression or having received a formal diagnosis of perinatal depression for Moroccan-Dutch women. Informed consent was obtained from all participants after they were informed about the goal of the study. Based on the literature, a semi-structured topic-list was developed for both midwives and Moroccan-Dutch clients to identify the most salient communication barriers (see Appendix for both topic-lists). Interviews with midwives were held by two trained research assistants from the Academy for Midwifery Amsterdam. Interviews with Moroccan-Dutch women were held by a trained female Moroccan-Dutch research assistant. As all Moroccan-Dutch women were fluent in Dutch, these interviews were held in the Dutch language. Interviews were held at a time and location chosen by the participants, lasted between 30 and 50 min each, and were transcribed verbatim. Three midwives received a summary of their individual results and were asked to check whether these were an accurate representation of the content of their interview; they all confirmed to be in agreement with the results. We used ATLAS-ti 8.0 to help manage all data analysis, which was based on the constant comparative method [23]. In the first phase, transcripts were read closely line-by-line and

first-order codings were created. In the second phase, a second-order coding was employed by grouping the first-order codings into the main identified barriers, 14 in total. All interviews with midwives and Moroccan-Dutch women were analyzed separately by two coders and differences in codes were discussed until agreement was achieved.

2.3. Results interview-study

Almost all midwives were female (n = 7), had a Dutch ethnic background (n = 7), and their age ranged from 30 to 59 years. Their work experience as a midwife ranged from 1.5 to 29 years and the percentage of Moroccan-Dutch and Turkish-Dutch clients during the previous year in their practice ranged from 20% to 70%. Age of the Moroccan-Dutch women ranged from 23 to 34 year, five were born in the Netherlands, they were all married and they all identified as being Muslim. Their educational levels ranged from low (only primary school) to high (university). At the time of the study, three women were pregnant with their third child, one was pregnant with her first child, and two women had given birth respectively 4 months and 1,5 years prior to the study. Two of them did receive a formal diagnosis of perinatal depression, one a formal diagnosis of depression and burn-out and three of them self-identified as having depression but did not receive a formal diagnosis.

Three types of communication barriers were identified based on the interviews with both midwives and Moroccan-Dutch women: 1) client-related barriers, 2) midwife-related barriers, and 3) educational-related barriers. In Table 1 all barriers that emerged from the interviews and illustrative quotes can be found. Client-related communication barriers mentioned by midwives entailed both language-related barriers (i.e. client not having sufficient Dutch language proficiency) and culture-related barriers, mostly about the taboo surrounding mental health disorders in the Moroccan and Turkish culture. To illustrate, one midwife said: *"I regularly notice that in the medical file it is noted: do not discuss with family […]. Apparently, it is not allowed to discuss it [depression]."* Midwife-related barriers entailed a lack of cultural competencies and time during consultations to properly discuss mental health problems with their clients. Educational-related barriers consisted of both a lack of available culturally sensitive instruments to screen for depression and a lack of adequate patient educational materials to educate their clients about depression.

The results found among the Moroccan-Dutch women largely mirrored those of the midwives. With regard to client-related barriers they often mentioned the same cultural taboo around depression and the tendency to cope with depression-related symptoms by turning to their religion instead of seeking treatment, or as one woman mentioned: *"What will others think of you? Depression is a stigma; you will be judged negatively."* Regarding midwife-related barriers, similar to midwives themselves, they noted that midwives lack adequate communication skills to discuss depression with them and are mostly focused on biomedical issues surrounding their pregnancy. Educational-related barriers reported were a lack of culturally sensitive patient education materials about perinatal depression, also for the women's husbands.

2.4. Participants and procedure of the survey-study

Midwifery practices that were eligible for inclusion in the survey-study had to be located in a municipality with at least 25% of the population consisting of non-Western ethnic minorities. Based on this criterion, a list of 90 midwifery practices in ten municipalities was compiled, in which around 450 midwives practiced. All 90 practices received an invitation by email to take part in the online survey. A reminder email was sent after five days and all practices were also contacted by phone a week after having received this

Table 1
Identified barriers and illustrative quotes.

Barriers	Midwives (N = 8)	Moroccan-Dutch women (N = 6)
Barriers related to the clients		
Somatizing	*'Among Turkish-Dutch and Moroccan-Dutch people you often see that it [depression-related symptoms] becomes somatic.'*	*'Some physical complaints are caused by depression. Perhaps you have a headache and you think it is a physical issue, but it is not a physical issue at all…'*
Cultural taboo	*'They [the clients] are afraid that it [depression] will be told to others.'*	*'It is as if depression does not exist in Moroccan culture.'*
Feeling ashamed	*'The communication process is different. You can notice that they are ashamed that they feel this way [depressed] while being pregnant.'*	*'I could not talk to anyone about it [depression], I felt a bit ashamed.'*
Partners impede communication	*'If you talk about it [depression] when their partner is not around, they might talk more elaborate about it.'*	*'I can talk more freely when he[husband] is not there with me.'*
Low Dutch language proficiency	*'Turkish-Dutch and Moroccan-Dutch women who do not speak Dutch well […], they are more difficult to treat adequately.'*	*'When I came here [to the Netherlands], I did not speak the language. So, when I had to go to the doctor, my husband had to come with me […] to translate. That was difficult.'*
Partners do not interpret well	*'… when the husband is there, you often wonder about the extent to which he translates. That is a barrier of course.'*	*'First, I had him [husband] as my interpreter, yes, but now I can explain everything myself. […]. He just does not understand it.'*
Lack of trust	*'So, their lack of trust increases,[due to] the non-personal treatment, the different disciplines, different people, difference faces [.].'*	*'I should have been stricter with my midwife and with the nurse in the hospital and not have believed everything they told me.'*
No show	*'A high no-show percentage [.]; they are so depressed that they do not feel like coming [to the consultation].'*	Not mentioned
Barriers related to the midwives		
Time	*'… there is often not enough time to ask more in-depth question.'*	Not mentioned
Intercultural communication skills	*'Post-graduate education, I think that would be very useful. It would teach us techniques to start the conversation.'*	*"I think that the midwife could have brought up that mothers should not be under this much pressure.'*
Knowledge about depression	*'You can read a book about practical psychology […] and then you will know the theories. But you need practical information, you need to be trained with cases to learn…'*	*'They [midwives] only focused on the baby […], I never had the feeling that they asked me how I was doing.'*
Beyond task duties	*'We are not psychologists […], so it is obviously not our task to coach this [.].'*	*'To tell the midwife I feel depressed, that is a bit…well, I don't know.'*
Barriers related to education		
Lack of patient education	*'That we would have leaflets we could give about mental health issues […]. That a leaflet would inform [the client] that it is normal [to feel depressed], that you should always be able to talk about it.'*	*'There are some movies made by imams about depression, but […] it was more about women being in a rut […]. They gave insufficient information.'*
Lack of screening	*'Some instruments are very specific. These lists ask about your income, for instance. Those are tough questions to ask.'*	*'Yes, she [midwife] should have screened for depression, as it can lead to suicide.'*

email asking them to fill out the survey. Written informed consent was obtained from all midwives before filling out the online survey.

2.5. Measures

The survey started with eliciting the following background variables: age, gender, years practicing as a midwife, ethnic background, having had intercultural communication training, municipality where the practice is located, and perceived number of clients from Moroccan-Dutch and Turkish-Dutch background with depression-related symptoms in the previous two years. After that, they assessed for 14 barriers (see Table 3) both the extent to which they perceived this to be a barrier during consultations on a 7-point scale (1 = *strongly disagree* to 7 = *strongly agree*), and how often the barrier occurred on a 4-point scale (1 = *never* to 4 = *always*). Eight barriers concerned client-related barriers, four barriers concerned midwife-related barriers, and two barriers concerned educational-related barriers.

2.6. Data analysis

Quality Index Indices (QII) were calculated based on the QUOTE methodology [25] by multiplying the mean barrier rating with the proportion of participants that frequently encountered that barrier in practice. First, occurrence ratings were dichotomized into 0 for the answer categories 1 = *never* and 2 = *sometimes,* and 1 for the answer categories 3 = *often* and 4 = *always*. Hence, when participants had a mean barrier rating of 4.20 on the 7-point perceived barrier scale and this barrier occurred often/always according to 45.5% of the respondents, the QII score would be 4.20 * 0.455 = 1.91. QII scores of 0.60 or higher indicate a potential barrier, whereas QII scores of 1.75 or higher indicate an influential barrier.

3. Results

3.1. Sample characteristics

The final sample consisted of 60 midwives (response rate 13.3%; see Table 2 for all sample characteristics). Main reasons for not filling out the survey that were reported during the follow-up phone-calls were lack of time and having insufficient experience with communicating about depression with Moroccan-Dutch and Turkish-Dutch clients. Mean age of the midwives was 39.5 years (SD = 10.4), all but one were female, and they had on average 14.6 years (SD = 9.6) working experience as a midwife. Most had a Dutch ethnic background (76.6%) and they had seen an average of 3.3 Moroccan-Dutch and Turkish-Dutch clients with depression-related symptoms in the previous 2 years.

Table 2
Sample characteristics.

Characteristic	N (%)
Gender	
Female	59 (98.3)
Male	1 (1.7)
Age	
M (SD)	39.5 (10.4)
Years working experience midwife	
M (SD)	14.6 (9.6)
Ethnic background	
Dutch	46 (76.7%)
Other (e.g. Turkish, Moroccan, Surinamese)	14 (23.3%)
Intercultural communication training	
Yes	20 (33.3%)
No	40 (66.7%)
Number of Moroccan-Dutch and Turkish-Dutch clients with depression in previous two years	
M (SD)	3.3 (1.2)

3.2. QII scores barriers

Midwives perceived educational-related barriers as being the most influential barriers in communicating about depression with their Moroccan-Dutch and Turkish-Dutch clients (see Table 3). Both the lack of culturally sensitive patient education materials (QII = 3.47) and the lack of culturally sensitive screening instruments for depression (QII = 3.04) were seen as influential barriers. Within client-related barriers, three barriers were perceived as an influential barrier, four barriers were perceived as potential barrier and one barrier was not perceived as being a barrier. The three influential client-related barriers were clients somatizing symptoms of depression, the cultural taboo around talking about depression, and clients feeling ashamed to talk about depression. Last, within midwife-related barriers, no barriers emerged as influential barriers, three barriers were perceived as potential barrier and one barrier was not perceived as a barrier. Of the potential barriers, the lack of time to discuss depression-related issues had the highest QII score (QII = 0.93).

4. Discussion and conclusion

4.1. Discussion

The aim of this study was to examine midwives' perceived barriers to communicating about depression with their Moroccan-Dutch and Turkish-Dutch clients, based on a two-phase approach in which possible barriers were first identified in a qualitative interview-study, which were subsequently quantitatively assessed in a survey-study. Results show that midwives perceive educational-related barriers as the most influential barriers that impede the communication process about depression-related symptoms with Moroccan-Dutch and Turkish-Dutch clients, followed by culture-related client-related barriers, among which the cultural taboo around depression in the Moroccan and Turkish culture and the tendency to somatize symptoms of depression by these women. None of the midwife-related barriers emerged as influential barriers, although they expressed having insufficient time to discuss depression-related symptoms, not being sufficiently trained in intercultural communication skills and having insufficient knowledge about depression as potential barriers. Potential client-related barriers mostly concerned the language barrier (e.g. clients having a low Dutch language proficiency, family members not interpreting adequately).

The high QII scores on the two educational-related barriers are partly in alignment with previous research [19] and indicate the need to both develop culturally sensitive patient education materials as well as screening instruments to detect depression. Although several validated screening instruments for postnatal depression exist, of which the Edinburgh Postnatal Depression Scale is the most accurate one [26], it is unclear whether these screening instruments are universally valid across cultures [27]. Cross-cultural differences in interpreting and disclosing symptoms of depression [15,16] warrant further validation of these screening instruments among different cultural and ethnic minority groups. Furthermore, although there is a growing call to integrate mental health screening in routine care for pregnant women [28] and some Dutch protocols do exist to support midwives in detecting mental health disorders during pregnancy (e.g. inquiring about (previous) mental health issues during the first consultation, use of screening instruments, giving patient education about mood imbalances, referral guidelines [29]), results of this study suggest that implementation in midwifery

Table 3
Perceived barriers, occurrence rates and QII scores barriers.

Barrier item	Perceived barrier rating *M* (SD)	Occurrence (% often/ always)	QII score
Educational-related barriers			
There is a lack of culturally sensitive patient education material about depression	5.35 (0.94)	64.8	3.47
There is a lack of culturally sensitive screening instruments for depression	5.12 (1.02)	59.3	3.04
Client-related barriers			
Moroccan-Dutch and Turkish-Dutch clients somatize symptoms of depressions	5.04 (1.05)	51.8	2.61
Talking about depression is taboo in the Moroccan and Turkish culture	4.68 (1.11)	46.3	2.17
Moroccan-Dutch and Turkish-Dutch feel ashamed to talk about depression	4.75 (1.43)	44.5	2.11
Partner/other family members impede communicating about depression with	4.39 (1.45)	33.4	1.47
Moroccan-Dutch and Turkish-Dutch clients	3.75 (1.44)	38.9	1.46
Moroccan-Dutch and Turkish-Dutch clients have a low Dutch language proficiency	4.40 (1.24)	29.7	1.31
Partner/other family members who come along to interpret, do not translate well	3.81 (1.20)	16.7	0.64
Moroccan-Dutch and Turkish-Dutch clients have a lack of trust in the healthcare system		14.8	0.54
Moroccan-Dutch and Turkish-Dutch clients with depression-related complaints do not show up for appointments	3.67 (1.35)		
Midwife-related barriers			
I have insufficient time to discuss depression-related complaints	3.84 (1.81)	24.1	0.93
I am insufficiently trained in intercultural communication skills	3.93 (1.52)	22.2	0.87
I have insufficient knowledge about depression-related problems	3.67 (1.34)	18.5	0.68
Communicating about depression-related complaints falls outside the scope of my tasks	2.75 (1.34)	11.2	0.31

practice of these protocols lags behind. Results of previous research have indeed indicated that midwives seldomly discuss psychosocial issues during consultations [30]. Hence, implementation of existing guidelines in practice requires more effort.

Although no influential midwife-related barriers emerged in this study, this might partly be explained by a cognitive bias to attribute blame, in this case of communication barriers, to the 'victim' (i.e. the ethnic minority client) [31]. That is, it might be psychologically easier to attribute these barriers to causes outside oneself than to take responsibility for solving this (difficult) problem oneself. The fact that most QII scores, both for educational-related and client-related barriers, were higher than the QII scores of the midwife-related barriers, might be an indication that this bias might have been present in this study and points to the need to conduct further research into these biases and their possible impact on the communication process. For instance, although only a third of the participants did receive training in intercultural communication skills, this barrier was rated as a rather neutral one. Moreover, according to only about 20% of the respondents does this barrier occur often in practice. However, ample research has indicated that training in intercultural competencies and communication skills is effective in enhancing the healthcare communication process with ethnic minority and migrant patients [32], and might support midwives in discussing depression-related symptoms and other mental health issues during their consultations.

Notwithstanding the above, client-related barriers undoubtedly do play an important role in midwives' experienced difficulties regarding communicating about depression with their Moroccan-Dutch and Turkish-Dutch clients. The most influential client-related barriers all centered around the cultural aspect of communicating about depression, and are in alignment which previous research pointing to cultural taboos around talking about mental health issues [12,13]. Although the presence of husbands and family members impeding the communication process only emerged as a potential barrier, our interview results indicated that some of these clients may have a need for educational materials about perinatal depression specifically targeted at husbands. Previous research has indeed indicated that interpersonal psychotherapy to treat major depressive disorder, which aims to improve the client's social relationships and functioning by addressing the immediate social context of the client, is more effective than cognitive behavioral therapy [33]. Hence, including the husband or partner of pregnant Moroccan-Dutch and Turkish-Dutch women who suffer from depression-related symptoms in a culturally sensitive manner, may help in opening up the communication process about mental health problems and facilitate further treatment.

4.2. Study limitations and suggestions for further research

Despite our efforts to achieve a higher sample size, including follow-up phone calls, the main limitation of this survey-study is the relatively low sample size and response-rate. Hence, study findings have to be interpreted with caution and replication studies among bigger samples are needed to corroborate our findings. One interesting reason though for not participating mentioned by several midwives was their lack of experience with treating pregnant Moroccan-Dutch and Turkish-Dutch women who suffer from depression-related symptoms. Given the high prevalence rates found in previous research among these women [5], it is unlikely that they did not actually encounter these women in their practice. Rather, an equally if not more likely reason may be that they did not detect depression in these clients, lending further support to the finding that severe obstacles do indeed exist in communicating about depression-related symptoms with Moroccan-Dutch and Turkish-Dutch pregnant clients.

Another study limitation is that we did not interview Turkish-Dutch women in the first phase of our study. As our study's focus was on the perceived barriers of midwives, and the findings among Moroccan-Dutch women were in alignment with the broader research literature, we did not expect to identify additional barriers by including Turkish-Dutch women too, more so because the two ethnic minority groups are similar in some respects, such as their migration history and religious background. However, as there are some notable differences as well between the two groups, such as a different pattern of usage of healthcare services among Turkish-Dutch people compared to Moroccan-Dutch people [34], we recommend to do future research on barriers to communicating about perinatal depression among Turkish-Dutch women as well. Relatedly, future studies around this topic should try to reach both Moroccan-Dutch and Turkish-Dutch women who, because of a language barrier, might not be receiving any (adequate) medical care at all during their pregnancies, as the severity of barriers to communication about depression could very well be higher in these specific subpopulations. As a next step to such client interviews, a survey

study among Moroccan-Dutch and Turkish-Dutch women to assess their perceived barriers to communication about depression with their midwife might yield interesting further insights and possible discrepancies between midwives and their ethnic minority clients. Identifying discrepancies and commonalities between these two groups might lead to a stronger base for developing communication strategies to mitigate the communication barriers.

4.3. Conclusion

The most influential barriers perceived by midwives to communicate about depression during consultations with Moroccan-Dutch and Turkish-Dutch clients are related to the lack of patient educational materials and screening instruments to detect depression in a culturally sensitive manner. To mitigate these barriers, these materials and instruments need to be developed, validated and implemented in practice by means of a collaborative approach, in which all stakeholders, i.e. clients and client representatives, midwives, mental healthcare professionals and policy makers, should be included.

4.4. Practice implications

Based on the findings of this study, communication strategies can be developed that may support midwives and pregnant Moroccan-Dutch and Turkish-Dutch women with depression to decrease the identified client-related and midwife-related barriers. For instance, midwives can be trained in developing intercultural communication knowledge and skills and educated in detecting depression in an efficient and culturally sensitive manner during consultations. Clients may be empowered to disclose their depression-related symptoms by creating patient educational materials that also include their immediate social environment, thereby diminishing the cultural taboo around communicating about depression. In addition, patient education in mosques delivered by Imams about mental health issues might be helpful in breaking this taboo further. Last, eHealth interventions and treatment programs in which one can remain anonymous might be helpful for women for which this cultural taboo cannot be overcome yet.

CRediT authorship contribution statement

All authors have contributed to the design of the study, data-collection and analysis and writing the manuscript.

Declaration of interests

None.

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Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.pec.2021.07.032.

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