The Influence of Culture on Perinatal Mental Health

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18.1 Introduction

The experience of pregnancy and childbirth is deeply influenced by social and cultural factors, and therefore culture plays an important role in the mental health of women in the perinatal period. Culture is known to shape the way one thinks, feels, and behaves and also responds to different life stages. Cultural factors are also known to influence the way one experiences and expresses mental distress and the psychopathology in case of a psychiatric disorder [1]. The influence of culture is also seen in ways in which a society labels a disorder and seeks help.

18.2 Impact of Culture on Perinatal Psychopathology

Like in other mental health conditions, the impact of culture on perinatal psychopathology may be patho-plastic (shaping of symptoms), pathogenic (causation of symptoms), patho-elaborative (exacerbation/exaggeration of symptoms), or patho-facilitative (conferring risk or protection).

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18.2.1 Patho-plastic Influence

Although a wide range of symptoms are shaped by cultural influence, we discuss those where the influence is clinically conspicuous.

18.2.1.1 Somatic Symptoms

While somatic symptoms such as changes in sleep and appetite, and fatigue are innate to the physiological perinatal state, they can be valid indicators for depression. In several situations depressed women are less likely to articulate their problems as "depression" but rather report somatic complaints. Moreover, pregnant women with depressive and anxiety disorders may present with "an amplification of physical symptoms of pregnancy" [2]. These somatic complaints may not only represent a means of culture-specific expression of psychosocial distress but also indicate the presence of an underlying mental disorder. Especially in non-western cultures somatic symptoms are the predominant presentation of distress, and they are indeed considered as a direct manifestation of distress [3].

18.2.1.2 Delusions and Infanticidal Behavior

Culture may strongly influence the theme of delusions in women with postpartum psychosis. A study from India reported many religious themes among women with postpartum psychosis [4]. Women with postpartum psychosis may manifest delusional thoughts of harming the infant [5]. Filicidal behavior among mothers with mental illness usually has an altruistic reason or could arise out of a psychotic experience [6], and there could be an influence of the culture in shaping the filicidal behavior of the mother. Religious delusions, which are strongly pinned to cultural context, are linked to filicidal acts suggesting a dynamic interaction between culture and the filicidal behavior on account of mental illness [7, 8].

18.2.1.3 Dissociation/Conversion

In general, dissociative/conversion disorders, especially those of trance and possession, are fairly common in low- and middle-income countries [9]. Cross-cultural variability in their association with other psychiatric symptoms has led to difficulties in their nomenclature as well, and this has become much more challenging from the perspective of those cultures that are transitioning from orthodoxy to modernization. These challenges are pertinent to perinatal women as well. The experience of labor pain is itself culturally determined—so much so that women belonging to some cultures (such as Ghanaian) deny (or dissociate) labor pain because those who are unable to endure labor pain are labelled emotionally weak [10]. Cultural variations in the experience and report of labor pain have also been reported [11].

18.2.1.4 Catatonia

The prevalence of catatonia during the postpartum period is not infrequent. A prevalence rate of 20% among postpartum women with psychosis has been reported from a Mother-Baby Unit in India [12]. Although some ethnic variation in prevalence of

catatonia among certain cultures is noted [13], broad cultural variation in the presentation of catatonia and specific to postpartum psychosis remains to be explored systematically.

18.2.2 Pathogenic Influence

Mental health illnesses that have direct pathogenic effect of culture are "culture-bound syndromes." Culture-bound syndrome is a condition that is "understood only in certain cultural context" and is labelled based on "the specific ways in which each cultural group understands distress, tension, illness and health" [14]. The *Diagnostic and Statistical Manual of Mental Disorders, fifth edition: DSM-5* uses the terms "cultural syndromes," "cultural concepts of distress," "cultural idioms of distress," and "cultural explanation/perceived causes." Some "cultural syndromes" that are specific to the perinatal women are discussed here.

As most of the cultures are on the crossroads of following traditional customs and of moving on with modernization, these syndromes are important to address. Moreover, the diagnostic challenge posed by these syndromes in psychiatric practice because of the resemblance with many primary axis diagnoses makes their discussion much more relevant. In the community, the symptoms of primary psychiatric disorders are misjudged as culture bound and are considered to have an "external" causality [14] whereas in the clinics, emphasis on the symptoms of primary axis diagnoses is greater, and consequently cultural connotations of these symptoms could be missed.

18.2.2.1 Susto

Susto is a cultural syndrome described in Latin Americans, Central and South Americans, and also in some Asian countries. The other terms that refer to syndromes that are similar to susto are "espanto," "pasmo," and "perdida de sombra." It is "an illness attributed to a *frightening* event that causes the soul to leave the body and results in unhappiness and sickness" [15]. If the event is "anger provoking" instead of "frightening," the illness is termed "Muinas." As "fright" and "anger" are believed to negatively influence the pregnant woman and the in utero baby, the family tries to prevent the pregnant woman from "receiving bad news or from getting them suddenly" as much as possible [14]. Any pregnancy complication (such as diabetes, hypertension) or malformations in the baby are not revealed to the woman. If such news is revealed accidentally or mistakenly and the pregnant woman becomes "frightened," then it is believed that "good fortune or soul" has abandoned the body of the future mother and the baby, and that susto has set in. The susto pregnant woman becomes anxious, restless, unable to sleep, irritable, and emotionally vulnerable, and the susto baby doesn't sleep and eat well, is too sober or anxious, is easily startled, and cries excessively. As a remedy for susto, a curandero (healer) or a shaman will offer special prayers and administer special medicinal potions to the woman and the baby so as to make the "good fortune or soul" return the body [14].

18.2.2.2 Toas

Toas, seen in Cambodia [16], is considered an incurable illness characterized by chronic abdominal pain, weakness, headache, diarrhea, palpitations, weight loss, and poor appetite. Toas, which roughly translates to "conflict," is believed to be caused due to not adhering to customs followed during the postpartum period. Interestingly, a postpartum woman is considered a queen, and the family (and the woman herself) needs to assure adherence to the prescribed customs in order to maintain balance. These customs typically are "ang pleung (warming the mother on a bamboo bed with fire below)," food restrictions, physical activity restrictions, sexual activity restrictions, restrictions on bathing and exposure to rain/dew, and to be free on emotional distress or worry. Five different types of toas, depending on which custom was not adhered to, are described as – toas chamney (eating wrong food); toas sor sai (lifting heavy weight or doing hard work); toas damnek (resuming sexual intercourse before 3 months postpartum); toas tek pleany (exposure to rain/dew or bathing); and toas pruey cet (experiencing emotional distress) [16]. Thematically, toas pruey cet is similar to the concept of susto.

18.2.2.3 Lom pid duan

Lom pid duan is a cultural syndrome prevalent in Thailand. Like toas, it is characterized by body aches and weakness and thought to be caused due to not adhering to a postpartum custom – "yu duan." Yu duan is a 30-day period where postpartum women are cared by female family members and their husbands [17].

18.2.2.4 Aire

Aire, seen in Latin Americans, is a disease that develops as a result of penetration of air into the body. It is believed that if a postpartum woman is exposed to cold air, it shall interrupt the production of milk. There is a great amount of anxiety in the family members to completely wrap the mother and the baby, even to the extent that head of the baby remains covered even in summers so as to prevent air from entering the body by eyes and mouth. A risky tradition termed as "moxibustion," where alcohol is burnt in a glass cup and applied to the "affected area," is followed as a remedy for aire [14].

18.2.2.5 Caida de mollera

Caida de mollera is a syndrome seen in Latin America, where an infant's (anterior) fontanelle is perceived to be sunken or concave (often due to dehydration) and to cause the baby to be listless, less responsive, eating less, intensely crying, and irritable. It is believed to be due to "negative" suction inside the head. The usual remedy is by holding the baby upside down and hitting the soles; this tradition risks the occurrence of the shaken baby syndrome [14].

18.2.2.6 Sanni, Janni, Janni Ekkendi, and Sanni Patam

These are the terms referred to distress and madness during the postpartum period in southern India. While the term "bananti" refers to a woman in her postpartum period, Sanni and Janni are specific terms used to refer to psychosis during the

Table 18.1 Cultural syndromes related to perinatal mental health

S. no.	Cultural syndrome	Description	Region
01	*Susto*	Woman becomes anxious, restless, unable to sleep, irritable, and emotionally vulnerable when she faces a frightening situation. "Frightened" woman's "good fortune or soul" is believed to have abandoned her body	Latin, Central and South America, Some parts of Asia
02	*Toas*	Not adhering to customs followed during the postpartum period leads to an incurable illness characterized by chronic abdominal pain, weakness, headache, diarrhea, palpitations, weight loss, and poor appetite	Cambodia
03	*Lom pid duan*	Not adhering to a postpartum custom – "yu duan" – leads to an illness characterized by body aches and weakness	Thailand
04	*Aire*	An illness characterized by multiple somatic complaints develops as a result of penetration of air into the body	Latin America
05	*Caida de mollera*	"Negative" suction inside the head leads to sunken or concave fontanelle and causes the baby to be listless, less responsive, eating less, intensely crying, and irritable	Latin America
06	*Sanni/ Janni*	Psychosis during the postpartum period	South India

postpartum period. These syndromes are believed to have a supernatural causation and are attributed to ghosts, demons, black magic, "bad breeze," and bad fate [18].

A brief description of the cultural syndromes described in this section is presented in Table 18.1.

18.2.3 Patho-elaborating Influence

In this section, we discuss perinatal problems that might be exaggerated through certain cultural reinforcements.

18.2.3.1 Poor Control Over Contraception due to Lack of Agency or Religious Beliefs

Poor control over contraception mainly has two outcomes pertinent to perinatal mental health – multiparity, and unwanted pregnancy. Cultural context has one of the strongest influences on the acceptance and use of contraception by couples. Different religious backgrounds and different sects within religions influence control over contraception in many distinct ways [19]. While it is important to understand these cultural differences for competently delivering care by healthcare providers, certain beliefs of "prohibition of contraception" among certain masses [20] may have negative influence on the mental health of perinatal women. Women

who have many children have significantly greater concerns regarding lack of financial and social support [21]. Unwanted pregnancy, the other outcome of poor control over contraception, has indeed been directly linked to postpartum depression [22]. Apart from multiparity and unwanted pregnancies, one would assume poor spacing between pregnancies also could negatively affect the mental health of perinatal women. Interestingly, shorter inter-birth spacing has been known to have a negative impact on marital relationships [23], which might mediate its relationship with poor perinatal mental health.

18.2.3.2 Gender Preference

Patriarchal culture has made the male gender the preferred one for the newborn. Unfortunately, "a daughter is pitied at birth and the mother is blamed" [24]. Understandably therefore, the pregnant woman is put under tremendous stress by family as well as herself to give birth to a male child in many cultures like Indian and Chinese. In India, significantly higher number of pregnant women prefer male as the newborn gender; and women who report male gender preference have been found to have higher anxiety and stress [25] and also to be at risk for postnatal depression [26]. This risk, however, does not seem to be present in certain western cultures [27]. Maternal filicide is among most severe consequence related to "birth of non-preferred new born gender" [6]. Also, sex-selective abortions are usually the consequence of preference to infant's male gender adding to a woman's distress.

18.3 Modern Cultural Contexts: Family Structure, Workplace, and Maternity Leave

In many cultures, including traditional societies, more women reside now in nuclear families. Both nuclear and extended families have their advantages and disadvantages in the context of a woman's mental health [28]. One important advantage of living in societies that are socially connected is the availability of social (family) support. Social support is a predictor of antenatal mental well-being. And lack of social support is an important predictor of postpartum distress [29].

Maternal employment and therefore the workplace also add to the social support network. Perhaps, employed status and good support from workplace is associated with lower chances of perinatal psychopathology [30]. Within the context of maternal employment is the important aspect of maternity leaves. Across cultures (North American, European, Australian, and Middle East Asian), longer paid maternity leaves not only translates to improved pregnancy-related outcomes such as breastfeeding but also better maternal mental health [31]. Unfortunately, the access to paid maternity leaves is not straightforward and disparities exist in sanction of such leaves.

With the "cultural change" and the "changing roles of women" that are happening across the globe, there is a likelihood that factors conferring protection against

perinatal mental health problems such as better education, employment, and therefore self-esteem, are likely to improve. While the support structure in the traditional "ethnokinship" cultures is clearly defined, they are mostly dependent on maternity and paternity leaves in modern "technocentric" cultures [32]. Along with the changing roles of women, the social support and its seeking by perinatal women also depends on the deep-rooted distinctive gender roles, both in western societies and traditional ones [33, 34]. Moreover, there is some evidence to suggest that several factors related to the "modern civilization" such as early weaning, low levels of physical activity, and diets deficient in essential fatty acids are also related to postpartum psychopathology [35]. Since these factors vary across cultures, they differentially influence the prevalence of perinatal mental illnesses.

18.3.1 Patho-facilitative Influence

Prevalence of perinatal mental illnesses varies, in fact quite remarkably so, between different regions [36–38]. This remarkable variability, to a large extent attributed could be due to the role of cultural differences across these regions.

Prevalence of antenatal distress (anxiety/depression) varies between 6% and 29% in developed countries and between 20% and 60% in developing countries [38]. Social support (including quality of marital relationship) and a lack of it have been consistently suggested to be protective and risk factor for antenatal distress, respectively. Further, self-confidence has been claimed as another protective factor against antenatal distress in developed countries [38]. Cumulative stressful life events and domestic violence are the other sociocultural determinants that confer risk of antenatal distress.

Prevalence of postpartum depression varies between 0.5% to 63% [36, 37]. Similar to antenatal distress, the prevalence rates of postnatal distress too are higher in developing countries than developed ones [38]. While Pakistan, Guyana, Italy, South Africa, and Korea report high prevalence countires such as Singapore, Denmark, and Malaysia report low rates [36]. In Pakistan, the identified risk factors included low social support, stressful life events, poverty, multiparity, and low education. Birth of a female baby has been found to be a significant risk factor for postpartum depression in India, Turkey, China, and Japan [37]. The single mother status, which is more prevalent in developed countries, has been found to be a risk factor for postpartum depression [38]. The association of antenatal distress with postpartum psychopathology appears to be culture-free (found across nations and cultures) [38]. In South Africa, where the prevalence rates of postpartum depression are high, literacy has been found as the protective factor. Expectedly, good social support is protective across all cultures. Immigrant status, being a homemaker and unemployed, uneducated husband, polygamy, domestic violence, poor living conditions and birth of a female baby are cultural risk factors for postpartum depression in Asian countries [37].

18.4 Influence of Traditional Customs/Rituals on Perinatal Mental Health

The traditional customs and rituals that vary from culture to culture have evolved over years probably with an intention of providing emotional strength support as well as dealing with the unique needs of the motherhood. Organized support and a rest period, which are mostly universal across cultures, appear to provide support to the perinatal woman during her later part of pregnancy and early postpartum [39]. However, the changing role of women might not allow a woman to participate in these rituals for the prescribed time period of rest, which vary from 3 weeks to 10 weeks or even longer across cultures. Apart from the time at disposal, it may not be also feasible many a time for women, especially those from nuclear families, to arrange for availability of required number of female family members for the support [39]. Hence, strictly adhering to these rituals is not possible, and the possible mental health benefits of them (i.e., long needed rest) may not be availed despite being culturally allowed.

Apart from not being able to avail the benefits, the very nature of these customs, i.e., voluntary or forced, and restrictive or flexible, determines the way they influence the mental health of the perinatal women. Voluntary and flexible rituals are likely to have good mental health outcomes, while forced and restrictive ones, due to the resultant tension, stress, and emotional disturbance could lead to perinatal psychopathology [36]. In fact, being in conflict with traditional rituals has been identified as a stressful situation that contributes to occurrence of postpartum distress [37]. There is perhaps an incongruity between the expectation and perception of an "ideal motherhood" role and the realistic nature of the "changed" role, which has "multiple roles and tasks." These "crushed maternal role expectations" and the resultant "going into hiding" and "intense feeling of vulnerability" due to sense of shame, helplessness, and dependency have been included in the qualitative, meta-synthetic, practical life concerns-based theories of postpartum depression [40]. Moreover, as discussed earlier too, the failure to adhere to these traditional customs also has a likelihood of being branded with certain culture-bound syndromes like susto, toas, lom pid duan, aire, etc. [14, 16, 17]

Interestingly and commonly across cultures, foods are idiosyncratically divided into "hot" and "cold." Usually, there is a strict prohibition of "cold" foods and encouragement of consumption of "hot" foods/herbal preparations during the postpartum period since postpartum is considered as a "cold" state [39]. The food prescription for the perinatal women, especially those in their postpartum period, becomes very restrictive. This restriction might have a negative influence on the perinatal woman's "food choice," which is an important component of food security [41].

While adhering to traditional customs seems to offer some protection to perinatal mental women in some cultures, they seem to be "not supportive" in some even when the women has adhered to the cultural prescription of the rituals. While some Taiwanese ("doing the month") and Turkish-Islamic customs were found to be protective for postpartum depression, the Japanese, the Vietnamese, and the Iranians

reported that their respective postpartum rituals (such as "Satogaeribunben," "Zuo Yue Zi," etc.) did not offer any protection [37, 42, 43]. In fact, in Malaysia and Singapore, where the postpartum depression rates are quite low, practicing and adhering to the postnatal rituals ("Pantang" and Singaporean confinement, respectively) was rather associated with more negative mental health consequences [37]. Whether or not such negative mental health consequences are associated with other idiosyncratic rituals and practices related to "hygiene and physical warmth" such as the Islamic—"ghusl"—and the Thai, "kao krachome" and "yu fai" [39] remains to be specifically assessed. Further, there is a stark contrast in the nature of these rituals—while baths are restricted in some cultures like Mexican and Chinese, they are acceptable and encouraged in Malaysian, Indian, and Thai cultures [39]. Apart from being idiosyncratic, certain rituals, especially those related to breastfeeding and infant feeding, may contradict the scientifically undermined essential medical advice. Breastfeeding, medically recommended to be initiated within the first hour of birth, is delayed for 2–3 days or even till the sixth day "Chatti" in some parts of India. In fact, colostrum, which is considered as an immune booster, is perceived as "dirty" and indigestible in South Asian and Guatemalan cultures [39]. The contrast between medical advice and characteristics of traditional rituals is likely to result in stress among perinatal women [37].

Although linked to religion, afore discussed traditional customs and rituals commonly cut across various religions. Interestingly, studies have found that religiosity and participation in organized religious participation is indeed protective for perinatal women [44]. Negative religious coping appears to be associated with higher levels of perinatal psychopathology. Intriguingly, certain religious practices also tend to have negative effects on antenatal as well as postnatal psychopathology. One such interesting practice is that of "Marianismo." Marianismo is an orthodox Christianity-based self-sacrificing and subordination idealism followed in Latina women, where they assume "a role of virtue, passivity and priority to others over oneself." Marianismo is found to be significantly associated with postpartum depression, although the association of antenatal depression is not consistent. Several negative cognitive-emotional factors and poor mental healthcare seeking have also been associated with the practice of Marianismo [45].

18.5 Migration, Culture, and Postpartum Mental Health

Feelings of loneliness among migrant women may worsen during the perinatal period especially during the postpartum. Few stressors associated with migration such as leaving behind one's social network and having to face unfamiliar circumstances and uncertainties about income, healthcare access, and residential status exacerbate the sense of solitude among women and more so if a woman is depressed. Migrant women with PPD have fears about accessing healthcare, worries about being labelled, and fear of losing children to state care on being perceived as incompetent. Mothers who had migrated and had postpartum depression reported a crushed maternal role, disruption in sense of self, vulnerable feelings such as

helplessness, and daily practical concerns [40]. Expectations about being a good mother and perceptions about availability of support can vary in the new country and can be stressful to the immigrant mothers. Further, societal expectations that a new mother has to be happy all the time contrast with the maternal experiences of adjusting to the challenges of motherhood in a new country.

Migration within the country is also associated with challenges for women during perinatal period, and factors such as poor income, low social support, and disrupted marital relationships are associated with perinatal depression [46]. Immigrant women are particularly at risk for postpartum depression [47].

Research examining the role of specific cultural aspects such as degree of acculturation and religiosity in the manifestation of perinatal depression has remained inconclusive.

In a Canadian setting, the prevalence of PPD among immigrants was similar to the local population. Poor social support, lesser duration of stay in Canada, poor physical health and mental well-being, living among immigrant communities, and financial constraints appear to have a more bearing on PPD than acculturation alone [48].

Migrant mothers with PPD often do not speak about their problems for fear of stigma. The feeling of fear, shame, and guilt that accompany PPD often leads to a position wherein the mother thinks that she should cope on her own. Further, some women may not be even aware of their depressed state being as a problem and could deny the existence of depression during postpartum period. They tend to "suffer in silence" for fear of being labelled, being prescribed medications, and being diagnosed with severe mental illness at a later point of time. Hence, perinatal depression remains an invisible illness. Disruption in rituals due to migration could be a source of stress due to perceived guilt of missing the rituals. Often, the distress associated with PPD is shaped by cultural context and beliefs—e.g., exposure to cold and water in a Canadian migrant women of Asian descent. Further, while depressed they are more likely to voice concern about settlement, social isolation, gainful employment, being lonely, and having no one around to help during the adverse times. Some women of Asian origin may also have to face the aspirations for a male baby from the families despite moving to a new culture where there is not much emphasis on gender of infant.

Migrant women from certain cultures may not have a cultural equivalent to describe their postpartum depressed state in a western healthcare setting and may attribute the distress to practical issues such as being busy with household responsibilities with no time to rest. Depressive symptoms are also attributed to economic factors—as poor income—and social factors such as family problems.

The barriers to healthcare access among migrants with PPD include the fear of stigma and alienation on being diagnosed with a clinical condition from the healthcare system in the new country [49]. The barriers to access of care include lack of therapists who are tuned to cultural nuances, perception that one may not get access to healthcare system, transportation, care of the child, unemployment and language incompatibility. Migrant women may downplay their emotional problems because

of the likelihood being prescribed pills on disclosing emotional distress to a health-care provider and may prefer counselling and non-pharmacological measure.

18.6 Cultural Formulation in Perinatal Psychiatry

Popular methods for forming a cultural formulation include the Explanatory Model Interview Catalogue (EMIC) for cultural epidemiological studies, the Short Explanatory Model Interview (SEMI), and the Cultural Formulation Interview (CFI) of the American Psychiatric Association (APA). The CFI-APA involves interviewing patient and reliable informants in order to understand the cultural aspects of the individual's problem [50]. The salient points of the CFI are mentioned in Table 18.2.

CFI may be helpful in evaluating perinatal women who are from a different cultural background. In some cultures, the presence of relatives during an interview with a woman could interfere with the responses [51]. Hence, it would be worthwhile to interview caregivers and the woman separately.

Formulating a cultural formulation in perinatal mental health may involve asking open-ended questions during the beginning of a clinical interview which include the following:

- What brings you here?
- How would you explain your problem?

Table 18.2 A perinatal mental health cultural formulation interview

Definition of the problem – Explore the woman's view of the problems with a focus on the perinatal context, and her current social situation
Perception of cause, context, and supports – Focus on the woman's ideas and of those in her family about the possible causes of her problems – Explore regarding her support systems and ongoing stressors, if any – Assess the woman's background and cultural identity that could be either ameliorating or worsening the problems; explore for the role of discrimination due to migration, race/ethnicity, or gender; conflicts in the family arising out of migration, and any feelings of isolation
Help-seeking – Gather information on how the woman and her family have handled the problem so far – Explore the sources of help sought by the individual for resolution of the problems including traditional healers – Explore the usefulness of the sources if help in reducing the problem – Examine the barriers that prevented an individual to seek help and care from a mental health facility
Present help-seeking – Ask the current needs and expectations regarding the help; help from the social network – Examine if the individual has concerns about clinician-patient relationship due to differences in ethnicity, language, or cultural differences and any ideas about she can resolve them

- How would you describe your problem to family/friends?
- Among the described problems, which one bothers you most?
- What is your understanding about how your current problem is related to your pregnancy or the postpartum period?

Later, the interview could be more explorative by asking the below questions:

- What do you think are the causes of your problems? Specific questions about the meaning of motherhood in that culture and rituals that are known to be protective and practices that are known to be harmful can be explored.
- According to your family/friends, what are the possible causes of your problem? Explore factors such as diet, black magic, postpartum rituals, not resting, and cold food.
- Could you tell me about the factors that worsen/make better the problems you are going through?
- What have you done from your end to overcome these problems?
- Could you tell me the details of help sought by you for your problems? Specifically, it may be important to ask about the use of alternative and complementary methods. Most women prefer not to use modern medicine (pharmacological) during pregnancy or postpartum thinking that it might cause harm to the fetus or infant. Use of other methods of healing needs to be explored.
- To examine for barriers of care questions—such as "Has anything prevented you from accessing help to overcome the problems?"—may be useful.
- Questions for their expectations from care and satisfaction in relation to their explanatory models need to be explored with questions such as "What kind of care did you expect?" and "What types of care are likely to be most useful?".
- Has anyone else known to you suggested other types of care?
- Explore the role of the infant: How do you feel about the infant? Are there expectations from the family about your infant that you would like to talk about? Are their concerns about an evil eye on the infant, the infant bringing you good or bad luck, rituals, and traditions related to the infant?
- About breastfeeding: What are the attitudes to whether you can or cannot feed your infant because of the problems you are facing?

A well-conducted interview with the woman and her caregivers will help in developing a cultural formulation that can be extremely beneficial in management, and facilitate better communication between the treatment team and the woman.

18.7 Cultural Competence in Perinatal Mental Health Services

Enhancement of cultural competence among healthcare providers when working with mothers with mental health problems is very important especially if the health provider and the woman come from different cultures. One must remember that

many times these differences may be evident even within the same culture because of religious differences or urban-rural and educational variations.

A culturally sensitive training program for perinatal healthcare providers should consider the needs and viewpoints of local population as well as that of healthcare providers. The framework for a training program should include consideration for therapist gender preferences of mothers with illness, local language compatibility and availability of interpreters, understanding of metaphorical expressions, as well as a curiosity to understand the illness from the mother's cultural viewpoint.

Psychosocial interventions also need to be tailored to the cultural characteristics of the target group [52]. Bernal and Sáez-Santiago [53] provide a framework for culturally sensitive psychosocial interventions—language adaptations of the interventions should include local expressions or idioms of distress instead of technical terminology. Further, a provider who could share experiences and also is aware of local culture would be of most help in delivery of interventions. Incorporation of local stories, characters similar to patient's psychosocial environment, and the use of metaphors and symbols help to understand and quantify distress of patients. Addressing the local customs prevalent in the community is likely to improve the acceptability of the psychosocial interventions [54].

18.8 Conclusions

Culture is important in shaping how mental health problems are perceived, experienced, labelled, and handled. This is even more relevant for mental health problems in pregnancy and the postpartum where traditions, rituals, and practices are closely linked with both the physical and emotional health of the mother-fetus-infant dyad. A good understanding of a woman's cultural background, her beliefs, and how she experiences her mental health condition is an important aspect of providing care. While it may not be realistic for mental health professionals to be aware of all the possible cultural aspects, developing cultural competence will lead to pregnant and postpartum women feeling better understood at this vulnerable time of their lives.

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