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Original contribution

Healthcare worker's perceptions of barriers to care by immigrant women with postpartum depression: an exploratory qualitative study

L. Teng[1], **E. Robertson Blackmore**[2], and **D. E. Stewart**[3]

[1] University of Toronto, Toronto, Canada
[2] Department of Psychiatry, University of Rochester Medical Center, New York, U.S.A.
[3] University Health Network and University of Toronto, Toronto, Canada

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Summary

Objective: We interviewed healthcare workers working in Toronto, Canada, regarding their experience of providing care to recent immigrant women suffering from postpartum depression. The objective was two-fold: 1) to identify potential barriers to care that recent immigrant women may encounter as perceived by healthcare workers; and 2) to identify challenges healthcare workers felt that they faced as providers of care to this population.

Methods: Qualitative semi-structured interviews were conducted with 16 key informants from various disciplines employed by healthcare agencies providing care to postpartum immigrant women in Toronto. Constant comparative analysis was used to analyze the data.

Results: Two main categories of barriers to care for recent immigrant women were identified: 'practical barriers' and 'culturally determined barriers'. Practical barriers included knowing where and how to access services, and language difficulties. Cultural barriers included fear of stigma and lack of validation of depressive symptoms by family and society. The challenges experienced by healthcare providers working with this population were organized into two other categories: 'professional limitations', and 'social/cultural barriers'. 'Professional limitations' included fear of incompetence, language barriers, and inadequate assessment tools. 'Social/cultural barriers' included the experience of cultural uncertainty.

Conclusions: The results suggest that not only are there important barriers to accessing postpartum care for recent immigrant women, but it can also be challenging for healthcare workers to deliver such needed care. Understanding some of these barriers and challenges from the perspective of healthcare providers is an important step to remedying gaps and obstacles in the service system.

Keywords: Postpartum depression; barriers; recent immigrant women; healthcare providers.

Introduction

Non-psychotic postpartum depression is the most common complication of childbearing (Stocky & Lynch, 2000), with a prevalence of approximately 13% (O'Hara & Swain, 1996), and as such represents a considerable public health problem affecting women and their families (Cooper & Murray, 1995; Murray et al, 1996; Mayberry & Affonso, 1993; Warner et al, 1996). The effects of postpartum depression on the mother, her marital relationship, and her children make it an important condition to diagnose, treat and prevent (Robinson & Stewart, 2001).

The majority of research on postpartum depression has been conducted with samples of Caucasian, English-speaking women residing in Western nations (Ross et al, 2006; Cox, 1988; Kumar, 1994; O'Hara, 1994), although in recent years more research has included other cultures (Chan & Levy, 2004; Chan et al, 2002; Rodrigues et al, 2003; Thome, 2003). Research has confirmed the existence of morbid unhappiness following childbirth across different cultural populations, however the illness models and beliefs regarding the etiology and treatment of postpartum depression vary widely (Oates et al, 2004). While rates of postpartum mood disorders are comparable between Western and non-Western cultures (Affonso et al, 2000), it has been suggested that recent immigrant women, may be at *higher* risk of postpartum depression than native born women (Barclay & Kent, 1998; Danaci et al, 2002; Dankner et al, 2000; Dennis et al, 2004; Glasser et al, 1998; Katz & Gagnon, 2002). For example, one study of approximately 600 new mothers in Canada indicated that immigrant mothers (who had im-

migrated within the last 5 years) had five times the risk of exhibiting depressive symptoms in comparison with Canadian-born women (Dennis et al, 2004).

An examination of the psychosocial needs of new mothers revealed that recent immigrant women frequently feel overwhelmed and socially isolated in the postpartum period (Katz & Gagnon, 2002). Research has identified consistent risk factors for developing postpartum depression (Robertson et al, 2004; O'Hara & Swain, 1996), and it is not unreasonable to expect that some of the most important risk factors, particularly stressful life events and poor social support, would be especially pertinent to many recently immigrated women. Depending on the disparity between the original and new culture and the circumstances of immigration, the physical, psychological, and emotional strain of motherhood may be especially overwhelming for recent immigrant women as they navigate through an unfamiliar healthcare system, often separated from the comfort of traditional postpartum practices and support networks (Barclay & Kent, 1998; Glasser et al, 1998).

Despite the increased risk of postpartum depression in immigrant women, few studies have specifically examined the provision of postpartum care to this population (Katz & Gagnon, 2002; Kinnon, 1999). Providing effective care to this at-risk population after giving birth is a challenging task that may be difficult for many healthcare workers. For example, a pilot study of postpartum care for immigrant women living in a major urban center in Canada showed that 40–100% of concerns were not recorded as having been resolved and 30–100% of families were not recorded as having received optimal care as defined in the literature (Katz & Gagnon, 2002). Given that approximately 200,000 immigrants arrive each year in Canada as permanent residents (Statistics Canada, 2001), more definitive investigation is needed to elucidate and verify the gap in effective postpartum care for recent immigrant women. It would also be of value to identify what experienced healthcare workers perceive to be barriers to providing quality care to this population. In this study we aimed to explore healthcare worker's experiences of providing care to recently immigrated women suffering from postpartum depression. We were particularly interested in their opinions on specific potential barriers to care that recent immigrant women may encounter as well as the challenges that healthcare workers felt that they themselves faced as providers of care to this population.

Methods

A qualitative approach was used to examine healthcare providers' perceptions of barriers to care by recent immigrant women suffering from postpartum depression. We chose to use a qualitative methodology for its flexibility and openness to explorations of particular themes and issues. Ethics approval was obtained and all participants provided written informed consent.

Informants

We identified key informants from agencies providing postpartum care to immigrant women in Metropolitan Toronto. Toronto absorbs more than a quarter of the 200,000 new immigrants that come into Canada each year (Statistics Canada, 2001), and has been designated by the United Nations as the most multicultural city in the world. In order to obtain as diverse a range of perspectives as possible we employed purposive sampling from agencies comprising multidisciplinary provider groups, and those who worked for agencies specifically aimed at immigrant groups as well as local women. Potential participants were contacted and asked if they would be willing to talk about their experience of providing care to recent immigrant women with postpartum depression.

Interviews

The key themes and questions devised for the interview were obtained through a review of the literature and discussion by the researchers, two of whom have clinical and academic experience in postpartum depression. The semi-structured interview focused on five main themes: a) risk factors for postpartum depression in recent immigrant women, b) barriers to accessing postpartum depression services for recent immigrant women, c) special needs of depressed recent immigrant women, d) ways of minimizing/reducing barriers, and e) unique challenges to providing care to this population.

The majority of interviews were conducted face to face at the participants' place of work, but two telephone interviews were also conducted. Interviews lasted on average 1 hour and all were conducted by LT. Recruitment and interviews continued until theme saturation occurred, after the 16th interview.

Sample

The characteristics of the key informants are shown in Table 1. 15 of the 16 participants were female. Their professional designations included social worker, public health nurse, registered nurse, practical nurse, home visitor, psychologist, family doctor and psychiatrist. The interviewees had spent an average of 15 years (SD = 10, range = 2–27 years) providing care to new mothers with a variety of problems which included postpartum depression. Seven of those interviewed were immigrants themselves and four women had suffered from postpartum mood disorders as new immigrants.

Analysis

Interviews were audiotaped with the participants' permission and transcribed verbatim. Grounded theory principles were em-

Table 1. Characteristics of the participants

Name*	Provider background	Agency	Experienced PPD	Immigrant
Amy	practical nurse, home visitor	community agency	no	yes (China)
Betty	registered nurse, home visitor	community agency	no	yes (South Africa)
Carolyn	home visitor	community agency	no	no
Dana	home visitor	community agency	yes	yes (Pakistan)
Debbie	home visitor	community agency	no	yes (Vietnam)
Greta	psychologist	hospital	no	no
Jackie	public health nurse	community agency	yes	yes (China)
Jane	social worker	hospital	no	no
Jesse	home visitor	community agency	yes	yes (Afghanistan)
John	psychiatrist	hospital	no	yes (Hong Kong)
Julia	psychiatrist	hospital	no	no
Katherine	family doctor	hospital	no	no
Lindsay	psychiatrist	hospital	no	no
Mary	social worker	hospital	no	no
Sandra	registered nurse, home visitor	community agency	yes	yes (India)
Sarah	family doctor	hospital	no	no

* Pseudonyms used throughout the study.

ployed to analyze the interview data and create an explanatory framework. Grounded theory provides a set of guidelines for identifying categories (or themes) within a set of data, looking at links between categories, and how they relate to one anther (Glaser & Strauss, 1967). Through this process of identifying, refining and integrating categories, a theory of the phenomenon under investigation is generated (Willig, 2001).

Each interview was transcribed and then read a number of times in order to familiarize the researchers with its content. Data were coded into main themes and subthemes throughout the interview period. Similarities and differences both within and between emerging categories were identified (providing *constant comparative analysis*). This enables the researcher to both build up and break down categories into smaller units of meaning. Any discrepancies were resolved through discussion, and all three authors read the final themes and findings for congruence and reliability.

Results and discussion

This study examined (a) healthcare workers' (HCWs) perceptions of potential barriers to care that recently immigrated women with postpartum depression may encounter, as well as (b) challenges the HCWs felt that they themselves faced as providers of care to this population. Two major categories of barriers for immigrant women were identified: 'practical barriers' and 'culturally determined barriers'.

Barriers for immigrant women

We grouped under "practical barriers" those challenges that HCWs perceived as making it logistically difficult for recent immigrant women to procure the care they want, whereas under "culturally determined barriers" we grouped those challenges arising from value judgments that deter recent immigrant women from seeking help. We saw "practical barriers" as challenges that are more likely to be relevant to women of all cultures (that is, most immigrant women who have recently immigrated), whereas by definition "culturally determined barriers" are likely to be specific to women of particular cultures (Chan & Levy, 2004; Chan et al, 2002; Dennis & Leinic, 2006; Edge et al, 2004; Parvin et al, 2004).

Practical barriers

Unsurprisingly, lack of functional fluency in English was cited in all interviews as one of the major perceived barriers to accessing postpartum depression care for immigrant women, as is consistent with literature (Dennis & Leinic, 2006; Templeton et al, 2003). Providers felt that the women had to be able to identify *where* and *how* to get the necessary information, required not only language proficiency but also an understanding and skill set of how to *access* information.

> Debbie [home visitor]: 'you need to get to the right starting points first. . .for example, you have to know how to search the phone book, which is usually in English.'

Many postpartum care agencies and programs offered services in a range of different languages, and where necessary employed translators. While the key informants in this study acknowledged that using a translator was helpful, they felt that it was not ideal, and found the process halting and superficial.

> Greta [psychologist]: 'in my experience, trying to communicate with a woman suffering from PPD

through a translator [sometimes] feels like. . .an exercise in futility.'

A number of individual or personality factors were identified which may preclude many recent immigrant women from seeking help.

Jesse [home visitor]: 'help seeking. . .requires a level of confidence and assertiveness. . .you have to make people understand what you need.'

The process to access an appropriate agency or program was highlighted as being complex and time consuming, requiring knowledge about the healthcare system and motivation on the part of the woman.

Amy [practical nurse, home visitor]: 'anything short of being highly functional and the woman is likely to abandon the process.'

Extensive research has shown that women from diverse cultures do not proactively seek help for postpartum depression (Chan & Levy, 2004; Chan et al, 2002; Dennis & Leinic, 2006; Rodrigues et al, 2003), oftentimes due to lack of knowledge of where to seek assistance (Holopainen, 2002), or of what options for assistance are available (Boath et al, 2004; Templeton et al, 2003), or even of the role of healthcare providers with respect to their emotional health (Oates et al, 2004; Thome, 2003; Parvin et al, 2004). It was emphasized by many we interviewed that these obstacles – although probably not unique to recent immigrant women – are likely to be more pronounced for this population as they navigate through an unfamiliar healthcare system.

Other frequently mentioned logistical barriers for recent immigrant women included getting transportation to and from an appointment, and being able to find and afford a babysitter. Again, these barriers were perceived not as being unique to recent immigrant women, but rather as being especially significant for them.

Jane [social worker]: '(these). . . seem simple enough to most of us. . .but when you're an isolated new immigrant woman – and especially if you're living in poverty – these barriers can be very significant.'

Culturally determined barriers

The healthcare providers we interviewed felt that barriers rooted in cultural values were the most complicated and difficult to address. We identified two related categories within this concept: internal and external conflicts. We conceptualized internal conflicts as those that occur when a woman has difficulty reconciling her needs with her own beliefs or values. External conflicts occur when the woman's needs conflict with others' desires and expectations – or her *perception* of these desires and expectations (O'Connor et al, 2002).

Lack of knowledge and understanding of postpartum depression on the part of recent immigrant women was identified as a major limitation to help-seeking.

Mary [social worker]: 'some women will find their way to our program when they're initially seeking help for other difficulties. . .then realize (they have) something called postpartum depression.'

A new immigrant woman suffering from postpartum depression may experience conflict between her need for assistance and her understanding of her distress (Dennis & Leinic, 2006; Ugarriza, 2004). Many cultures do not perceive postpartum depression as a 'medical' problem requiring intervention from a health provider (Holopainen, 2002; Rodrigues, 2003; Templeton et al, 2003; Thome, 2003; Ugarriza, 2004). The lack of cultural recognition and open discussion of postpartum depression may lead many recent immigrant women to dismiss or deny their distress (Chan et al, 2002; Chan & Levy, 2004; Parvin, 2004; Rodrigues, 2003; Templeton et al, 2003; Tammentie et al, 2004). Again, it was perceived by the healthcare workers we interviewed that although these obstacles may not be unique to new immigrant women, they are much more common among this population, particularly women from non-western countries.

Mental illness is heavily stigmatized within many cultures (Arboleda-Florez, 2003; Dennis & Leinic, 2006) with attributions of shame commonplace; for some, this shame, stigma, and fear of being labeled mentally ill may be especially pronounced with respect to postpartum depression.

Sandra [registered nurse, home visitor]: 'Some cultures tend to believe that depression of any kind is a form of madness. Those who admit to suffering from depression after the joyous birth of a baby – especially of a boy – are labeled 'crazy'.'

The stigma of suffering from postpartum depression is not restricted to the individual, but also extends to other female relatives.

Dana [home visitor]: 'in some Asian cultures. . .if word got out [that the immigrant woman suffers from depression], the stigma spreads to all the relatives. . .sisters back in the home country would be labeled as at risk for madness, and would have difficulty finding suitors.'

Even those women who are able to identify their distress and who want help, may be unwilling to seek it. In many cultures seeking help outside of the family, especially for emotional distress, is not encouraged.

> Jane [social worker]: 'many of our clients were brought up with the understanding that you shouldn't air your dirty laundry outside.'

Women may feel compelled to hide their distress for fear of being alienated or breaking family harmony. Many of the healthcare workers we interviewed spoke of the obligation many immigrant women may feel to maintain family harmony at the expense of personal sacrifices. This may be particularly true for women who emigrated to a new country for the purpose of entering into an arranged marriage. What "family" she has in the new country are all strangers and there is often pressure from the home country, where family members may have pooled together resources to send the bride overseas. There is usually significant pressure and expectation for future support and sponsorship.

> Julia [psychiatrist]: 'a theme I hear often from some of my recent immigrant patients is their sense of obligation to their family. . .the pressure they feel to make the marriage work. . .and sometimes this means keeping all the morbid sadness to themselves.'

Networks of family and friends may be more restricted for recent immigrant women; many of the respondents felt that newcomer women were more dependent on their husband's family, and opportunities for networks outside of the family were limited.

> Jesse [home visitor]: 'immigrant women. . .need a lot of help. . .with many things that may seem simple. . .but if you're new to the country, most of your family is probably not here, and you probably haven't had enough time to make friends who will help you out much.'

A lack of spousal support and validation of the need to seek help may be a more pertinent barrier to accessing services for immigrant women.

> Sarah [family doctor]: 'some recent immigrant husbands are quite ignorant about PPD. . .and if her husband doesn't think she has a legitimate problem or thinks she's being crazy. . .then the wife is probably going to feel silly going to outside resources for help.'

New immigrant women may find themselves living with their mother-in-law and extended family. In some cultures, the husband's mother is seen as an authority figure due to her age and life experience. While this may objectively be seen a source of support for the woman, it can also be a source of conflict.

> Debbie [home visitor]: 'whenever I visit this client, her mother-in-law is always around and always insists that her daughter-in-law is fine and doesn't need any more home visits. . .that she could take care of her daughter-in-law herself.'

This can be problematic not only for the new mother suffering from depression, but also for the healthcare worker trying to provide effective care. The health provider seeking to establish an openness and trust, as well as elicit symptoms with the client may need to find ways of ensuring that the client is able to express herself freely.

> Debbie [home visitor]: 'I only got an idea of how awful my client was really feeling when I brought another colleague of mine to the home visit one day to distract the mother-in-law while my client and I went for a walk with the baby.'

It has been argued that the generally low numbers of healthcare workers from minority ethnic backgrounds is a barrier to help-seeking by immigrant women (Templeton et al, 2003), however in this study, providers reported that some women preferred working with providers of a *different* culture. Women were worried about being judged by a cultural peer, and perhaps more surprisingly were concerned about the health provider maintaining confidentiality.

> Debbie [home visitor]: 'some women worry about stigma more if they're working with someone of their own culture. . .fear of judgment and because there's greater probability of sharing the same social sphere.'

Many women, irrespective of cultural background, may be unwilling or unable to disclose depressive symptoms. There are a myriad of reasons for non-disclosure including not recognizing the symptoms as pathological (Edge et al, 2004; Kim & Buist, 2005), feeling that they are a bad mother because they are not coping (Mauthner, 1999), or feelings of embarrassment or guilt (Parvin et al, 2004). The healthcare workers we interviewed emphasized that perhaps the greatest barrier to help-seeking is the fear of new immigrant mothers that disclosure of their depressive symptoms will lead to the loss of their baby to child welfare agencies, a fear that has been described by other researchers (Mauthner, 1999; Shakespeare et al, 2003; Templeton et al, 2003). It was perceived that for recent immigrant women this fear

may be compounded by lack of understanding of the healthcare and social services system, and their perceptions of postpartum depression. Healthcare providers need to be aware of, and sensitive to these fears and assuage such concerns.

> Dana [home visitor]: 'I've heard of [health and welfare providers] making threats to women about taking their baby away…they don't take the time to listen, to try to understand what…help these women really need.'

Challenges for HCWs

Two categories of challenges experienced by HCWs were identified: 'professional limitations', and 'social/cultural barriers'. We conceptualized professional limitations as those barriers that rest with the HCWs and with the tools that they have available to them. This includes fear of incompetence, language barriers, and inadequate assessment tools. We conceptualized social/cultural barriers as those challenges that arise from cultural differences between the HCWs and the recent immigrant women, notably the experience of cultural uncertainty.

Fear of incompetence

Some of the HCWs interviewed felt that the biggest challenge in working with new immigrant women with postpartum depression was their own fear of not being equipped to provide adequate care.

> Lindsay [psychiatrist]: "it can be tough if you're not really sure that you truly understand the situation… you might not feel competent in a cross-cultural setting…you don't want to make things worse."

Some HCWs felt that formal training in cross-cultural care would be beneficial, whereas others felt that formal training would not be helpful – rather, experience and open-mindedness was the only solution.

> Jackie [public health nurse]: "…actually, I don't think formal training would do much good. In the end you need to gain experience to achieve a sense of competence, and you need to always keep an open mind in terms of what you're seeing."

Language barriers

All the HCWs interviewed felt that language was as much a barrier to providing care as it was to accessing care.

> John [psychiatrist]: "Language is a barrier that can be hard to get away from, especially in the type of work that we do…where communication is key to providing the service that we offer. It can be very frustrating trying to have a discussion about something as subtle and complicated as emotions through a translator."

Inadequate assessment tools

Some HCWs felt that existing assessment tools were inadequate for screening for postpartum depression in immigrant women given that what is considered "normal" or "abnormal" may vary across cultures.

> Jesse [home visitor]: "Our criteria for what constitutes postpartum depression may not be suitable for women from certain cultures…for example, in some… cultures, it is customary to act sad about the birth of your baby because of the belief in the Evil Eye…I think not having the right tools for proper assessment is a problem."

Cultural uncertainty

The difference in cultural background between themselves and the immigrant women was identified as a source of challenge for some of the HCWs interviewed.

> Jackie [public health nurse]: "it can be harder trying to understand the experience of someone who may have lead a very different life from you [compared to understanding the experience of someone of the same cultural background]…they may have very different expectations or understandings."

Summary of findings

This study explored healthcare workers' experiences of providing care to recent immigrant women with postpartum depression in order to further our understanding of barriers to service provision and access. Our findings regarding practical barriers to care supported those of previous literature: recent immigrant women have difficulty accessing appropriate services due to a number of factors including language fluency and the ability to identify and access sources of information (Amankwaa, 2003; Dennis & Leinic, 2006; Matthews & Hughes, 2001; Phan, 2000).

Perhaps more importantly, many of the barriers to care observed by the healthcare workers we interviewed were rooted in cultural understandings of postpartum depression. This is consistent with literature indicating that many immigrant women have a poor understanding of postpartum depression and are thus unable or unwilling

to disclose their feelings to healthcare workers, or even to partners, family members or friends (Amankwaa, 2003; Dennis & Leinic, 2006; Rodrigues et al, 2003). The literature has shown that ethnic minorities under-use formal systems of mental health services (Cheung & Snowden, 1990), including those specific to postpartum depression (Rodrigues et al, 2003).

Stigma was identified by the study participants as a multi-faceted barrier to care. They felt that stigma prevented some recent immigrant women from initiating service use not only due to conflict with personal beliefs and values, but also due to fear of being alienated by others and bringing shame to the family. This is consistent with literature indicating that shame, stigma, and the fear of being labeled mentally ill are significant deterrents to seeking or accepting help for postpartum depression (Amankwaa, 2003; Chan et al, 2002; Holopainen, 2002; Mauthner, 1999; Shakespear et al, 2003; Templeton, 2003; Ugarriza, 2004). It may be helpful to include multilingual information sheets about postpartum depression in the inserts given to new mothers when leaving hospitals after birth. These could include both information about depression causes and symptoms, practical advice and locations of support centres and healthcare locations that provide mental healthcare. The information should emphasize that depression is not a character flaw and that depression can be effectively treated.

Lack of social support and relationship difficulties during pregnancy or in the immediate puerperium are associated with a higher risk of developing postpartum depression (Robertson et al, 2004; O'Hara & Swain, 1996). One Canadian study on the factors associated with depression in pregnant immigrant women found that 42% scored above the cutoff for depression and were associated with poorer functional status and more somatic symptoms. Depressed women reported a lack of social support, more stressful life events and poorer maternal adjustment (Zelkowitz et al, 2004). Practical assistance for immigrant mothers to locate new mother centres or groups where nonjudgmental support, social support or mental healthcare is available, may be extremely helpful. For example, arranging transportation, childcare or someone to accompany the recent immigrant mother to the location may make the difference between receiving or not receiving necessary care. In some cultures, family members may actively discourage women from obtaining help as it is perceived to be inappropriate to seek external assistance for depressive symptoms (Chan et al, 2002; Rodrigues et al, 2003; Templeton, 2003), which may be a very significant barrier to accessing care for recent immigrant women suffering from postpartum depression. This suggests that women should be interviewed privately using a non-family interpreter when possible.

While it may be assumed that optimal care is provided by culturally matching the client and provider (Prieto et al, 2001), this did not hold true within this sample. Healthcare providers reported that clients were concerned about being judged by their peers, and perhaps more surprisingly felt that healthcare providers may breech confidentiality, particularly when they shared the same social community. This concern was most forcibly expressed by closely knit and smaller immigrant communities who often shared churches, social spheres and who may be inter-related or worse yet engaged in civil conflict in the country of origin. Some mental health providers reported that some immigrant women would request that they be treated by providers from outside their cultural group. Preferences about cultural matching if available should be discussed with the woman herself without assumptions that she will welcome being treated by someone from her own culture and country.

Some of the healthcare workers we interviewed felt that one of the biggest challenges in working with immigrant women was overcoming their own lack of experience dealing with this population. This is an important issue as the literature indicates that inappropriate assessments paralleled with an insufficient knowledge pose a significant postpartum depression treatment barriers (Mauthner, 1997; Thome, 2003; Ugarriza, 2004). However, the literature indicates that in addition to being able to recognized depressive symptoms and not normalize or dismiss them as self-limiting (Dennis & Leinic, 2006; Mauthner, 1997; McIntosh, 1993), what is perhaps even more important in promoting help-seeking and effective treatment is care that is delivered with the right attitude – that is, care that is compassionate, attentive, and non-patronizing (Dennis & Leinic, 2006; Holopainen, 2002).

The limitations of this study need to be mentioned. This is an exploratory study which has raised a number of issues, however its results require replication in further samples of healthcare providers. Toronto is a multicultural city and its healthcare providers may have an increased sensitivity and awareness of the needs of the immigrant population, and it is likely that a high proportion of providers are immigrants themselves. Another limitation is that some communities may not have home health visitors for any new mothers. It should also be noted that this study reflects healthcare providers' perceptions of barriers to care, and not the experiences of

recent immigrant women with postpartum depression. However, when considering the provision of culturally appropriate mental healthcare it is imperative to examine and establish potential barriers to care from both provider and consumer perspectives. The results of this study have been used to inform a similar study of perceived barriers to care which interviews recent immigrant women suffering from postpartum depression. It is also relevant to note that five of the informants were themselves immigrants, and provide a unique understanding of the needs and experience of newcomers to North America. Furthermore, three of these five women had experienced postpartum depression as a new immigrant and therefore can provide both a provider and personal opinion on perceived barriers to care and experiences of working with women with postpartum depression.

Conclusion

Given that many Western countries are home to evergrowing numbers of recent immigrant women of diverse ethnic origin, and given that different cultures have different beliefs and traditions not only about childbirth, but also about mental illness, it is helpful that healthcare providers are informed and sensitive to the special needs of new immigrant women suffering from postpartum depression. The healthcare providers in this study identified many practical and culturally determined barriers to accessing and providing postpartum depression care for recent immigrant women. Their experiences indicate that there are multiple, wide ranging barriers to accessing quality care. Understanding some of these barriers from the perspective of healthcare providers is a vital aspect to remedying gaps and obstacles in the service system. Acknowledging and understanding the challenges may be an important step in overcoming and working with them. Future research, however, should also listen to recent immigrant womens' voices to learn their perspectives. This will be of interest not only as a means of furthering our understanding of barriers to postpartum depression care for recent immigrant women, but also as a comparison for assessing discrepancies between the experiences and understandings of healthcare providers and new immigrant women themselves.

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Correspondence: Donna E. Stewart, MD, FRCPC, University Health Network Women's Health Program, 200 Elizabeth St, EN-7-229, Toronto, M5G2C4 Canada; e-mail: donna.stewart@uhn.on.ca