Treatment in Psychiatry begins with a hypothetical case illustrating a problem in current clinical practice. The authors review current data on prevalence, diagnosis, pathophysiology, and treatment. The article concludes with the authors' treatment recommendations for cases like the one presented.

Cross-Cultural Evaluation of Maternal Competence in a Culturally Diverse Society

Mary V. Seeman, M.D.

"Ms. A" is a 27-year-old recent immigrant from China who was hospitalized twice in her early twenties because of psychotic symptoms. She was treated and maintained on antipsychotic medication at low dosages. Ms. A subsequently had a short-lived relationship with a man who disappeared from her life when he learned that she was pregnant. She decided to carry the pregnancy to term and to keep the child, not an easy decision because she had virtually no family support and few friends. However, she was intelligent and resourceful, lived in a relatively comfortable apartment in Toronto, and was able to support herself and her child on a disability pension. She had a good relationship with her psychiatrist and her social worker. Ms. A's mother and several siblings lived in the same city, but Ms. A did not perceive them as supportive.

Ms. A received good prenatal care and was familiar with the hospital at which her delivery was to take place. However, she went into labor during the 2003 epidemic of severe acute respiratory syndrome (SARS) in Toronto, and her hospital was closed to new admissions. Instead she was redirected to an unfamiliar setting for labor and delivery, which very likely increased her already considerable anxiety. Because of the epidemic, health care providers at the time of Ms. A's admission were required to wear protective attire—masks, gloves, and gowns—which may also have increased her sense of unfamiliarity and fear.

Ms. A's delivery went smoothly and resulted in the birth of a healthy baby girl. The nursing staff soon remarked, however, that Ms. A did not react to the birth in the way they expected. She was essentially mute and appeared unduly suspicious. The nursing staff also observed that Ms. A was taking prescribed antipsychotic medication. They called Ms. A's psychiatrist, who spoke to the patient on the phone (no visits were permitted because of SARS; health professionals were not permitted to visit hospitals other than their own). Over the telephone, the psychiatrist congratulated Ms. A on the birth of her daughter and asked whether she had decided on a name yet. This was met with silence at first and then with the question, "Why are you asking me all these questions? Everybody is asking me questions. What do you mean by this?" The response and the tone of voice concerned the psychiatrist sufficiently that she agreed with the hospital staff that the Children's Aid Society (CAS) should be called to assess parenting capacity. An attempt was also made to contact relatives, and a voicemail message was left for a sibling asking the family to contact the hospital. A CAS worker came to the hospital and tried to talk to Ms. A, but was met with silence and with what was reported as strange behavior—covering the face, turning the head, closing the eyes. That, along with the history of psychotic disorder, was enough for CAS to place the baby in foster care, precipitating a serious depression in the mother.

Many women with schizophrenia lose custody of their children at birth (1), and approximately one-half of women with schizophrenia are not the primary caregivers of their children (2). This is partly because of cognitive inabilities, poverty, isolation, and lack of family support but also because child and adult mental health services are not well coordinated and child care workers often erroneously assume that a woman with schizophrenia cannot be an adequate parent (3–5). The problem is aggravated when mothers and caregivers come from different cul-

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tures, misunderstand each other, and hold different opinions about what constitutes adequate parenting (6–8)—and all the more so when caregivers are under stress, as in the public health crisis created by the SARS epidemic, as described in the vignette.

In retrospect, Ms. A's baby should not have been removed from her care and placed in foster care. When the baby was finally returned to her, Ms. A proved to be an attentive and competent mother. What had seemed like delusional behavior, once understood, was best explained by traditional Chinese beliefs about the postpartum period and not by psychotic thinking (9).

Cultural Context

In Chinese tradition, the name of the baby is never told to strangers. Before a newborn's name can be chosen, the larger family is needed because a name is thought to exert magical power on the child's destiny. Naming a child is based on five principles: 1) the name must have a favorable meaning; 2) it must sound pleasant when spoken; 3) it must be harmonious with regard to yin and yang; 4) it must possess one of the five elements of metal, water, earth, fire or wood; and 5) the total number of strokes used in writing out the name must be favorable (each character of the name is written with a certain number of brush strokes, corresponding to one of the five elements; for instance, a two-stroke character is associated with wood; a total of 81 strokes, for example, confers prosperity) (10).

"Exposure of a child to postpartum depression should be considered an exposure in the same way that taking an antidepressant while breastfeeding is an exposure."

There is a general injunction against interacting with non-family members after childbirth (11). Postpartum Chinese mothers expect to be kept warm, to be given warm drinks, and to be protected from infection, which means staying away from strangers (12, 13). At the same time, Asian cultures teach respect for authority, so Ms. A would not have been able to express her discomfort in a clear-cut way. In addition to the stress of meeting strangers, she would not have understood the idea of "rooming in" with the baby since, in her culture, the new mother must rest and sleep as much as possible. Given Ms. A's tendency to be somewhat suspicious of others' intent, she would have interpreted the seeming lack of staff interest in her welfare (compared with their attention to the baby), the lack of family visitors (they were forbidden to visit because of SARS), the (to her) unusual interest in the baby's name, the improper (in her view) food she was served, and the relatively cold room temperature as indicating an intention to do her harm.

The CAS worker who came to see Ms. A in hospital, being unfamiliar with Chinese customs and beliefs, understandably but mistakenly attributed Ms. A's behavior to psychosis (14). In fact, the Chinese tradition of *zuo yuezi* (*cho yuet* in Cantonese)—"doing the month"—dictates that for 40 days after giving birth, mothers must stay inside and avoid bathing, washing their hair, or brushing their teeth. Since not bathing at all could increase the risk of infection, grandmothers or other caregivers bathe the mother using boiled water, sometimes mixed with wine or motherwort herb to prevent the absorption of too much "wind" through the skin. After childbirth, the mother's skin is thought to be loose, with large pores through which wind can enter and cause illness (15). Wine and motherwort are also endowed with disinfecting properties. Brushing the teeth is discouraged because it can make gums bleed and loosen the teeth. Cotton is used to clean the teeth, and use of boiled water makes brushing safer. Puerperal women must cover their heads to prevent chills, keep the windows sealed to avoid wind, and remain in bed for as long as possible. In the *zuo yuezi* tradition, mothers should avoid all forms of stress, including talking, for an entire cycle of the moon. They must not eat cold foods, such as cool drinks, ice cream, fruits, or vegetables, but must be given hot foods, like boiled eggs, chicken, and fish soup, considered to aid in milk production. A well-known Chinese herbal drink called *shenghua tang* is recommended to slow vaginal bleeding.

The injunction against leaving home during the first month after birth has to do with evil spirits. This also explains the avoidance of strangers and the hesitancy about revealing the child's name. Keeping the baby's name secret deceives the evil spirits (16).

In Chinese traditional medicine, puerperal women are in a weak state because of "Qi" deficiency and blood loss. Their body can thus be easily attacked by cold, which may later cause health problems such as dizziness, headache, backache, and arthralgia. Wine, ginger, or dates are often added to the diet to make food hotter, but in moderation, for if the foot is too hot, it can make the baby restless and cause nosebleeds in the mother (17, 18).

The traditional belief is that mothers should lie in bed for the whole month, avoid social activity, and limit visitors, who may bring infection, negatively affect milk production, and prevent the mother from resting. Housework is avoided lest it tire the weak mother and expose her to wind or water. Traditionally, the grandmother looks after the mother and baby (19). In Ms. A's case, this did not happen, partly because the mother-daughter relationship was strained and partly because of the SARS epidemic, which prevented her family members from visiting her in the hospital. Although family members seem to be natural supports for mothers with mental illness, their involvement at this critical time may, in fact, prove counterproductive (4).

Relative alienation from her family did not prevent Ms. A from fearing their censure. Fear of blame from family members and the wider community heavily influences

women's adoption of traditional practices, reflecting the importance, for most Chinese women, of conforming to societal values (20). Chinese women believe that if they fail to follow postpartum rituals, they will experience hormone problems, weak bones, arthritis, ovarian problems, and menopause problems when they are older. Indeed, Ms. A's depression after her baby was taken from her expressed itself in many somatic complaints that could be understood as her perception that her body had been weakened because she had not followed traditional postbirth customs. She complained of headache, backache, stomachache, and joint pains and showed a general lack of interest in interacting with people, even family. Her constant expressions of pain and her avoidance of people reinforced CAS's belief that she was not able to look after her daughter. When she did begin to communicate with CAS workers, Ms. A dwelt at length on her intuitive, extrasensory premonition that the baby's father would miraculously appear, show an interest in the baby, and turn into the ideal mate of her fantasy. This seeming irrationality only increased the general perception that she was delusional. And yet, in traditional societies, the period surrounding the birth of a child is imbued with special qualities, often involving an altered state of consciousness in the mother. Many believe that puerperal women possess supernatural powers not accessible at ordinary times (21).

Summary and Recommendations

How might our approach to intercultural interventions be improved to prevent situations such as Ms. A's, in which her baby was needlessly, if temporarily, taken from her?

1. To prevent traditional beliefs from being misconstrued, nurses and child protection staff need cultural competency training (22).

2. Consultation and advice seeking are always important when critical decisions are being made.

3. Slow, deliberate decision making is especially indicated during times of crisis, when staff are stressed and under time pressure (such as during the Toronto SARS epidemic).

4. Parenting capacity evaluations should be carried out over several sessions, and assessors need to use a variety of evaluation instruments. There are no universally accepted standards of parenting adequacy, and the various criteria and scales that are in current use may not be appropriate to specific families. No measure is culture neutral (23, 24), which is a problem given the global mobility of populations. Consider, for example, that the United States accepted approximately 1 million permanent residents from other countries in each of 2004, 2005, and 2006; for that 3-year period, about 632,000 were from Asian countries, nearly one-third of them (212,000) from the People's Republic of China (25).

5. Optimal parenting risk assessments for mentally ill mothers assess multiple domains, evaluating behavior, support, stress, and illness-related variables, such as symptom severity and treatment response, as well as attitudes about caregiving. Multiple sources of information are required (26, 27).

While children of psychiatric patients do have a higher risk of sudden infant death and mortality due to homicide than children in the general population, there is no evidence that parental schizophrenia is responsible. In fact, the relative risk for neonatal death is more strongly associated with maternal affective disorders than with schizophrenia (28, 29). It is most often the indirect rather than the direct effects of the mother's illness—poverty, poor nutrition, and social isolation—that affect children adversely. Whatever the culture, in the absence of neglect or abuse, children of mothers with mental illness are better served by home support and the development of social networks than by removal from the home (30–32).

Received Nov. 3, 2007; revision received Dec. 18, 2007; accepted Dec. 21, 2007 (doi: 10.1176/appi.ajp.2007.07111714). From the Centre for Addiction and Mental Health, Department of Psychiatry, University of Toronto. Address correspondence and reprint requests to Dr. Seeman, Department of Psychiatry, Centre for Addiction and Mental Health, University of Toronto, Toronto, ON, M5G 1R8, Canada; mary.seeman@utoronto.ca (e-mail).

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