Perinatal Experiences in a Foreign Land

PHOTO Mu Cang Chai, Vietnam - Hmong ethnic mother carrying her child. May 2017. QUANG PRAHA

PHOTO: IS EPROM

HEALTH

Giving birth in a foreign country can be fraught with difficulties and misunderstandings. Cross-cultural psychologist GABRIELA SALABERT writes about child-bearing practices across cultures.

The perinatal period – the time from pregnancy to the first year after the baby is born – is an exciting and happy time for most mothers, as well as a time of great emotional and physical changes. However, national and international research tells us about 15 percent of women will experience antenatal or postnatal depression or anxiety.

Women who have already suffered mental health problems fear a relapse during this time and the same happens to husbands. Refugees and migrant families are also more vulnerable to depression from past traumatic experiences, having suffered multiple losses, different forms of violence, social isolation and psychosocial presentations.

This means perinatal depression and anxiety tend to be prevalent among migrant and refugee women, who in some cases cannot identify depression, have little understanding of the health system and often do not receive the care they need.

At the same time resettlement in a new country and communication barriers also have a severe impact on the stress of the mother during pregnancy and after the birth, which make this population more vulnerable and at risk.

So it is crucial to increase awareness among these communities, and particularly among health workers, of maternal stress and its impact on the baby's brain development, different cross-cultural child-rearing practices and intergenerational trauma. Health providers need to look at these variables to improve strategies, overcome barriers and facilitate culturally and linguistically diverse communities' access to services and treatment.

The National Perinatal Depression Initiative (NPDI) has been developed to identify women at risk of perinatal mental health disorders. Also, the NSW SAFE START programs implemented within the Families NSW framework seeks to identify and support women and families with social and emotional issues during pregnancy and following birth.

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SAFE START is an interagency of primary health workers covering midwives, early childhood nurses, drug and alcohol services, NSW Transcultural Mental Health, Aboriginal health, Family and Community Services, Karitane, and so on. It runs this program in public hospitals and offers appropriate care and support. It has been designed for antenatal prevention, risk management and proper follow-ups of cases after birth. Fathers and families are also referred to these agencies for them to gain an understanding about the relationship between mental health and the parenting role.

One of the ways NSW SAFE START achieves this is through the provision of comprehensive psychosocial assessments (including screening for domestic violence, substance abuse problems, anxiety and depression). Psychosocial assessments include the Multilingual Edinburgh Antenatal Depression Scale and are conducted at the first point of contact during pregnancy, before birth (36 weeks) and in the first 12 months after birth. Psychosocial difficulties and other mental health problems emerging during the critical perinatal and postnatal periods are screened by SAFE START for high-risk pregnancies.

In the case of refugee women, multiple bereavement before and during the refugee journey, rape, sexual assault and family violence resulting in pregnancies and miscarriages, impact not only on women's mental health but also in the consequent attachment to their babies.

There is lack of knowledge among professionals in the reproductive health care system about trauma in relation to birthing experiences. Experiences of torture and rape can create difficulties with the birth experience, which as a painful, life-threatening situation may trigger traumatic memories, worsening preexisting mental health conditions and interfering with mothers bonding with their babies. At the same time, feeling shame as a result of experiencing emotional and mental health problems is very prevalent in some communities and as a result "bad mothers" or mothers experiencing difficulties are at risk of stigma, social isolation and violence.

The most frequent perinatal clinical presentations include antenatal-postnatal depression, anxiety disorders, post-traumatic stress disorders (PTSD), puerperal psychosis, grief and loss/bereavement, and borderline personality disorders. Sometimes medications prescribed by doctors overseas are continued in Australia and women do not have information on the possible impacts of these drugs on their baby's development.

Previous history of trauma, post-traumatic stress disorders, obsessive compulsive disorders, panic disorders plus unresolved grief and loss from miscarriages and traumatic deaths of children tend to cause high levels of anxiety and, if unresolved, leads to the use of rituals and social isolation. These symptoms occur particularly at eight months of the pregnancy cycle, when symptoms tend to worsen due to the fears of childbirth and physical changes.

In clinical practice we see how violence affects women's reproductive health as some women are unable to access reasonable contraception, protect themselves against infections like HIV or sexually transmitted diseases and are unable to plan their pregnancies. They

PHOTO: Cambodian mother, Cambodia. AAP IMAGE / UIG / GODONG

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are also unable to feel safe from an assault during their pregnancy, or to access antenatal or postnatal care. Unfortunately, family violence on pregnant women seems to take place more frequently than other obstetric complications such as pre-eclampsia or gestational diabetes, which happen frequently as well.

Separation from family members who could provide emotional and practical support is another problem especially when women come from countries where the extended family plays an essential role in everyday life. Losing husbands, mothers and other relatives who offered support are common presentations. At the same time many women become depressed and anxious and fear for the safety of family members in countries of origin, particularly in cases where their husbands and older children find themselves in warzones at risk of being killed.

Cultural contexts and perinatal culture

There is a need to review contrasting beliefs, values and birthing practices among different refugee communities (including female genital mutilation). Families have different cultural, spiritual and religious understandings of the birth process, distress and illness.

According to psychologists G. Stern and L. Kruckman, there is cross-cultural evidence that birth is almost universally treated as a traumatic event. According to them, birth and the immediate postpartum period are times when both mother and infant are vulnerable. Societies have beliefs and practices in place to manage the physiological and social problems associated with birth that make sense in their own cultural context.

Access to perinatal formal education and exposure to perinatal information does help refugee families to adjust to the new environment, system and health culture in a new country. The migration process also affects cultural birthing customs and causes gaps in women's knowledge that is normally passed across generations in the family. The health system in Australia often challenges different birthing norms.

For instance, in most countries of Asia, including China and India, it is believed that women are predisposed to attacks from the wind or cold. After giving birth they have rituals that involve diet restrictions, plus minimal physical activity such as confinement (putting mothers at risk of thrombosis),

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and they need daily assistance from their mother and other female relatives who pass on knowledge about child-rearing and offer practical support.

In particular, the Cambodian culture believes postpartum women are in fragile health, that they get cold after giving birth and are at risk of developing "Tos" – a similar but more physical and benign form of postpartum depression. Rituals such as roasting, steaming and fire-warming rocks are practised to avoid long-term complications.

Somali women are usually young mothers, who have numerous children who are considered gifts from Allah (God). Female circumcision is a common practice. This means they have to have more caesarean births in Australia and have a high incidence of perinatal loss; however, it is accepted because of their religion.

Cultures also differ in terms of the emotional expressiveness at the time of birth. It is expected that in some cultures women should not be loud at the time of birth, while in others women usually cry and scream as the birth approaches. In many cultures the placenta may be disposed of by burying it under the floor of the room where the birth occurred, or in the courtyard of the house. The placenta is buried to keep an enemy or evil spirit from seizing it and influencing the well-being and longevity of the child.

Hospitals should offer the placenta to a postpartum woman for the symbolic effect of safety. For instance, in some cases offering hot water and soup after birth, instead of cold water with ice and sandwiches, could be a more culturally appropriate practice for hospitals, it will not involve an extra cost and families will be more at ease.

In terms of parenting, health providers should realise that in migrant and refugee communities the male-female roles are defined differently than in Western countries and the meaning/value of medical treatment and the level of acculturation to Australia can be different as well.

In terms of birth practices and parenting, first- and second-generation refugee families are divided by conflicting loyalties between their own family belief systems, practices and traditions and those policies and practices embraced by NSW health services. Cultural norms usually come from successful survival experiences and expectations of adult behaviours valued by a particular society.

Women who successfully gave birth and raised children in their own countries are often told by health services and postnatal groups that the type of birth and parenting practices they are familiar with are actually unsafe and they need to change them in order to fit into the mandatory requirements of mainstream health services in Australia. This causes a withdrawal from health services and from participating and socialising in important parenting programs.

Cultural differences mean that people have fundamentally different constructs of the self and of others, which impacts on family dynamics. There is a lot to say about socio-cultural ideologies in families. The individualistic, nuclear family approach of Australian health care interventions is often rejected by people from other cultures because in collectivistic societies, the self is defined relative to others via a sense of belonging, dependency, empathy, and reciprocity. Personal space, time for oneself and privacy are

PHOTO: Mother and child, Bangladesh.
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considered by many mothers as secondary or even foreign to them, because their role and identity is defined through relationships and interdependence.

Asian, African, Latin American, African and Mediterranean countries value interdependence, group achievement, sharing and collaboration with the family group. Feeding practises, sleeping arrangements, acceptance of family roles are also influenced by their collectivist ideology.

According to African mothers who carry their babies on their back (like many other mothers of the world), the mother is the expert on the baby's needs: "Read your baby, not the books" is the common saying. Research also supports the fact that the emotional learning and mother-child bonding goes beyond verbal stimulation. Children need touch and attention, not just a verbal response.

For example, the practise of putting babies in separate beds or bedrooms and not responding to their cries causes horror among most of the cultures of the world. However, the latest research in the US in the field of anxiety demonstrates that these practices teach helplessness to newborns, impacting on their brains and nervous system development, and may lead to a greater incidence of post-traumatic stress and panic disorders among adults.

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Some strategies for intervention

Perinatal mental health needs to consider the mental health needs of both parents. The social isolation of the family, the different presentation of emotional distress as somatic symptoms, the cultural and spiritual belief systems and a reluctance to share personal information with unknown clinicians are some of the issues health professionals may encounter.

Linking families to cross-cultural services and to clinicians is essential to re-establish trust and improve access to health services. The early intervention of families at risk in the perinatal period is very important. All migrant and refugee women should attend a hospital for the birth of their babies. Family needs and risks can be identified and organised through appropriate interventions before mothers are discharged into the community.

Working with care providers who are not mental health specialists can also expand the scope of these interventions, addressing service barriers and advocating on behalf of family needs in the broader system, as well as appropriate postnatal and parenting programs, which could be run by migrant resource centres.

Screening tools include the Edinburg Scale for Antenatal/Postnatal Depression (EDS), validated and translated in many languages and clinical interviews, as well as health professionals being familiarised with specific SAFE START referrals and the protocols and assessment forms designed to screen the emotional and psychosocial needs of mothers and families. All public hospitals have SAFE START meetings where high-risk pregnancy, psychosocial and mental health presentation are reviewed.

Other recommended strategies for health professionals to work effectively with mothers and families during the perinatal period include being familiar with different cultural values and historical experiences, and examining health professionals' own cultural beliefs and values to avoid imposing ethno-centric values and unnecessary interventions, instead respecting cultural preferences. Clinicians should assess the history of trauma across generations, take into account family and network concerns and follow a strengths-based perspective.

Parents need a better partnership with their child's paediatrician. Women's beliefs about sleep practices should be explored to avoid alienation or judgment for not following Australian professional guidelines. ℞