Postnatal Depression Vs Suffering

An Anthropological Approach to South Asian Migrant Women's Postnatal Feelings

Manonita Ghosh

Master in Sociology 1991
University of Dhaka, Bangladesh

This thesis is presented for the degree of Master of Arts

The University of Western Australia
School of Social and Cultural Studies
Discipline of Anthropology and Sociology

2005

ABSTRACT

This thesis is an ethnography of the postnatal experiences of South Asian migrant women in Perth, Western Australia. I examine cultural differences relating to mothering and argue that the South Asian culture in which these migrant women were socialized can impact greatly on how they experience the feelings of what is called “postnatal depression” in the Western medical arena. I carried out ethnographic research among the members of the Bangladeshi and Indian communities in Perth. The main focus group of this study is first time mothers who gave birth in Australia, but I also worked with other women who had grown up children.

Due to migration the South Asian women and their families experienced social isolation, cultural differences, language difficulties, economic hardship and low job satisfaction. Moreover, when these women gave birth in Perth they were faced with a lack of physical and emotional support, and also distress at not being able to perform their traditional birth rituals. Their difficult situations led the women to cry, feel despondent, to suffer and to experience a sense of hopelessness. Their painful postnatal feelings can be defined as an illness – depression – by the Western medicine. However, I found these women did not perceive their negative postnatal feelings as an illness, but accepted them as a part of life.

I analysed these women’s postnatal psychological understandings about “postnatal depression” by examining the South Asian convention of female virtue which is practiced through restrictions on female behaviour. The migrant women in my study, having internalizing the South Asian cultural schema of womanhood, articulate their negative postnatal feelings as a prerequisite of motherhood.

In this thesis I argue that feelings are not the totality of experience, rather, experience is also formulated by the particular sociocultural perspective of the individual who is having the experience. The culture a person belongs to, defines how that person will experience his or her feelings. I also suggest that it is possible to modify dysphoric affect by altering the meaning of feelings.

ACKNOWLEDGEMENTS

I cannot express my gratitude enough to those women, who must remain anonymous, whose life stories inspired me to write this thesis. I am deeply grateful to my supervisor Associate Professor Victoria Burbank for her continuous and careful guidance and substantial contributions of time and support. I particularly appreciated her for supporting me both academically and emotionally through the completion of this thesis. I owe my special and heartfelt thanks to my co-supervisor Associate Professor Loretta Baldassar who gave me consistent encouragement and contributed a lot of constructive suggestions during my work on this thesis. I thank both my supervisors for encouraging me to work towards publishing two papers based on this research.

I am also indebted to Dr. Cheryl Lange for her encouragement, invaluable comments, and editing my thesis. Dr. Lange was always available for support and a friendly chat.

Heartfelt thanks to the coordinator of Ishar, Shobhana Chakrabarti for letting me do my participant observation there and to interview Ishar's psychologists, nurses and some mothers associated with the centre.

I gratefully acknowledge the financial support and facilities made available to me by the Discipline of Anthropology and Sociology, School of Social and Cultural Studies, The University of Western Australia, and the Office of Women's Policy for the Grace Vaughan Award. I particularly appreciated the School and University travel grants which enabled me to present a paper, "Social Capital and Postnatal Depression", at the 18th European Conference on Modern South Asian Studies in Sweden.

I would like to thank my husband Jahar Choudhury for his unwavering support and for doing the lion's share of childcare. For bearing with my absence from home, I am grateful to my lovely sons Omrik and Ovik who used to ask me, "why univicity everyday"? They will be relieved to know that from now on their mother will not be going to "univicity" everyday.

This thesis is dedicated to two women: one is my mother with whom I share the joys and pain of motherhood; the other is Lois Hall who gave me motherly love and support throughout my pregnancy and after birth.

TABLE OF CONTENTS

PROLOGUE

The Voice of a Migrant Woman

Hello! I am the Voice — a migrant woman. This is not my name, but it is enough for now. For I speak not only for myself, I speak also for other migrant women — women without voices, without faces, without names, without an identity to call their own. For I am she and she is I, and this is our story, this is my story.

I am a 24 year-old-mother with two children, aged three and one. I arrived in Western Australia three years ago while I was pregnant with my first child. In the beginning, I found it very hard to cope with my life in this new country and with an entirely new and different culture. Firstly, I did not have any relatives or friends, and although I was fortunate enough to meet people from my own ethnic community with whom I could talk in my own language, I was not able to communicate with the local people because I was not able to speak English well. Secondly, my husband, a geologist, was looking for a job desperately. Every time his application was refused he became frustrated and this affected our relationship. When he was unhappy, I too was unhappy. Thirdly, and most importantly, we were not prepared for the pregnancy. In fact, I did not even know I was expecting until we arrived here, and what a shock it was when we got the news that I was pregnant.

However, we accepted the pregnancy and everything went on as usual until my husband got a job when I was seven months pregnant. He had to leave me and go far away to the mining sites for days on end. Sometimes he would be gone for 20 days and could not contact me either by phone or by mail. Alone in the house I was frightened all the time, especially at night. I could not sleep. I used to have horrible nightmares. Often in my nightmares, I saw someone putting his fingers tightly on my throat, trying to kill me. I tried so hard to escape by calling out for my husband as loudly as I could, and fighting with the stranger with all my strength. But this was in my dreams. In reality, however, I could neither make a sound nor could I move. My nightmares were so frequent that I actually stopped sleeping at night. I was even afraid of crying, in case someone knew that I was in the house

and came to kill me. My fear became so bad that I ended up staying with a friend whenever my husband was out of town.

After my baby was born, the nightmares left but yet, I could not sleep. This time it was my baby who kept me awake all night long, screaming. In the day the baby slept but I was too tired to get some sleep myself. I felt so miserable and hopeless — all I wanted was to die. I cannot even remember very well now how I actually managed — then I became pregnant again. After I gave birth to my second child, I was really too tired to take care of myself. I always felt that my house was very messy and so I would put all my energy into keeping it nice and clean. I would spend two hours with each child for every meal. I cannot stand to have my friends see my messy house or my unhealthy children. Yet I don't seem to have the time to take care of myself.

I am careful, however, to present myself as best as I can in our community gatherings or at social events. Every woman in the community dresses her best, so why shouldn't I? However, I know I do not look good any more. My hair has been falling out since my first baby was born and I cannot manage to style my hair these days. I have been losing weight. I cannot stand up for more than 30 minutes as my knees start to ache. I do not feel as happy as I used to. I feel bad and humiliated as I think that my husband does not want to understand me. I cry very often. I used to take some courses and wanted to do some further study before I got pregnant, but my husband wanted a second child.

I cook, I clean, I do all the house work, and take care of my children, yet my husband thinks I could do more, like learning to drive so that I could do our weekly shopping on my own. One day when my husband found out that I had been talking to a child health nurse about my feelings he warned me against telling her such things, as "they will make trouble for us". Sometimes I just want to run away.

Above I have described Mina's experience which is representative of the array of difficulties many South Asian women face as new migrant mothers. My South Asian

informants were almost invariably afflicted with postnatal vulnerability. During the prenatal and postnatal period the mothers experienced enormous stress, anxiety, abandonment, guilt, loneliness, crying all the time and fear. This period of despair has a phenomenological resemblance to the “symptoms” associated with what is called postnatal depression — tearfulness, despondency, fatigue, feeling guilt, anxiousness and sleep disturbance. My contention is that the constellation of feelings which are defined in Western societies as symptoms of an illness — depression — are interpreted differently within a South Asian cultural system where the same set of feelings is understood as a accepted part of life. I argue, using the work of Gananath Obeyesekere (1985, 1990) and William Reddy (1997, 2001) that feelings are not the totality of experience, rather, experience is also formulated by the particular sociocultural perspective of the individual who is having the experience. Human feeling is a combination of the two forces: physiobiology and culture. The culture people belong to defines how that they will experience their feelings. Culture allows people to connect their feelings to a pre-given cultural symbolic system which allows them to bring some order to, and control over, their psychic conflicts.

In Mina’s case, she proves to herself and others in her community that she is both a good mother and a perfect woman by having healthy children and by keeping the house tidy and being well dressed all the time. In doing so, Mina is able to transform her painful postnatal experiences into a culturally acceptable way of expressing, controlling and coping with her pain.

1 POSTNATAL DEPRESSION AND THE TRANSLATION OF EMOTION

My thesis is an ethnography of the postnatal experiences of South Asian migrant women in Perth, Western Australia. In using the term South-Asia throughout my thesis, I refer to women from Bangladesh and India, and acknowledge that it includes differences of location, nationality, religious interpretation, language, class and ethnic identity. I compare the South Asian migrant women's experience of the constellation of feelings defined as postnatal depression by Western medicine. I conceptualise this comparison within broader understandings of South Asian cultural perspectives and Western perspectives. By Western I mean the primarily Anglo-Saxon traditions that characterise Australian society and in which Western medical models are favoured. I also use the term Western to refer to medical practitioners who are trained in Western medicine. My conceptual approach draws upon Gananath Obeyesekere's (1985, 1990) discussion of the "work of culture" and William Reddy's (1997, 2001) idea about "emotives". Both Gananath Obeyesekere and William Reddy have very similar approaches to the experience of specific emotions. According to Obeyesekere, the work of culture "is the process whereby painful motives and affects such as those occurring in depression are transformed into publicly accepted sets of meanings and symbols" (1985:147). Obeyesekere suggests that when people have psychic conflict, it motivates them to look into their cultural environment for a way of both expressing and resolving the pain. At the same time, the culture provides symbols that individuals can attach their pain to. Then people transform the symptom into a symbolic, and hence meaningful act (Obeyesekere 1990:xix).

Obeyesekere criticizes Western medical psychologists who claim depression as a universal illness. He argues that depression as it is understood in Western medicine is not anchored to ideology, and therefore is identifiable and amenable to labelling. Drawing on examples from Sri Lanka, Obeyesekere says that painful affects are not free floating, "but instead are intrinsically locked into larger cultural and philosophical issues of existence" (1985:126). For example, Obeyesekere points out that, from the perspective of the Buddhist Singhalas in Sri Lanka, the phenomenological world is considered to consist of cycles of suffering, hopelessness and sorrow, which are understood to be a rational response to life as it is experienced. He says that when

Singhala people talk about sorrow they connect it to Buddhist ideology and they cannot separate suffering or sorrow from their life, just as people cannot avoid old age, loss and death. In contrast, in a Western perspective, feelings such as suffering, hopelessness and sorrow are often thought of as “abnormal”, that is, not a normal part of life and are thus labelled as symptoms of the illness — depression.

Obeyesekere also argues that the socio-cultural-psychological conditions which produce this perspective on life and suffering among the Singhalas are anchored to ideology in Buddhist Sri Lanka. In this thesis, I argue that this perspective may be part of a more widespread worldview that is not limited to Buddhism, but is also shared by adherents of Hinduism, Christianity and Islam in the region of South Asia. Obeyesekere forces us to consider why a symbolic system of painful emotion “works” for some and not for others, and why certain symbolic transformations may “work” for a given individual. By “work” he means that people experiencing conflict and other negative affect may appropriate cultural symbols to understand, communicate about and ultimately transform these feelings. Obeyesekere goes further suggesting that the concept of “work” implies the possibility of failure as well as success. It may be the case that the painful emotions must be related to the context of the individual’s life experience in manipulating cultural meanings (Hollan 1994:83).

In this study, I am concerned with South Asian migrant women’s cultural conceptions of postnatal negative feelings and how these women experience what Westerners might call postnatal depression but which may in fact be interpreted by them as a somewhat different experience. I look at how South Asian migrant mothers, even those with “psychotic symptoms of postnatal depression”, experience feelings that Westerns might call depressive, and at the same time how these mothers learn to function more of less effectively in the society. I argue that emotional experiences like “post natal depression” are a product of physiobiology and culture. My work suggests that the culture in which women were socialised can impact greatly on how women experience the feelings of what is called depression in the West.

Despite focusing on cultural issues throughout his argument, in his conclusion Obeyesekere admits that there must be some biological factors which are responsible for the existence of a core of depression and that these biological factors may be universal. He says “ . . . any such identifiable operational core of the “disease” must be

biogenetic — either as an antecedent cause of the affects or as a consequence or both. The identification of such factors may have universal cross-cultural validity . . .” (1985:149-150). In this case it is possible that “sorrowful affects may not be capable of transformation into public meanings under certain circumstances” (1985:148).

It is my hypothesis that the biogenetic factors at the core of depression are clearly explained by the notion of ‘emotive’ (Reddy 1997, 2001), which incorporates physio-biological and cultural approaches of emotions. For Reddy,

> Emotives are translations into words about, into “descriptions” of, the ongoing translation tasks that currently occupies attention as well as of the other such tasks that remain in the queue, overflowing its current capacities. Emotives are influenced directly by, and alter, what they “refer” to. Thus, emotives are similar to performatives . . . in that emotives do things to the world. Emotives are themselves instruments for directly changing, building, hiding, intensifying emotions, instruments that may be more or less successful (2001:105).

Reddy distinguishes between emotions and emotives. He says emotions are “goal-relevant activations of thought material that exceed the translating capacity of attention with a short time horizon” (2001:128), whereas emotives are,

> a type of speech act different from both performative and constative utterances, which both describes (like constative utterances) and changes (like performatives) the world, because emotional expression has an exploratory and a self-altering effect on the activated thought material of emotion (2001:128).

Thus no one can fully know the content of an emotion, because emotions are always changeable and in the process of formation. This process of formation of emotion is what Reddy calls translation. Reddy suggests that it is though this translation, though it is normally a largely unconscious process, that we can consciously explore and alter our feelings. In this process we can consciously and purposefully elevate some feelings over others (Burbank 2004:6).

According to Reddy, as feelings flow from one part of the nervous system to the other, they get translated and during translation some feelings are missed out. Reddy says that feelings are always near the surface and ready to burst into language, what he calls "chronic activation" (2001:89) in attention mode. Feeling is chronically activated but not yet in attention because feelings run through complex "many to many mappings" (2001:89). These feelings or thoughts are all competing for attention and all want to be recognised. However " . . . both full and activated thoughts can be in a state of "chronic" activation that makes them highly likely to leap forward into ongoing translation tasks" (2001:89).

Thus translation appears to be the act of evaluating the competing feelings at the surface and making a decision about which thoughts are appropriate. Hence Reddy suggests that "translation tasks are always incomplete" (2001:95) because not all feelings, felt underneath, are expressed in the end.

> An emotion is a range of loosely connected thought material, formulated in varying codes, that has goal-relevant valence and intensity, that may constitute a "schema" . . . ; this range of thoughts tends to be activated together . . . but, when activated, exceeds attention's capacity to translate it into action or into talk in a short time horizon. Its loose and often variegated character is a reflection of the complexity of translation tasks (2001:94).

Here culture comes into the picture to direct the person how to feel, what to feel and what emotions mean. Arguing that emotion is culturally constructed rather than biological and universal, psychological anthropologist Catherine Lutz (1985) defines emotion as rational, learned, voluntary, controlled and cultural. Lutz says:

> The concept of emotion is . . . placed in a mediating position between events or relationships and individuals; culturally constructed and recognized emotions define events or relationships for people and they define people's roles and behaviour within them. Whether that meaning is constructed as primarily moral or psychobiological (or both), social or individual (or both), is culturally specific (1985:65-66).

Looking at emotions in relation to cultural knowledge systems Rosaldo (1984:140-141) considers:

> If culturally organized views of possibility and sense must figure centrally in the acquisition of sense of self — providing images in terms of which we unselfconsciously connect ideas and actions — then culture makes a difference that concerns not simply *what* we think but how we feel about and live our lives. Affects, then, are no less cultural and no more private than beliefs. They are instead, cognitions — or more aptly, perhaps, interpretations — always culturally informed, in which the actor finds that body, self, and identity are immediately involved.

Here emotional experiences themselves actually change and culture tells us what these changes signify. According to Reddy, mood associated thought or emotion has a better chance to be translated into language, emotive statement or action. Our culturally available emotion discourses enable some feelings and diminish others. Thus, when two people from two different cultures are in what an outsider might describe as the same circumstances, the situation would be perceived differently by those two people who would react to the situation on the basis of their prior concept associated with their action. Where those two people have been in their life, determines how they will translate their emotions and how they will act on the basis of that translation.

I wish to emphasise here Reddy's point that this external process has internal effects. "Insofar as an emotion claim is *self-exploratory*, its effects on the self may tend to confirm or disconfirm the claim; insofar as an emotion claim is *self-altering*, its effects on the self may intensify or attenuate the state claimed" (2001:103). A South Asian mother may feel something like sadness, but her understanding of sadness will influence how she actually feels even though she has feeling similar to a Western mother who is depressed. The cultural direction she receives may take her into a different experiential space.

Thus biogenetic factors such as feelings, which are responsible for the existence of the universal core of depression that Obeyesekere is concerned about, can, according to Reddy, be altered through emotives. A South Asian mother and a Western mother biologically have the same hormonal flows and hormonal changes, and may experience

much the same negative feelings following birth. Their negative feelings can be seen as postnatal depression from a Western medical point of view. However, I argue that the South Asian mother will translate these feelings by saying “this is life as it should be”.

1.1 Culture, Discourse and Postnatal Feelings

A South Asian mother’s interpretation of depression as “life as it should be” must be understood in light of her prior socialisation as a woman in South Asia. The power of socialisation can be understood through cognitive anthropologist Naomi Quinn’s (Strauss and Quinn 1997, Quinn 2005) idea of schema which explains how shared understandings are learned and organised in the mind. Obeyesekere’s ‘work of culture’, Reddy’s ‘emotive’ and Quinn’s ‘schema’ are all just different ways of understanding how and what comes to individuals from outside and becomes part of his or her life.

> People in a given group share, to greater or lesser extent, understandings of the world that have been learned and internalised in the course of their shared experience, and that individuals rely heavily on these shared understandings to comprehend and organize experience, including their own thoughts, feelings, motivations, and actions, and the actions of other people (Quinn 2005:3-4).

Schema works to produce our experiences and to produce what we say about our experiences, which is our way of communicating our experiences to other people. In other words schema generate narratives. Quinn (2005) suggests that schema can be discovered through discourse that is to say, narratives. Thus the work of culture and emotive are implicated in what people say.

I will follow Quinn’s idea about finding culture in discourse and her very fruitful example of using key concepts which she calls metaphors. I will use key concepts to get a better grasp of the meaning that concepts have for the women from South Asia. I agree with Quinn that speakers use key concepts to clarify points they try to get across to listeners. I have found some key concepts from my informants’ conversations for describing motherhood. I could do so “because selection of metaphors, reasoning and use of the [key concepts] are all in different ways governed by cultural schemas, [and] each provided an excellent window into the shared schema on which its usage was

predicated" (Quinn 2005:14). All my informants said that their vulnerability in the postnatal period was mainly because of having economic difficulties and no support from relatives. Some mentioned that medical staff had told them that their feelings were due to hormonal changes which occur during pregnancy and childbirth. However, at the same time, I found them incorporating all the key concepts with motherhood metaphorically. I have selected four key concepts: *sakti* (power), suffering, sacrifice, and *lajja* (shame/honour) that I believe arise from a shared schema or an emotive of motherhood. I will elaborate on these notions and practices through examining the institution of *purda* (veil) in chapter five before returning to a discussion of these key concepts in chapter six. *Purda* is like an umbrella institution, which, by producing the practices of female purity, pollution, *lajja* (shame/honour), *sakti* (power), suffering, and sacrifice, ensures female subordination. I believe that the four key concepts I analyse from the women's discourses derive from their shared enculturation.

1.2 Theorizing Depression and Postnatal Depression

Kleinman (1978) has attempted to conceptualise the distinction between 'disease' and 'illness':

> . . . disease in the Western medical paradigm is malfunctioning or maladaption of biologic and psychophysiologic processes in the individual; whereas illness represents personal, interpersonal, and cultural reactions to disease or discomfort. Illness is shaped by cultural factors governing perception, labelling, explanation, and valuation of the discomforting experience, processes embedded in a complex family, social, and cultural nexus. Because illness experience is an intimate part of social systems of meanings and rules for behaviour, it is strongly influenced by culture: it is . . . culturally constructed.

Kleinman and Good (1985:2) have defined "depression" in particular. They say:

> Depression is a transitory mood or emotion experienced at various times by all individuals. It is also a symptom associated with a variety of psychiatric disorders, from severe and debilitating diseases such as schizophrenia to milder anxiety disorders. It is also a commonly diagnosed mental illness".

Depression is thus referred to as mood, symptom and illness, and the relationship among these three concepts is what Kleinman and Good have found problematic. They identify "dysphoria" as sadness, hopelessness, unhappiness, lack of pleasure with social relationships, and acknowledge that dysphoria has different meanings and forms of expression in different cultures (1985:3). Identifying dysphoria and admitting cultural differences, they address the question of whether "depression" is an emotion or an illness. Jenkins, Kleinman and Good (1991:67) suggest that some forms of depression can be found in all populations although it is culturally constructed.

Like Reddy (1997&2001) and Obeyesekere (1985&1990), Jenkins et al. (1991) assume a kind of universal source of emotion. They consider some sense of psychic unity, but unlike Reddy and Obeyesekere, Jenkins et al. do not explain clearly what the universal source of emotion might be. On the other hand, Reddy and Obeyesekere suggest a universal human being and shared experiences. If Jenkins et al. say that "depression can be found everywhere but it is culturally constructed", then how can we say that 'it is all depression'? Reddy addressed the question by putting universal psychobiology and cultural approaches of emotions together and developing the idea of emotive which was discussed earlier.

Because Jenkins et al. believe that depression is experienced differently in different cultures:

> Observation of striking cultural and social class variations in symptoms is frequently used to support the view that culture affects the content but not the process or structure of psychopathology. We argue that culture is of profound importance to the experience of depression, the construction of meaning and social response to depressive illness within families and communities, the course and outcome of the disorder, and thus to the very constitution of depressive illness (1991:68).

Accordingly they suggest that depression should be identified by using ethnographic methods including observational analysis and interviewing people with shared cultural meaning and behaviour. They conclude that it would be possible to examine "the complexity of the social origins and consequences of depression" (Jenkins et al. 1991:91).

Following Jenkins et al.'s argument, Kumar (1994:261) compares postnatal negative feelings to a depression that women experience after childbirth, and thus he considers the postnatal negative feelings as an illness that can be found in every population. Kumar argues that the physiology of childbirth is universal but it is differently conceptualised, organised, structured and experienced. He says, "The physiology of human pregnancy and childbirth is the same in Bangor as it is in Bangkok, but the event is very differently conceptualised and structured and, hence, experienced by the mother and by her social group" (Kumar 1994:251).

Thus Kumar suspects that applying only mundane, routine diagnostic tests, will not lead to the detection of mental disorders in the postnatal period in some cultural and ethnic settings. Therefore, he looks for a standardized and systematic technique which could be used across cultures and would lead to better recognition, prevention and management of what he calls "postnatal depression". Through such research, he wishes to discover cross cultural similarities and universalities in psychiatric disorder. Such research attempts to demonstrate that postnatal negative feelings are like other mental disorders, occur in all societies and can be found if standardized diagnostic tests are applied; ". . . it is possible that careful questioning, as in a semi-structured interview, may detect psychological dysfunctioning in the puerperium in some cultural and ethnic settings in which it has been suggested that disorders such as postnatal depression, do not occur" (Kumar 1994:251).

1.3 The Phenomenon of Postnatal Depression

In the Western medical literature mental disorder following childbirth is generally recognized in three relatively distinct forms. The most severe and least common emotional disorder following childbirth is labelled postnatal psychosis or puerperal psychosis which is varyingly estimated at between 2 and 4 cases per 1000 births (Kumar 1994:253). This condition is usually found within three weeks of delivery with the symptoms of confusion, irritability, feelings of hopelessness and shame, sleep disorder, hyperactivity, hallucinations, and is considered life threatening (Ugarriza 1992:31). Postnatal psychosis is rare and is not the focus of the majority of studies concerning postnatal depression.

The mildest form of mental disorder, known as “baby blues” or “maternity blues” is observed with a high frequency, as high as 80% in puerperal women (Kumar 1994:252). It is generally accepted that this particular emotional response is due to the wide hormonal fluctuations following the delivery with the defined syndrome characterized by frequent and prolonged crying, mood changes, fatigue, anxiety and a sense of vulnerability which may continue for several weeks (Najman et al. 2000:20).

The intermediate form of postnatal depression is characterized by greater debilitation than the blues and is more common than postnatal psychosis. This form of postnatal depression is the core topic of my thesis. It reputedly affects between 10% and 20% of mothers shortly after delivery (Copper and Murray 1998:97). Postnatal depression is an ill-defined condition characterized variously by tearfulness, despondency, fatigue, irritability, poor memory, feeling guilt, anxiousness, social withdrawal, and sleep disturbance (Copper and Murray 1998:98). The duration of postnatal depression is considered to vary from six weeks postnatal to one year after the birth (Romito et al. 1999:1659). Some researchers found mothers to be more depressed during the six to nine months following birth than at three months (Seguin et al. 1999:161). Others could not identify any symptoms of depression during the first six month postnatal period. Rather they found an increasing level of depressive symptoms starting six months after delivery and lasting up to five years (Najman et al. 2000:25).

1.4 The Biomedical Perspective of Postnatal Depression

The nature and prevalence of postnatal depression remains a subject of debate in both the medical and anthropological arenas. Over the past several decades, investigators have hypothesized a wide variety of biological and sociocultural reasons for puerperal psychological dysfunction. However, neither biology nor psychosocial factors have provided an adequate explanation for the aetiology of postnatal depression.

It has been suggested that in a small subgroup of those experiencing postnatal depression there might be low prolactin and high progesterone levels (Abou-Saleh et al. 1998) or thyroid dysfunction (Hendrick et al. 1998), factors that are most frequently discussed as having the strongest associations with postnatal depression. Although these suggestions merit attention if substantiated, it has been argued that linking these hormones to the development of postnatal depression could be secondary to

immunological changes brought about by stress (Cooper and Murray 1998:1885). In many studies, a strictly hormonal aetiology for postnatal depression is untenable (Harris et al. 1994, O'Hara et al. 1991 Pedersen et al. 1993). Therefore it has been suggested that the psychosocial aspects are more likely determinants of postnatal depression than the important hormonal changes that occur after childbirth (Seguin et al. 1999:157).

I do not say that biological factors are absent in postnatal depression, but it is not a topic that I will pursue here. Instead, I take an integrative approach to the human experience of specific emotions and argue that the feeling of intense sadness that may be precipitated by biological factors as Obeyesekere thinks, is nevertheless considered by the South Asian migrant mother as a rational response to life as experienced.

1.5 Evolutionary Aspects of Depression and Postnatal Depression

Depression and postnatal depression are current subjects of debate among neo-Darwinian theorists who see depression as adaptive (McGuire and Troisi 1998, McGuire et al. 1997, Nesse 2000, 1998 and Watson and Andrews 2002). Both Obeyesekere and the evolutionary theorists are challenging the Western idea of depression as an illness. The evolutionary context of depression and postnatal depression is based on the Darwinian concept of "fitness". The main argument of the evolutionary approach to depression and postnatal depression is that specific kinds of situations with major adaptive challenges have recurred in the course of evolution and individuals have a genetic potential to adjust to these challenges, which has had a significant impact on fitness.

Evolutionary psychology provides a useful framework for analysing depression and postnatal depression. The core idea of the evolutionary perspective of emotion is that "certain specific kinds of situations with major adaptive challenges arose frequently in the course of evolution and individuals with a genetic tendency to cope" experienced increased reproductive success (Nesse 1998:398). For example, an organism whose genotype allowed for the development of feet had a greater chance of survival compared to an organism with no feet. Feet allow an organism to move around so it can go for food instead of waiting for food to come to it. An adaptation is only one interaction with an environment. In the kind of world we evolved in, feet are the adaptation to chase after food. "Certain situations seem to have recurred often enough in the course of

evolution, and have had enough impact on fitness, to shape special emotional states" (Nesse 1998:398).

Thus the evolutionary approach proposes that depression is an adaptation (Nesse 2000:15), and that humans have an evolved potential for depression which is a specific fitness enhancing attribute (McGuire et al. 1997:263). Evolutionary psychologists attempt to explain that traits for depression have undergone substantial evolution in responding to the human social environment and this adaptation serves a social problem-solving function (McGuire et al. 1997:263). They argue that genes for depression would not have evolved unless it granted net benefits (Nesse 2000:15). To explain possible functions of depression and to support his argument, Nesse quoted Hamburg (1974:240 cited in Nesse 2000:16) who says:

> [When] the subject estimates the probability of effective action is low . . . the depressive responses can be viewed as adaptive. . . . Feelings of sadness and discouragement may be a useful stimulus to consider ways of changing [the] situation. . . . Moreover, [the] state of sadness may elicit heightened interest and sympathetic consideration on the part of significant other people.

In an evolutionary approach, depression is a consequence of living in a stressful social environment, loss and/or failing to achieve an unobtainable social goal (McGuire et al. 1997:263). Social and emotional aspects are interrelated and form a dense network and disturbances in this network might contribute to depression (Rottenberg and Gottib 2004:64). Nesse (2000:16) says depression precipitates when an individual tacitly realises that he/she will not succeed to reach goals. Individuals get depressed when they do not perceive that their social situation is undesirable and difficult to change and depression very often resolves when the sufferer realizes that the social situation will never change, and thus gives up the pursuit of an unobtainable goals (Nesse 2000:16). Nesse argues that depression is actually shaped to help individuals cope with unpropitious situations. Thus depression is useful because it "disengages" individuals from unreachable goals in order to regulate their expenditures of energy and effort both in time and direction so as to get maximum benefit (Nesse 1998:405).

Depression as emotional pain is often seen to be analogous to physical pain. Physical pain draws attention to a problem in the social environment that is causing damage. Analogously, emotional pain is thought to draw attention to a problem in the environment (Thornhill and Thornhill 1989). Depression may be seen as a coping mechanism which serves strategic options and motivates people to get out of their social problems (Watson and Andrews 2002:3).

The predominant medical view of postnatal depression as it is for depression, is that it is an emotional disorder. Among evolutionary psychologists the condition of postnatal depression is seen to be "an adaptive aspect of maternal responsiveness that has evolved through natural selection in a context where some environmental factors can challenge the mother's capacity to provide continuing care for the infant" (Crouch 1998:170).

Crouch suggests that in many Anglo-Western settings where the mother-infant relationship is under challenge and the mother's mental health is under threat, her painful emotional state becomes dysfunctional and gets worse. Crouch argues that a mother's painful emotional state, which is diagnosed as postnatal depression, is not necessarily an abnormality. Rather it is an evolved defensive pattern of the mother-infant relationship that has become entrenched through the evolutionary process. When this process is disrupted in many contemporary societies, postnatal depression is seen as an adaptive response to the mother's inability to be continuously responsiveness to her infant (Crouch 1998:173). Hrdy (2000:172) found in her research on non-humans that there are female species who are defensive and aggressive in order to protect their infants from predators. Thus she considers that aggressive behaviour after giving birth is deeply rooted in the human mother and thus is to be expected. Hrdy goes on to say that modern Anglo-Western society teaches women to be cheerful and not to feel or behave in an antagonistic way. So when women express the "unexpressable", hostility might be recognized as "postnatal depression" (Hrdy 2000:172).

In summary it can be said that constant care taking and nourishment which represent the pattern of mother infant relations has become entrenched through the evolutionary process (Trevathan and McKenna 1994:90). When this process is disturbed and interrupted in contemporary Western society mothers get depressed and cry for help. Thus postnatal depression can be interpreted as a response to contemporary Western women's inability to nurture continuously. Postnatal depression becomes a strategy for

the new mother to defend herself and to recruit social support so that both mother and infant can survive. Postnatal depression has the potential to engage maximum support which may help restore effective maternal responsiveness. The discourse on postnatal depression is thus represented by evolutionary critics as positive and functional.

I do not pursue the evolutionary approach to depression in the core argument of my thesis, neither am I interested in arguments that postnatal depression is an evolved adapted mechanism. What I am interested in is that research from an evolutionary perspective suggests that women after birth are vulnerable to depression-like feelings. I use this idea to support my argument that South Asian women, like other women, have the potential to experience negative feelings after birth. However, the determination of this experience as an illness depends on specific cultural circumstances and constructions. These feelings are more functional in the South Asian setting, where the symptoms are recognized as a sensible reaction to life.

Postnatal depression may be a strategy to negotiate greater investment from the father or other kin, or to reduce the mother's load. However, looking back at Mina's story described in the Prologue, can we say that she was depressed and crying out for help? Although she was debilitated, she had control over her life and feelings. In that story we see that South Asian migrant women face lots of difficulties on coming to Australia. They deal with economic disadvantage, low job satisfaction, few relatives and friends, and little that is culturally familiar and relevant. In this situation, giving birth becomes a double burden for them. They need family support during labour, plenty of rest, healthy food, lots of help with household tasks and the babies, and enormous physical and emotional support, but they do not have it. They also feel anxiety about their financial situation, being home alone and not being able to speak English properly. Moreover, their expectations of getting traditional social recognition as a new mother are not fulfilled. This situation increases their vulnerability. A neo-Darwinian would expect these women to get 'depressed'. However, I argue that the South Asian culture in which these women were socialised impacts greatly on how they perceive the dysphoria which in the West is diagnosed as postnatal depression.

1.6 Thesis Outline

Each chapter in this thesis analyses a different aspect of the South Asian migrant mothers' understanding of their postnatal depression-like experiences. Chapter one has provided the theoretical background of my thesis which is based upon Obeyesekere's (1995, 1990) notion of "work of culture" and Reddy's (1997, 2001) discussion of emotives. The literature review in this chapter has looked at postnatal depression from a number of different perspectives such as biomedical and evolutionary approaches. Chapter two focuses on the methodology of this research. In this chapter, I mainly concentrate on my fieldwork experiences, and include a description of my shared communality with South Asian migrant women who have been through childbirth in Perth. I analyse their comments on their postnatal experiences particularly on the diagnostic methods which are used to detect postnatal depression.

In chapter three I consider the common difficulties that South Asian women faced after having a baby in Perth in order to see how they located themselves with regard to issues of economic insufficiency, having little or no support with house work, and their isolation from family. These common difficulties are considered by much of the medical and anthropological literature as predicators of postnatal depression. Chapter four presents four life stories, which are aimed at giving the reader a more complete picture of South Asian migrant women including their experiences of childbirth, their cultural traditions and beliefs. Each narrative tells the reader about the difficulties experienced by an individual woman. As well, it provides evidence of how culture itself has influenced the way the women deal with their difficulties. It is hoped that the narratives will help the reader better understand the postnatal feelings of the South Asian migrant women.

The sociocultural context for women in South Asia is thoroughly examined in chapter five. In this chapter I examine the institution of *purda* (veil) which ensures female subordination and produces notions and practices of female purity, pollution, *lajja* (shame/honour), *sakti* (power), and suffering. I explore how female subordination in these societies, which is achieved through these notions of female virtue and power, prepares women to endure hardships such as postnatal mental anguish. I argue that these ideas and practices of female virtue and power are internalised and thus help women mitigate what elsewhere might be described as postnatal depression.

Chapter six addresses the cultural discourse of the postnatal experience. In this chapter, I draw on four key concepts: *sakti* (power), suffering, sacrifice and *lajja* (shame/honour), which have been derived from South Asian migrant mothers' talk about their postnatal experiences and feelings. I analyse the way in which these key concepts provide a shared knowledge of motherhood for South Asian migrant women, and how their shared schema of motherhood is related to hardship and sacrifice. This chapter also re-examines and redefines postnatal depression-like experiences from a South Asian migrant mother's perspective. Filtered throughout the various chapters, this thesis is an exploration of how South Asian migrant mothers in Perth perceive their negative postnatal feelings, and how those feelings, developed in a South Asian cultural context, prepare the women to understand their negative experiences.

2 FIELDWORK AND IT'S CONTEXT

In this chapter I discuss my fieldwork experience and my research methodology. I explore the sociocultural factors of postnatal depression through an analysis of the in-depth interviews I conducted with fifteen South Asian migrant women in Perth. The South Asian woman in my thesis is a figure whose identity has developed and travelled through histories and geographies, and in this case through the mediated experiences of motherhood. The women I interviewed were born in and migrated from either Bangladesh or India. At the time of the interviews their age range was between 24 and 37 years, and most had graduated from a university in their home country. The education level of those women provided the opportunity to see how education may have impacted on their postnatal feelings. It is likely that women without formal education would not be aware of "postnatal depression". I assume that women with formal education would be affected by the Western notion of "postnatal depression" and thus be more prone to debilitation. However, while most informants were aware of postnatal depression, their comment suggest that they more often interpreted negative feeling in terms of South Asian notions of suffering and female power. The interviewees were from three different religious groups: Christian (5), Hindu (5) and Muslim (5). I found religious affiliation made little difference in this area of experience.

2.1 Understanding South Asian Experiences

Using a snowball technique I contacted many of my informants through the Bangladesh Australia Association of Western Australia (BAAWA). I migrated to Australia in late 1995 and soon after became a member as the spouse of my husband. My husband had migrated to Australia five years before we got married and had been an active member of the Association. Anyone, especially people from Bangladesh, can join the association for a small yearly fee. At the time I was doing my fieldwork, BAAWA was very small in size and everyone knew each other and met frequently. BAAWA was directed to promote educational, cultural and social activities within the community. This association celebrated festivals of religion, Bangladesh Independence Day, Bangla New Year, and raised funds for the association. BAAWA also organised a yearly picnic and sports. The main purpose of the association was to keep Bangladeshi people in Perth together and to keep them mindful of their connection to their culture. Members wanted to keep contact with their home country fellows and to celebrate their own culture together. One member of BAAWA told me "I do not feel about Anzac Day as much as I

feel about *Bijoy Dibos* (independence day of Bangladesh), therefore I want to celebrate it together with my people". They also take part in cultural practices with the purpose of passing this cultural knowledge on to the next generation. Let me quote a representative statement provided by a member, "We access our culture for our children so that they will know where they belong and what their own culture is". Most members of BAAWA have good relationships with people from the Indian community. They also foster inter community cooperative programs.

Through BAAWA members I was introduced to some women who agreed to let me interview them. At one social gathering I met a new mother with her six-month-old baby. During our conversation about her childbirth experiences I asked her how she was feeling emotionally. She said sadly "I think I've got what people here call postnatal depression". She then asked me "did you have postnatal depression Manonita?" She knew that I was raising my child without having any relatives around me. Thus began my interest in researching the emotional experiences of these new mothers from South Asian communities in Perth.

Getting women for an interview was not an easy task. Some women seemed offended, and some just refused to talk to me. Once one informant introduced me and told her friend about my research, and then asked her if she would mind giving me an interview. Her friend was very offended by the request and bitterly asked her "why me, do you think I am depressed"? I think perhaps the word 'depression' in my research title made some women a bit uncomfortable. It seemed there was a stigma attached to the word 'depression' for some women I wanted to interview.

<u>My connection with Ishar</u>

I recruited additional informants through a government health centre called 'Ishar Multicultural Centre for Women's Health' in Mirrabooka, Western Australia. Ishar was established in August 1992 to provide a gender specific and culturally appropriate and accessible health service to women from culturally and linguistically diverse backgrounds, women who might otherwise experience difficulty in getting acceptable health care. The core programs of this centre are: health education and health promotion programs, health information and referral programs, a clinical program, individual counselling services, and community therapeutic support programs (Annual report

2000:6). On occasion I have worked at Ishar in order to support my family financially and also with the intention of getting in touch with women from a range of different cultures. Through Ishar I had the opportunity to talk to many South Asian women some of whom agreed to be interviewed for my research.

2.2 The Interview

Like Quinn (2005), who aspired to collect natural discourse, I wanted my data to comprise women's ordinary talk about the emotions they experienced during their pregnancy, at childbirth and during the postnatal period. Thus, I wished to collect information such as when a woman shares her experiences in a gathering, with a friend in moments of confidence and with a therapist. I wanted the women to explain their emotions and experiences in an ordinary way, and I was afraid that an interview would be a strange experience to them and that they might not express their feelings in their usual way. I found that some women were not very relaxed during the interview and did not speak openly or at length about their experiences. At the beginning of the conversation a number of women asked me several times, "Is that what you want?" They seemed to feel much freer to talk to me about their experiences and revealed more about themselves when I did not appear as a researcher to them but as a friend.

I wanted ordinary talk, but like Quinn (2005:10), I found that it was not only impractical to collect but also sometimes unethical. It seemed extremely inefficient waiting for occasions on which people happened to talk about my research topic. Private occasions, on which women talk to their therapist, hardly seemed accessible to me. Once when I asked a woman if she would be interested in giving me an interview, she refused and said bitterly, "If I thought that you were trying to make me your subject for your project I would not talk to you any more". That woman had shared many intimate birth experiences with me. But it would be unethical to quote her without her permission even though every interviewee is anonymous. Despite the drawbacks, I finally decided on doing interviews. I was convinced by Quinn (2005:10) that interviews could come close enough to ordinary talk to provide a cultural understanding. I was also inspired by her innovative interviewing style. I think a narrative life story is always influenced by the cultural context, no matter where, when and how the life story is being told. Furthermore, I agree with Bruner (1984:7) who says:

> A life as lived is what actually happens. A life as experienced consists of images, feelings, sentiments, desires, thoughts, and meanings known to the person whose life it is. . . . A life as told, a life history, is a narrative, influenced by the cultural conventions of telling, by the audience, and by the social context.

I interviewed fifteen women, thirteen of whom had babies between one and seven months old, and eleven who were first time mothers. I did at least two interviews with each woman, and these were held at least six months apart. I also organised additional interviews with some of the women, as I wanted to get more information about some specific aspects. I interviewed each person more than once because I believe that people do not generally reveal their life stories all in one sitting and they always update and revise themselves (Lindo 1993:4). I left at least six months for my participants to revise their stories and reinterpret their experience. I came to understand that the interviews with the women about their postnatal experiences in a new society were a part of their whole life experience.

2.3 Their Experiences; My Experiences: My Communality with the Women

Shortly after I migrated to Perth I had a child. My background in this regard was very useful in my discussions with participants. Because I had been through migration and childbirth myself, the women seemed very comfortable talking to me and I felt that I could understand their experience more fully. On many occasions during interviews women asked me “what do you think”? “How did you feel”? “Now it is your turn to tell me about your experiences”. During my fieldwork I was able to draw on my own phenomenological, social and biomedical knowledge when asking questions and replying to inquiries.

Not only did I interview the fifteen informants; I also talked with several other women from South Asia about their postnatal experience in Australia. I had the opportunity to meet the participants on other occasions, such as at social gatherings and community cultural events where I talked to them in the company of other South Asian women who added comments on topics of relevance to my research. I observed interactions between new migrants and the migrants who had been living in Australia for many years. In addition, I interviewed nine health practitioners including doctors, nurses and health

workers in order to gain an understanding of their view of postnatal depression, their methods of identifying depressed women and their treatments.

I planned to conduct focus groups of five to six participants, but I found that my informants and other women did not want to come and talk in a gathering. However, on several occasions, when the women gathered for a social occasion, it was like a focus group. Since the women did not know that they were being observed they seemed to feel relaxed and felt free to talk about their experiences of motherhood. Studying people's behaviour in a natural environment is called naturalistic observation. People are not interviewed, but rather engage informally in conversation and thus are not required to give free and informed consent (NHMRC 2002:33). Observation of public life in social settings such as at open meetings, sporting occasions, school social events and so on, is acceptable according to NHMRC (2002:33) ethics guidelines, and is a standard form of qualitative research.

Most interviews were held in the participant's home which was very convenient for women with small babies. I wanted my informants to feel relaxed and comfortable. Only one woman, whose two year old child attended childcare, wanted to have the interview in her office. The length of most interviews was about an hour, sometimes a bit more depending on the situation. I had to think carefully about how much time to spend with my participants. I wanted them to talk freely, but at the same time I was aware that they had new babies who demanded most of their time. One hour was long enough to encourage the women to talk freely, but not so long that it tired them out. However, I stayed available to listen to them until they had nothing left to say. With the women's permission I taped all the interviews and then translated and transcribed them. I explained to all the women why I wanted to use a tape recorder. One woman asked not to be taped and I did not do so; otherwise taping never appeared to be an issue. I have chosen to use pseudonyms for the women whom I interviewed as they help preserve their confidentiality and create a symbolic distance between the researcher and the informants.

I did open-ended in-depth interviews. Before the interview I gave each woman a questionnaire to fill in (see appendix 1 for samples of the questionnaires used for these interviews). The areas covered by the questionnaire included: type of delivery, physical health factors (for mother and child), details of mother's own family, persons attending

the delivery, role of paid work (for partner and woman), role of community involvement and support. All those interviewed were asked about their experiences of giving birth in an entirely new society and how they felt about it. I had a questionnaire schedule to keep myself on track. Following Quinn's (2005) interviewing style, I wanted to conduct a one-sided talk. However, I found it difficult since some women wanted to listen to my story of childbirth and actually insisted on me participating in the conversation. I did so as I was also inspired by Leigh Berger (2001) who explores how sharing her own story with her field participants increased rapport between her and her informants. She says: "Sharing my stories with those engaged in my fieldwork fosters relationship formation and exchange between us, allowing all involved to feel a greater sense of rapport" (2001:507). I also found that disclosing my experiences with some of the women actually fostered their openness.

Again, following Quinn's interviewing method I tried not to interrupt when they were talking. My only intervention was to bring the participants back to the topic if they went too far off the track. I asked the women whenever it seemed appropriate to explain what they meant, or to give me some examples. I also prompted the interviewees when I wanted them to talk about a specific point they had not mentioned on their own. When they had apparently finished, I probed for more, either by a further question or by an extended silence. Further, while they were talking, I took note of comments or phrases they used or other clues that I might be able to refer back to at another time or at a later interview.

During the interviews, I encouraged my informants to describe and reflect upon what their experiences had been like for them. At the end of each set of these interviews, I asked specific questions e.g. what do you mean by postnatal depression? How do you feel about it? In such interviews,

> The investigator attempts to let the interview follow the respondent's lead to a large degree, in order to see how the respondent presents his or her statements on the assumption that the organization of these presentations may reveal patterning of both cultural and personal significance. In the course of interviews, personal emotional reactions are probed for by questions such as "How did you feel about that?" "What did you feel like doing then?" "What *did* you do?" "Why?" and the like. Such interviews

> produce rich material bearing on feelings and understandings about feelings and their transformations throughout various stages of life, on learning, on fantasy, on stress and anxiety, on moral ideas and emotions, on self-concept, and on other such personally centred dimensions of experience. While a question during an interview such as (in Tahiti) "What are the responsibilities of a chief here?" produces, for the most part, cultural information, the probe "What is it like for you to be a chief?" will elicit information about personal experience and organization (Levy and Wellenkamp 1980:224).

I applied this method to make sure I was finding out what each participant had to say about their lives as experienced, and in particular their experiences of being mothers.

The majority of interviews and fieldwork was done from August 2000 to May 2001. From August 2000 until March 2004, I regularly attended and participated in general meetings, social gathering, religious festivals and concerts of the Bangladeshi and Indian communities. I also went to cultural programs of other South Asian communities. I completed a three month course, "Workshop for mental health: an education program for community workers from Islamic communities" held by Ishar. By that time I had become a member of the 'Postnatal Depression Professionals Association INC' in WA, and I attended many seminars on postnatal depression organized by this association.

2.4 Edinburgh Postnatal Depression Scale (EPDS)

I first saw the Edinburgh Postnatal Depression Scale (EPDS) at Ishar during an interview with a clinical psychologist at the initial stage of my research. She described the EPDS as a useful diagnostic research instrument that has been developed to identify the early onset of depressive symptoms. Showing and explaining the scale she told me "this is how we find if a person has symptoms of depression". Later, every medical professional I interviewed mentioned the scale and described it as the most helpful screening instrument to measure depression at on early stage. One clinical nurse admitted that though the EPDS was the most widely used measuring tool, it might have different meanings to different people, and said, "Therefore we try to find out if a person is depressed through talking individually." She added that the EPDS has been

translated into many different languages including South Asian languages, which she thought would make it easier to identify depression accurately and transculturally.

Hence, I became interested in the EPDS and decided to use it in my research to find out if that scale could reflect the psychological states of my participants. Some of my informants mentioned the EPDS, and complained how misconceptions had arisen between the medical professional and them when they filled in the questionnaire. I used the English version of the EPDS (see appendix 2) with my participants. I tried to get copies of the EPDS that had been translated into South Asian languages but was unsuccessful. I wanted to see if the translated version of the scale could acknowledge and establish the cultural idioms of symptoms. Despite the fact that the EPDS has been translated into many different languages, I agree with psychosociologists Byron Good, Mary-Jo Del Vecchio Good and Robart Moradi (1985:372) who pointed out that,

> The universality of the category is *assumed*, eliminating the need to establish validity, and the tautological circle is completed when the symptoms that serve as criteria of diagnosis, because they are believed to reflect specific psychophysiological and hormonal states, are assumed to be universal.

The EPDS has been designed to reconstruct the understandings on which participants gave their ratings on this scale. It is a ten item self report scale specially validated for use with childbearing women. Items are scored on a scale of 0-3, where absence of a symptom scores 0, and maximum severity and duration scores 3. Total scores on this measure range from 0 to 30 with a cut off score of 12 or 13.

To identify postnatal depression among Indian women Patel (2002) used the EPDS though he admitted, “I completely agree that like all screening measures the Edinburgh Postnatal Depression Scale has imperfect sensitivity and specificity” (2002:1438). He then added “despite the Edinburgh Postnatal Depression Scale being a screening measure, it remains the most widely used case measure in epidemiological studies of postnatal depression” (2002:1438). Criticising Patel’s study, Saravanan (2002:1438) said that screening measures do not provide a clinical diagnosis of depression. Saravanan argued that studies that involved a questionnaire-based measurement of depression with cut offs might be arbitrary. Therefore, he said that some women scoring

above the threshold may not have a depressive illness, and some below the threshold may. It is also interesting to note that though this scale has been specially designed to measure postnatal depression, it does not make specific reference to pregnancy or childbirth.

In their research Fuggle et al. (2002) found EPDS as an appropriate, reliable and inexpensive method of identifying postnatal depression among 48 Bangladeshi postnatal women who were recruited both in Dhaka, through a private clinic, and in London (Fuggle et al. 2002). The researchers admit that this sample is not representative of the Bangladeshi population as a whole, as the majority of the population do not have access to private health care. To apply the scale effectively, a General Health Questionnaire (GHQ) was also used in this study to compare the score of the GHQ with the score of the EPDS, and both EPDS and GHQ were translated into Bangla. In addition, a Bangladeshi psychologist interviewed participants both in Dhaka and in London. The majority of items in the EPDS and the GHQ were found to have reasonable semantic equivalence; however, the researchers found the women to have conceptual differences of meaning for some items. For example in the GHQ with reference to enjoyment of day-to-day activities, some women commented, “what’s there to enjoy” (2002:76). Fuggle et al. also found many participants had difficulty with the acceptability of the items which referred to life as not worth living, harming oneself, or wishing to be dead. “Participants tended to respond to these items with a quick ‘No’ and often made comments like ‘I’m a mother, I have my children to live for’ or ‘my children need me, I could never think in this way” (2002:76).

Fuggle et al. identified six women, all of whom were immigrants to London, as having a clinical level of depression. If comments like “what’s there to enjoy” (2002:76) led the researchers to diagnose a woman as having postnatal depression, then I would not be surprised to find most Bangladeshi women are mentally depressed. This is how the women in Bangladesh see their lives, as a destiny rather than a question of enjoyment. From my experience of working with South Asian women, I do not think either the Bangla translation of the term postnatal depression or the concept itself makes much sense to most Bangladeshi women despite the fact that the same biological factors may be operative for women of both Western and non-Western cultural backgrounds. This point will be elaborated on chapter six.

Another study was conducted in Britain for the purpose of delivering appropriate health visiting services to the South Asian women by training and educating health visitors about different cultures (Thompson 1997). The EPDS was used to detect postnatal depression among South Asian migrant women because it was thought that failure to recognise postnatal depression in this particular culture would be a danger. The EPDS was used, although researchers were aware that it might not score accurately depending on the mother's mood. Thompson did not mention if the researchers themselves were from South Asia but she admitted that those researchers were afraid that the terminology used in the EPDS could have a different meaning to some women, or certain words or phrases like “depression” could not be translated into any of the South Asian languages. Thompson reported that the effectiveness of the EPDS was felt to be limited in this respect. Therefore, the health workers came up with a strategy to address the problem. They asked South Asian women if they were sad.

2.5 EPDS and South Asian Migrant Women

I gave the EPDS to all participants when I did the first interview, and asked them to fill it in. I also asked them to describe what they thought about the questionnaire and how they interpreted the questions on the scale. I did not use this scale as a diagnostic measure, but instead as a means of exploring the meaning that the scale's items had for this group of South Asian women. I explained this to some women who had problems understanding questions in the scale. Some women asked me which stage of feeling I wanted them to score e.g. during pregnancy, birth or aftermath. Obviously if I was using the scale as a diagnostic tool, I should have got the score of their emotion around the time of their pregnancy and birth. However, some women tried to capture their emotions of that period though I did not request them to do so. One woman complained and told me, “There is no point to know how I feel now when you are researching on postnatal depression, because I do not feel the same way, I [will] use [it] to gauge how I felt after my child was born”.

All my participants recognised the EPDS. Either they had been given it in the hospital during pregnancy or at childbirth, or they were working in the health sector. Only one woman was annoyed by my request that she fill in the EPDS. She said:

> "That was the thing I was given in the hospital when I went for the routine check up. They suspected that I had a postnatal depression and asked me to see a doctor. They made my life hell after I came home from the hospital. Manonita, you are not going to do that to me — are you?"

I said that I was not going to do that to her and reassured her by saying that what she thought about her experience of emotions was more valuable to me than what the score indicated in the EPDS.

Before I started interviewing, two of the fifteen women were diagnosed by health professionals as "clinically depressed" and thus were sent to professional care. However, they did not seek follow up treatments. According to my administration of the EPDS, eight women scored as depressed, using the conservative cut off point of thirteen for depression. Many of them perceived themselves as having been depressed, though did not see this as a disease. The remaining five women scored below 12, despite the fact that their complaints and experiences towards childbirth were not different from those women who scored 14 and 15. Not the score, but the respondent's answers are text which I analyse.

To find out what women think about their experience of depression, Small et al. (1994:90) did a study in Victoria, Australia among 1193 women who had given birth between one week and nine months before. Prior to the interview they used the EPDS and then followed up the study 12 to 18 months later. The research was targeted at finding answers to some relevant but neglected questions such as: What do women think about postnatal depression? What do women who experience depression do about it? Where do they turn for help? What do they say about the contributing factors? Do they recover? If so, what speeds up recovery? In their study, women who scored as depressed, believed they were suffering from depression. However, these women believed that the contributing factors towards their depression were isolation, lack of social support, fatigue and physical ill health. To recover from postnatal depression, these women were seeking help from their family members and friends, instead of professional sources (Small et al. 1994:100). My findings are similar to Small et al.'s (1994:100) new Victorian mothers who experienced signs associated with depression did not interpret their experiences as an illness, and were dealing as best as they could

with lack of support, isolation, fatigue and physical strain. From these women's point of view, they needed more support and understanding rather than a clinical diagnosis.

What does Parul think? EPDS and her response

In the following chapters I will discuss examples of how South Asian women perceive postnatal depression in general, and I will analyse their comments. However, here I give an example of what my South Asian participants thought about the EPDS in particular. When I gave a copy of the EPDS to Parul, a social worker in the mental health area, she recognised the scale, and acknowledged that it had been translated into many other languages.

I asked her if she knew any word for depression in Hindi or Tamil which are two dominant languages in India. When she spoke, she seemed confused and said,

> Well, there is a word in Hindi "*bechare*" which means people who are upset in mind. But I can't get the right feeling as depression. "*Bechare*" depends on the context, for example, it even can be used when you say "her mother died and she is upset". Technically we have got a word in Hindi that is "mono vyadhi" which is disease of mind. But people do not use this for everyday language. It is a word used by the health professional to address mental illness. Therefore I think the EPDS can not detect depression especially in India.

Then Parul added,

> I think depression is very often undetectable. I have seen people back home if they were depressed they just beat their children or yelled at their children, and that is how they were getting off their frustrations. Some people I knew whom I identified as a depressed person, or I could find some symptoms of depression, but they did not talk about it. In India that is the system in which people are grown up and they just think that they have to bear the problem, this is life and they just put up with everything.

I asked Parul if she thought that people who considered “depression” to be a part of their life could also regard it as a problem? Parul did not give any direct answer instead she said,

> It depends. People may have a short term of depression and some people just live with it. It is very difficult thing to answer but I know many people who could say it was OK to live with it. When I was working in the cancer hospital in India, I met many people who despite having a hard time, were doing everything e.g. cooking, cleaning, looking after their parents, children and other family members. They were doing it because they thought that it was their duty. When those people came to talk to me they broke down and cried and then suddenly said, "Oh I have just felt terrible today and that's why I have cried and that's all and I am all right now.

In answer to my question of what she though being depressed was, she said,

> Feeling low. Very often I use this word when I am not able to do what I want to do. Well, I use the word depression when I feel very low. I don't feel like doing anything. I really don't know about this, even though I am working with depressed people. It is also hard to explain when I am working with depressed people who have less confidence about their job and I help them through counselling.

Parul’s answers reflect some of the confusion she feels in working in a system that recognises postnatal depression even though it is not part of her cultural schema.

In their research among 860 adult Korean immigrants in Canada, Western trained Samuel Noh and Xinyin Chen (1998) set out to find depressive symptomatology and relate it to psychiatric treatment for depression. The purpose of their study was to present empirical evidence attesting to a potential bias in using a diagnostic measuring scale called the Centre for Epidemiologic Studies-Depression Scale (CES-D) for assessing depression among the Korean population in Toronto. Their work was an extension of earlier research on Koreans’ responses to the translated Korean version of the CES-D scale. The CES-D scale is a 20 item self-report measure for finding depressive symptoms (1989:361).

Noh and Chen noticed that in previous investigations there were four positive affect items in the translated Korean version of the CES-D. The four positive affect items were “felt as good as other people”, “felt hopeful about the future”, “was happy”, and “enjoyed life”, all of which were rated significantly lower by Asian immigrants than by North Americans. This finding was suggested as the possible source of measurement error by previous researchers (1998:360). To minimise the error, Noh and Chen, substituted those four positive affect items, which earlier investigators had recommended be deleted from the scale, and replaced them with items worded in negative affect terms to “tap core symptoms of depression, such as hopelessness and loss of self-worth” (1998:361). Using the scale with rephrased negative terms Noh and Chen were able to rate less depressed people among the Korean population compared to earlier studies. They claimed that the revised scale “resulted in an increase in the reliability and validity of the measure (1998:372). I acknowledge Noh and Chen’s concern about a valid assessment of depression among Korean immigrants, and I congratulate their achievement. However, I also would question how the researchers could be so sure that their assessment for finding depression in the Korean population was accurate. I would suggest they further investigate to check if Korean immigrants found to have “depressive symptoms” were functioning in the society as well as the North Americans without depressive symptoms. If they were, — then the central question in Noh and Chen’s research should have been, “how do they function and not how are they feeling”.

I believe Noh and Chen’s themselves came up with the answer by explaining why they replaced the positive items with rephrased negative items. Drawing upon a literature review they found that, in Asia, dysphoria is attached to Confucian and Taoist philosophies on the harmony of opposites that does not separate sorrow and happiness (1998:372). They also found that among the Korean population, the overt expression of positive affect is considered inappropriate and indicative of social immaturity. Thus, Korean people were reluctant to score their feelings in the positive affect items in the scale. Noh and Chen argued that for the Korean population the tendency of being reluctant to give vent to happy feelings could be a positive coping mechanism to deal with negative feelings.

Although Noh and Chen admitted that CES-D with rephrased items might result in reliable information on depression among Korean immigrants, they acknowledged the

cross-cultural differences in the conceptualisation, expression and experiences of psychiatric disorder. This is what I also argue that a depression measure scale like the EPDS or the CES-D, even a translated version may assess feelings but these feelings are not necessarily symptoms of psychiatric illness.

Drawing upon my informant's comments on the EPDS, my intention is to analyse the symptoms of depression in relation to their cultural context and to criticise the methodology of psychiatric epidemiology which treats dysphoria in isolation from cultural context. In the next chapter, I will present the aetiology of postnatal depression as discussed in the medical and anthropological literature where not biological but sociocultural factors are found to be powerful components of postnatal depression. There were six common sociocultural difficulties which my informants talked about in terms of migration and motherhood: social isolation; not getting a rest; lack of emotional support; having no traditional birth rituals; economic difficulties, and babies with serious health problems. I argue that their hard experiences have lead them to be anxious, stressed, suffering and vulnerable, however they do not see themselves as depressed. Rather, they see themselves as cooping normally.

3 RECOGNITION SOCIOCULTURAL FACTORS IN POSTNATAL DEPRESSION

It is difficult to make any definitive statement about the aetiology of postnatal depression. It is argued in the medical and anthropological literature that not biological but sociocultural factors are powerful mediators of postnatal depression (Behrndt 1995, Stern and Kruckman 1983, Stuchbery et al. 1998). For instance some researchers suggest that the gender of the infant (there is an increased incidence of depression for mothers of female infants) is a contributing factor in the occurrence of chronic depression (see Patel et al. 2002). This literature argues that social factors represent an important determinant of a new mother's emotional transition to motherhood and may influence her risk of manifesting postnatal depression.

I do not intend to review the debate regarding the aetiology of postnatal depression and social factors. Instead, I will focus on the social factors that may affect the postnatal experience of South Asian migrant women. The aim of this chapter is to examine the common difficulties the women experienced in the process of motherhood after they migrated to Perth. I analyse those aspects which have been identified by Western medicine as contributing most to postnatal depression. I provide a general overview; of first, the sociocultural factors that are expected to contribute to postnatal depression, and second the difficulties associated with the migration process which my informants experienced during their pregnancy, childbirth and postnatal period.

3.1 Social Support and Postnatal Depression

Major life events, inadequate social support, financial worries and a baby with serious health problem are recognized as the major sources of stress associated with maternal psychological distress (Romito et al. 1999). The lack of social support is described as the best predictor of postnatal depression in Chun and Yue's (1999:114) study among thirty-six mothers in Hong Kong. The study examined the relationship between postnatal depression and social support, and found that a lack of all kinds of support including emotional, instrumental, information, economic, and social interaction are equally important contributors to postnatal depression. They argue that mothers who receive lower levels of social support experience significantly higher levels of depression.

In their study, Stern and Kruckman (1983:1036,1039) described differences in the puerperal period across various cultural settings and found that non-Western cultures often have more socially structured puerperal periods, and that women from less Westernised cultural settings were relatively protected from postnatal depression as a result of institutionalised structuring of the postnatal period within the surrounding community and family. On the basis of their study the researchers identified six crucial cultural features, the presence or absence of which were consistently associated with postnatal depression. The six factors are (1) cultural structuring of a distinct postnatal period, during which normal duties of the mother are interrupted, (2) protective measures designed to reflect the vulnerability of the new mother, (3) social seclusion (4) mandated rest (5) instrumental support from relatives and (6) social recognition of the new status for the mother through rituals, gifts, or other means (1983:1039). The authors argue that lack of these elements in many Western societies may be an important contributor to high rates of postnatal depression. Here I would say that due to the migration process, my informants experienced a lack of many of these elements in their postnatal lives.

To support Stern and Kruckman's theory and to explore how the traditional culture may become a powerful mediating factor of postnatal depression, Sara Harkness (1987) did research in Kokwet communities in Kenya in East Africa. She identified three aetiological models of postnatal depression: the biological model, the psychological model and the interactive model (1987:195). In the biological model, postnatal depression is said to be triggered by hormonal changes, and in the psychological model, women's previous psychological development is interrupted by the experience of pregnancy and childbirth, and the interruption leads to postnatal depression. Although internal processes are considered to be the genesis of postnatal depression in the biological and the psychological models, her research illustrates the fact that such processes are given meaning by their sociolcultural context (p. 207).

The theoretical framework for Harkness's third model originates from studies on stress and coping. The interactive model interprets postnatal depression as the result of the stress of childbirth in interaction with other aspects. In this model she addresses women's emotional functioning, and argues that as childbirth is a highly stressful event, postnatal depression may be the result of a mother's perceived inability to cope with this stress. The author agues that the traditional role of Kokwet communities plays a

powerful mediating factor between the physiological processes and the emotional experiences of women during prenatal and postnatal periods when women are most vulnerable.

Harkness finds in Kokwet, birth is naturally expected to happen and it normally takes place at home, attended only by the women's close female relatives, especially her mother (p.199). This event is followed by a seven-day postpartum rest period when the new mother is looked after only by her close female relatives. The end of the rest period is signalled by a celebration when relatives and friends bring foods and gifts for the mother and the baby. Harkness suggests that the absence of this kind of sociocultural support in Western countries plays a vital role in the aetiology of postnatal depression.

3.2 South Asian Mothers and the Experienced Difficulties

Now let me further examine these sociocultural factors and social support which are said to play a vital role in the causes of postnatal depression. I examined these factors in terms of my informants' experiences after giving birth in a new country where most of them did not have any relatives around to support them. Much in the literature would lead us to assume that many of the South Asian women who gave birth in Perth and who lacked the six crucial cultural features identified by Stern and Kruckman (1983) would experience postnatal depression. However, I believe their mental states have to be understood with reference to the processes of the work of culture (Obeyesekere) and emotives (Reddy) as described in chapter one.

Social isolation

In her PhD thesis Margaret Behrndt (1995:415) emphasises social isolation as one of the major causes for postnatal depression. She found that the greater the distance between a mother's house and her own family's house, the greater her vulnerability to postnatal depression. Similarly Chun and Yue found that interaction with people in the community was crucial to new mothers' ability to cope with depression. All my informants were recent migrants. At the time they gave birth they had been in Australia from one month to three years. Other than their husband, eleven of the fifteen informants did not have any relatives in Perth. They had left their family and friends

back home and felt isolated. Moreover, many of them could not speak English well, thus they could not mix with the local people in Perth.

> I was left at home alone with the baby in the house. I missed my family and friends especially after my child was born. I didn't know many people here I can talk to. I couldn't go out with the young baby. I was just stuck at home. I felt isolated – you know (Merry).

Not getting a rest

> I am exhausted with the baby and house work. I had to cook after I came from the hospital. I wish I had only one person just to hold the baby while he is awake. I do not feel like doing anything, but have to do everything. I am just tired (Nazneen).

When the newborn mother's normal household duties and childcare are taken over by her relatives, it ensures that she rests. Having no help with the baby or the housework was an issue frequently raised by the women I interviewed, especially by those who were physically sick or who had other children to look after. According to Stern and Kruckman (1983:1037) this issue, as I have discussed before, is a significant factor in relation to the presence of postnatal depression. Behrndt (1995:428) also found that lack of time to herself increases a mother's vulnerability to postnatal depression.

Within traditional South Asian culture there is a great level of practical support for a mother; women are expected to rest for a period of time after giving birth. There is a restriction on new mothers handling water to protect the mothers from exposure to cold and there is recognition of the recent mother's nutritional needs and her vulnerable state of health. The separation and liminal stages of South Asian birth rituals, which I will elaborate on in chapter four, appear to address the practical support needs of the new mother.

My ethnographic data indicates that almost every mother I spoke to wanted some rest.

> I want to go home. I would have many people there to look after my child and me. I would sleep. Here I am tired all the time. There I will have my mother who will cook for me and I do not have to get hungry. Most of all she will understand me. I miss her and I want to see her (Mumtaj).

Lack of emotional support

Lack of emotional support from close family members, especially from their husband and mother, is also found to be associated with vulnerability to postnatal depression (Behrndt 1995:428). In Australia, Stuchbery et al. (1998:488) studied 105 Anglo-Celtic, 113 Vietnamese, and 98 Arabic immigrant mothers who were recruited from antenatal clinics in South Western Sydney six weeks after the birth of their child. In that study, immigrant mothers frequently complained about missing their mothers and receiving poor emotional support from their husbands. The authors argued that the absence of the new mother's own mother was commonly experienced as an emotional loss, or state which is associated with postnatal mood disorder.

In my study, most mothers mentioned that because they did not have any relatives in Perth they did not receive enough emotional support. They also complained that their husbands were either too busy working to pay attention to them, or did not know what to do.

> My husband told me, 'you do not have any problem so what is the problem?' He actually does not know what to do. Back home a new father does not have to do anything because there are other female relatives with whom a new mother shares her feelings (Marufa).

Some wanted to share their experience with other people in the local community but received "unsympathetic" responses.

> One day I was talking to my Aussie neighbour about my experience. I told her that my husband was not sympathetic and I was angry with him. She asked me, 'do you want to divorce him?' – well I did not mean to divorce him, but I just wanted to convey how much I was down-hearted (Sheila).

South Asian culture traditionally prescribes a high level of emotional support for a mother before and after birth, generally provided by the woman's own mother. It is reinforced by social customs, as Indian psychoanalyst Sudhir Kakar (1978:77) observed, where the expectant mother goes back to stay at her own mother's house a few months before the delivery. This stay helps her strengthen her identification with her mother. Kakar argues that the woman anticipating motherhood does not seem to feel anxiety or fear of dying because she knows that her own mother will be constantly at her side during labour.

Studies have shown that emotional support given during delivery helps to relax the birthing women and consequently reduces the intensity of her pain. Patel's (1994) study in a Rajasthani village in India suggests that a group of comforting and encouraging female relatives and neighbours surrounding the labouring women helped to relieve her stress and reduce the intensity of her pain. She writes, "The people around provide mechanisms that effectively prevent the labouring woman from turning hysterical or even losing her calm" (1994:117). Thus after the birth, "The new mother can bask in her delight in her child and also in her satisfaction with herself" (Kakar 1978:77). And all of this takes place in her own mother's house where she is surrounded by appreciative and sympathetic close kin. These social customs are reflected in Tania's words:

> I needed my mother so much that I wrote her a ten pages long letter. I wrote about how much I missed her and how much I wanted to see her. Every time I talk to her on the phone, I cry. She tells me that everything will be all right. Who can understand me better than her? Who can make me feel good other than she?

<u>Having no traditional birth rituals</u>

> I still cry when I recall my experiences at that time. I used to compare the situation to India. If I were at home, besides other activities like prayer and worship, there would be baby massage, and a new mother's bath with special oil. There would be a big celebration with lots of people gathering (Kabita).

Both Stuchbery et al. (1998:485) and Stern and Kruckman (1983:1036) found the absence of postnatal rituals to be one of the major risk factors for postnatal depression.

While living in Bangladesh and during my fieldwork in Perth I was invited on many occasions to a celebration called "*mukhe bhat*" (rice into mouth). This celebration is held when a baby is six or seven months old and occurs at the time the baby is weaned and is given his or her first solid food. Another celebration I frequently attended occurs when a baby is one month old. At the ceremony, which is called "*akhika*", the baby is given a formal name. This occasion is also marked by sacrificing an animal. Regardless of region and religion, these special events involve many relatives and friends gathering and bearing gifts for the baby and food for the mother. Few of my informants tried to celebrate these occasions, and many of them were not able to have a party. As Nahar said:

> Back home there would have been some celebration when my baby and I came home from the hospital. Lots of relatives and friends would come to see and to bless my child, and to wish for me. We celebrate when we named our baby and we invite many people. We sacrifice a cow or a goat for the baby's sake - celebration and celebration. I cannot do anything here because I don't have relatives and friends to organise the party and most important I don't have money.

<u>Economic difficulties</u>

> I could not sleep at night. I used to wake up very often thinking that the baby was coming, so we had to earn and save money (Bina).

Behrndt (1995:433) found that women whose husbands had no income were significantly more likely to be depressed. After studying 724 Italian and 629 French women twelve months after birth, Romito et al. (1999:1654) argued that in both countries mothers who reported on their husband's unemployment were more likely to be depressed. To find if there was a correlation between low socio-economic status and postnatal psychological distress, Seguin et al. (1999:161) studied 68 Canadian women with low socio-economic status who were six months postpartum. The women in the

study were all first time mothers who had a family income below the poverty level as established by the Canadian Council of Social Development (1999:158). The researchers were afraid that mothers of sick babies might be more prone to postnatal distress than mothers of healthy babies. Thus they excluded those mothers whose babies were sick or who had been hospitalised for more that two weeks after birth. Seguin et al. identified chronic stressors for financial difficulties among mothers with low incomes and those mothers showed a higher prevalence of depressive symptoms.

Many migrant women in my study had sold their property in their home country, resigned from their jobs and left their parents and friends in hope of a better future in Australia. However, once in Australia, most could hardly manage to pay the rent on the small flats they lived in or to buy their own transport. They even faced difficulties getting a job. Many of them had little or no English and because of their lack of knowledge of Australian culture, did not feel confident looking for work. Moreover, their overseas qualifications were rarely recognised in Australia and many work places required local experiences. Their financial situation generally got worse after having a baby. If they had no job, they had no money to buy things for the baby. If the husband had a job, then very often the new mother had no one to help her looking after the baby and doing the housework. Merry, a librarian in her home country, commented on her economic circumstances:

> In any relation, or situation, I think if you are financially secure then half of your problems are solved. We both were thinking about our future, about our job and our destiny. We did not know what his next job would be, would he pass his exam? Thinking about a job exhausted him. At the same time looking after the baby alone, and thinking of our unstable financial and social circumstances was an additional burden to me.

Babies with serious health problems

Apart from studying the financial difficulties of Italian and French mothers, Romito et al. (1999:1654) also found that having a baby with serious health problems was a major predictor of maternal depression. In my study, I interviewed five mothers whose babies had a serious health problem. These mothers frequently said how anxious and upset they were. However, they also mentioned that they did not have time to think if they felt

any dysphoria and did not care if they had enough rest, or performed any rituals. These mothers who had given birth up to two months premature came back home leaving their babies in hospital. In order to be with and to nurse their babies, they used to leave home very early in the morning, and come back home late at night. In the absence of a private car, two mothers had to rely on public transport, which was time consuming and inconvenient, especially at night and on public holidays when public transport was less frequent.

> Very often I had to take a bus because we did not have a car and my husband had to go back to work. My sister had only one car and after dropping her children to the school she had to go to her office and my hospital was in other direction. So I had to wake up very early in the morning to be the hospital on time. I carried an icebox with bottles of breast milk I pumped during the night, and also my lunch as well. I was so much focused on my baby that having a birth ritual was out of question. I even did not have time to think if I was getting enough rest or not (Sheila).

After analysing my informants' statements about their major difficulties, the point I wish to emphasize is that regardless of all the difficulties, the South Asian women in my study appear to have developed a capacity to deal with their problems. Cultural traditions and beliefs helped to mitigate (if not prevent) a break in the new mother's sense of worth as she faced the difficult transition to motherhood. I will discuss this further in chapter five.

Dankner et al. (2000:102) examined the cultural and religious elements of postnatal depression among 327 Jewish women in Jerusalem. In their study, traditional orthodox women were found to interpret depressive symptoms in relation to cultural themes in the Jewish ghetto. The researchers found orthodox families, who are generally large and interwoven into an extensive community network, maintain a strict set of social norms. Sadness or discontent are perceived as the will of God, and to commit suicide is interpreted as a sin and punished according to Judaic law (p.102). Contraception and abortion are culturally forbidden, and any pregnancy even if unfavourable is seen as God's blessing (p.98). The researchers suggest that traditional Jewish women's religiosity and cultural affiliation influence their physical and psychological transition

following childbirth and make them less prone to the experience of postnatal depression.

In another survey of 52 childbearing Hmong women in the USA, Stewart and Jambunathan (1996:321) found that cultural beliefs and practices influenced the Hmong mother's adjustment to postnatal depression. The authors suggest that whatever symptoms of depression the women had were associated with living in a different culture, lack of income, and rearing children with limited means. The women's responses to the Edinburgh postnatal depression scale's question: "Do you blame yourself unnecessarily when things go wrong?" appeared to be about acceptance of events, rather than blaming themselves, such as, "It's going to happen, and there isn't much you can do to prevent it", or "Depends; some things just happen and you can't control." (1996:328). On the other hand, some women in this study responded that they had thought of harming themselves, for example "Dying is much better. There is so much stress, so much confusion and problems, but if I die who will take care of my kids?" or "Better off dead than to be alive. [I] don't have much education, and [am] unable to do things for myself" (1996:327). The researchers argue these responses reflected anxiety and frustration about being in a different environment, having a low income and a lack of social support in addition to increased parental responsibility, rather than about the postnatal period.

Similarly, my argument is that South Asian women's anxiety and stress are related to living in a different culture, a lack of job opportunities and support from kin and a lack of knowledge of English. I also argue that these women understand negative feelings in relation to established themes in the South Asian cultural context. I will elaborate on this argument in chapter five but, before that let me conclude this chapter with Lee (1997:99) who argues that postnatal depression is not hormonally triggered and pathological, but rather a normal reaction to the transition to motherhood which should be understood in the broader social context. Most cultures view motherhood as both natural and easy; something that every woman desires. Motherhood is described in most cultures as a sign of true adulthood and true femininity, and it brings true fulfilment and happiness to women.

Lee argues that these are unrealistic stereotypes of motherhood that make the postnatal period difficult for those mothers who think that they are not good mothers and then

feel guilty which can lead them to depression. Lee argues that there is nothing wrong with a mother who feels guilty and it is just a normal experience of adjustment to the new role of motherhood. Some feminist writers, such as Johnson and Lloyd (2004), Maushart (2002, 2000) and McKenna (1997), recently have started to acknowledge how difficult mothering can be. These writers suggest that women should talk about their difficulties, and should unmask the stereotype of motherhood by taking the challenge of motherhood fearlessly, and without apology, guilt or pretence.

In the next chapter, I will present narratives from four of my informants. I believe that without attention to these narratives, which include details of their traditions and beliefs, the life of these migrant mothers cannot be fully understood. It is pertinent to include the narratives also because of "the universal tendency of people all over the world to understand complex matters presented as stories, whereas they might experience difficulty in the comprehension of general concepts" (Kakar 1990:2).

4 POSTNATAL DEPRESSION AND MIGRATION
Narrative and Issues of Representation

Now that a link between postnatal depression and social factors has been suggested, it seems appropriate to return to the discussion of postnatal depression and migration. As was shown in the preceding chapter, social isolation, interrupted rest, a lack of physical and emotional support, economic disadvantage and having a sick child have been identified by many scholars and medical anthropologists as contributing factors to postnatal depression. I now turn to use a case study approach to provide a greater amount of information for my research, and also to provide a deeper understanding of the "degree to which certain phenomena are present in a given group or how they vary across cases" (Flyvbjerg 2001:87). Flyvbjerg suggests that appropriate analysis of a case study is central to developing theories and propositions. As part of the case study I provide the reader with narratives of four women's pre and postnatal experiences after migration to Australia. I have chosen the stories of those women who I think had the worst experiences. Yet these still do not resembles what is thought of as "postnatal depression". Their experiences are not typical examples of South Asian women's postnatal experiences. However, I present the four stories with the hope that the reader will understand how other participants with "typical" South Asian migrant experiences feel. Through these experiences reader will get a detailed picture of how through the work of culture the South Asian women in my research view their suffering, and how they see themselves as bearers of misfortune and hardship which is not "postnatal depression".

4.1 Narrative and Shared Experiences

To describe the personal story, psycho-anthropologist Benedicte Grima (1992:134) in her vivid ethnographic review of Paxtun emotional conventions, uses the term "life story" and Gergen and Gergen (1997:162) call it "self-narrative". I employ the term "autonarrative" to mean the brief oral sketches of my informants' self experiences, and the little pieces of their life story that they use to express their experiences. My interest in including four women's autonarratives is that I believe that they provide an additional window on cultural themes which are relevant to my argument.

> "Narratives provide a repository of experiences to tap as people move through life. They not only 'write' culture in action, but inscribe individual experiences as well. They negotiate cultural absolutes and provide a sense of personal control over culture and self definition" (Early 1985:177).

In my use of the term narrative, I incorporate a notion of shared schema by which I mean the stories based on shared cultural understanding. Although narratives are told by individuals, they originated and developed within a social setting (Gergen and Gergen 1997:163). To understand the shared schema in narrative clearly it is worth quoting Gergen and Gergen at length:

> Narrative construction can never be entirely a private matter. In the reliance on a symbol system for relating or connecting events, one is engaging in an implicit social act. A concept acquires status as a symbol by virtue of its communicative capacity, that is, its position with a meaning system is shared by at least one other person. A movement of the hand is not a symbol, for example, unless it has the capacity to be understood by at least one other person. Thus, in understanding the relationship among events in one's life, one relies on symbols that inherently imply an audience. Further, not all symbols imply the same audience: personal narratives that have communicative value for certain audiences will be opaque to others (Gergen and Gergen 1997:176).

Thus, it is important not only to see how people understand themselves, but also to see how they judge themselves their actions and behaviours, and also how they present themselves as bearers of hardship in regards to migration and childbirth. Thus, we can see every narrative is the 'work of culture' (Obeyesekere 1985&1990) and is a mirror of an individual's emotive (Reddy 1997&2001). Each narrative represents not only the difficulties experienced by an individual woman, but also the evidence of how culture itself influences how people deal with the difficulties. Moreover, each narrative reveals how the individual negotiates cultural absolutes as well as yields a sense of personal control over experiences as a migrant, their stories of childbirth and accompanying mental states. They also develop a rapport between reader and text, providing a picture of the women's experiences and South Asian cultural forms that shape the way life is recounted.

Before presenting the South Asian migrant women's narratives, I must mention that due to economic class differences, practice of cultural norms vary between the South Asian migrant women. Kachru (1994:342) identified four categories of women in South Asian society and these are the poor, the lower middle class, the upper middle class and the rich. Kachru defined these categories according to socio-economic order. She described the poor as uneducated and subject to exploitation. And the lower middle class as moderately educated and having to work to supplement family income. She defined the upper middle class as well educated, and employed in mid level positions in government or industry. In contrast, the rich are identified as either having the highest education, political power and/or managerial positions, or, irrespective of education, having wealthy households.

According to Kachru's sociological definition of class of women in South Asia, The informants, all of whom come from urban areas, are from upper middle class backgrounds. They are well educated and many of them had or have professions. This group of South Asian women can afford to disregard social norms of purity and pollution and the strict rule of *purda* and *lajja*, which I will discuss in detail in the next chapter. Although these migrant women most probably would not have experienced the same birth practices that rural women in their home country have experienced, their belief system is not very different from rural women who have had very little formal education. These migrant women often label the rural cultural practices and norms as "backdated" or "superstitious". However, they share many, if not all of them, with their less educated rural sisters. As will be seen in chapter five they have internalised much of the South Asian culture. In this sense, they brought it with them when they migrated and have been practising it in many ways since arriving here.

Most of the women I interviewed felt isolated because their relatives were all still in their home country. In addition, they found local Perth people are "polite but cold". Their economic disadvantage caused them anxiety, worry, fear, nervousness and very often affected their relationships with their husbands. Some of the informants experienced difficulties associated with a complicated birth, or either themselves or the baby having a medical condition. As previously mentioned, I knew some of the women before I interviewed them. However, it is likely that I would never have known their case histories had I not interviewed them. I visited them several times before and after they gave birth, but did not discover the difficulties they experienced during birth and

their associated mental state until I had talked to them in a formal interview. I asked one woman why, before the interview, she had not mentioned the difficulties she had been through. She said,

> This is not such a major incident or it did not happen suddenly. It is not something like that someone in the family died in a car accident. You see, it is everyday life, not obvious and thus does not have significance to tell everybody. I am telling you because you have asked me for details.

I found all the women, except seven whom I interviewed in English, narrated their story in the present tense, thus recreating the immediacy of their difficulties during childbirth. Grima (1992:137) also observes the dynamic intensity of misfortune and illness narratives cast in the present tense among Paxtun Muslim women in Pakistan. She notes that using the present tense allows the woman "to perform the dialogue and literally repeat the same exclamations, just as emotionally and tragically charged as when she originally uttered them, stopping to rock, weep and wipe her eyes" (1992:137).

I need to mention that many of my informant's husbands were geologists or in mining and other geological employment. I noticed a flux of immigrants form South Asian who migrated to Perth with specialized jobs in mining and other geological areas around the 1990s. Many of them however, lost their jobs within a couple of years after they had arrived in Perth. Many of them started taxi driving after they lost their jobs. Taxi driving which is easily available, not very competitive, flexible and requires little experience has become a popular source of income for many South Asian immigrants. I need to mention this because some stories may sound similar due to this reason, although they are told by different women.

4.2 "I waited to see if my child would smile"

> I don't know if it can be related to depression. I don't think I was depressed but I was very, very anxious. If my child did not have any problem I could think about it but I could not think of anything until he was about one year old. And that was my milestone. I waited to see if my child would smile

> when other babies smile, or if he would walk when others do. I kept looking for it with a great obsession.

I begin with Parul whose comments I mentioned on the Edinburgh Postnatal Depression Scale in chapter two. It seems appropriate here to describe her experience of having a sick baby to elucidate the context in which she experienced the "dysphoric effect". I am interested in her story not only because some researchers have found a relationship between having a sick baby and postnatal depression, but also to share her experience so that readers may see how much trauma a complicated childbirth and sick baby can have for the mother.

At the time I interviewed Parul, she had been living in Australia for five years, and was working as a mental health access worker in a migrant resource centre. Before she migrated to Australia, Parul had been working as a social worker in a cancer hospital in India. I did all the interviews with Parul in her office which was unexpectedly quiet and comfortable. When I asked her to recall her birth experience she claimed "It was a nightmare. I do not want any more children. I'd be furious if I have to go through it all again." She went to hospital at five o'clock in the morning when her waters broke but she was not taken to a labour ward until after midnight because her cervix was not fully dilated. According to her, doctors were giving priority to other pregnant women and neglecting her. "I kept asking them to induce me because I was afraid that I would catch an infection as it had been more than twelve hours since my waters had broken. But the nurses kept telling me that I was not fully dilated, whereas there were some other women who were fully dilated. And as soon as the space was available they would take me to the labour ward".

At midnight Parul was taken to the labour ward, but she was not induced until the next morning. Shortly after that, the doctors found they had to do a caesarean because the baby's heartbeat could not be found and Parul had developed a high fever and high blood pressure. She was delirious, talking to herself and could not remember anything that happened at that time. She could not even remember the birth of the baby who was born in the next morning at eleven thirty, more than thirty hours after her waters had broken, and who was taken to the intensive care unit straight away. Parul complained that she had requested soon after her arrival that the obstetrician do a caesarean as her general practitioner had suggested from the very beginning of her pregnancy that it

would be advisable because the foetus was very long compared to her short height. The obstetrician did not listen to her and she felt that she had been ignored. According to her and like many of my informants, medical staff do not care about what migrant people say because they think that migrant people do not know anything about childbirth.

Parul was discharged three days after the birth of her baby. However, her child was required to stay in intensive care for a couple of weeks more. She was told that due to a loss of blood circulation during his birth, a blood clot had formed on his brain and that he needed to stay in the hospital to be monitored. Parul and her husband were sent to a neurologist who described to them what the consequences of the clot might be. The neurologist told them that her baby could have brain damage permanently and that he might be paralysed. “I was screaming after hearing that news”.

I asked Parul if she could describe the day she came home from hospital. “I can’t forget the day. It was the day the doctors told me those horrible things about my baby and told me that the baby was not coming home with me. I had a big fight with the doctors. I had a big fight with the neurologist. I was frightened and angry at the same time”. Parul burst into tears and then a couple of minutes later she continued, “Doctors gave me the worst picture. I came home alone without the baby. It disheartened me very much”.

Fifteen days after he was born, Parul’s baby came home from hospital. Parul was instructed what to do and what not to do. Parul contacted a neurologist in India whom she trusted, to get a second opinion and more support. Both practitioners told her that her child needed lots of stimulation, touching and motivation to use his body. Parul did this as best as she could. Her concern and anxiety mounted until her son was ten months old. Her doctor in India said that it was not possible to pick up anything wrong with the boy until he was about seven or eight months old, when the baby’s condition would start showing. “Before that age the baby’s movement is involuntary, and seven months is a long time to wait and see if there is any problem. Therefore I could not enjoy him until he was ten months old. I was constantly worried about him. I was obsessed with his condition.”

Parul explained how much time she spent massaging and stimulating her baby. She claimed that she was so concerned about and determined to do the best for her son’s well being that she rejected a job offer for a full time position and took a part time

position instead. She was also not aware that she had “severe back pain”. Parul presented herself as determined, her devotion to her son making it possible for him to surpass all the medical practitioners. “The neurologist was surprised. It was miracle to him that my baby was all right.” Parul said that she was happy knowing that her child was not in danger anymore. Although he still needed a little more attention from the physiotherapist, his remaining injuries were minor.

4.3 “I missed my mother when I was sick”

> I am feeling good that I am not in that condition again. What could be worse than what I went through, what could be more desirable than getting our life back? I missed my mother when I was sick. She would understand me and make me feel good. But now I do not bother about anything. Either my child or I could die - what can be worse than that? How can postnatal depression come to me?

My interest in Kamrun’s story developed as I questioned whether her sickness could have made her vulnerable to postnatal depression. Anyone would pick Kamrun as dysphoric as she was very eager to tell me how close she had been to dying after the birth – “All I thought at that time was that I was dying”. Then she felt guilty because she had been so concerned about herself that she had forgotten about her son – “How could I be so selfish that I only thought about myself? I even did not think that my son’s life was as much in danger as my life was”. I interviewed Kamrun seven months after she gave birth and when she had just recovered from sickness, though I kept in touch throughout her pregnancy and after birth.

Kamrun started her story by saying “I can’t remember enough about what happened during and after the birth. I was unconscious”. Kamrun was a journalist and working full time in Bangladesh until she married and migrated to Australia two years ago before giving birth. She did not enjoy working because the work was exhausting, and required lots of travelling which according to her was not safe for a woman in Bangladesh. After coming to Perth she tried to get a job in her field but found it difficult because she had neither an Australian degree nor experience. She wanted to take some

courses but became pregnant. She then added that she had waited to have a child until after her husband had got a job.

Let me now briefly consider Kamrun's experience with unemployment and being pregnant. I heard the same complaint from many other South Asian women during the study, that although they tried hard, they could not get a job in Perth because they did not have local experience. They talked about looking for jobs for a while but then they decided to become pregnant and soon gave up job hunting. Kamrun did not wait long to become pregnant as she had been married for only two years when her child was born. Neither did she seem desperate about finding a job.

For Kamrun, like other women in this research, lack of interest in finding a job and not delaying pregnancy were driven by both her and her community's schema of "married women and mother". In South Asia, regardless of economic class, religion and/or region, a woman knows that motherhood gives her a purpose, identity and status that nothing else in her culture can (Kakar 1978:56). I would say that for South Asians motherhood is a basic requirement for a married woman. For them motherhood is something married women need to be. I also argue that this is not only the case for South Asians but also for the vast majority of people in the Western societies where marriage and motherhood remain persistently intertwined. In the USA and Australian societies a marriage without children is still widely regarded as a social aberration (Maushart 2002:127).

Kamrun's relatives back home and the members from her community in Perth began asking her when she was going to have children as soon as she reunited with her husband in Perth five months after she married. The common question they used to ask her was, "What are you waiting for [to have a baby]?" As I show later, Kamrun's desire and her community's demands that women should have children as soon as they get married coalesced in her narration. The South Asian community in Perth also judge a mother working in a professional area as more prestigious.

The practice of female seclusion in South Asia could be a reason for Kamrun's unenthusiastic job searching. I will elaborate on the concept of *purda* as a means of female seclusion in chapter five. Although some women in South Asia work outside the home, due to *purda* they stop working as soon as the economic necessity is absent.

Therefore Kamrun was not eager to go back to her profession because her husband had a job. One might argue that there are differences in enthusiasm for having a job among women from different parts of South Asia (Afsar 2004: 204), but this is not the place for an extended analysis of the job-hunting process. Let me say, however, that in most South Asian families in Perth the sole earners are husbands - not wives.

Getting back to her birth experience, neither Kamrun nor her doctor realised how much she was in danger until they received her blood test report fifteen days before the due date of birth. Doctors then suspected she was HIV positive and admitted her into the hospital straight away. Kamrun experienced mild but very frequent fevers during her pregnancy. She had mentioned it to her general practitioner, but she was told that fever was not very unusual during pregnancy, and not to worry about it. Every time she complained about the fever, she was ignored by the medical practitioner. However, by the very end of her pregnancy doctors suspected something might be wrong and did a blood test. The blood test reported problems in her kidney and liver, which could be harmful for the unborn child. Thus they decided to deliver the baby right away.

On hearing the news, Kamrun was panicked and anxious, and began thinking of her mother whom she felt could assure her in this situation. She could only vaguely remember what happened after that. She remembered that her husband was beside her during the birth and that her baby boy was born with an infection and an aphonia (loss of voice as a result of infection), and taken to intensive care right after birth to be looked after by nurses and doctors. Kamrun, on the other hand, was left alone and ignored by the obstetricians who thought she was out of danger even though she told the nurses how weak and dizzy she felt. Two days after the birth she fainted, and was unconscious for the next two days. She does not remember anything that happened during the next eight days. She was told afterwards that she was fighting for her life. Her condition was defined as a fatty liver problem; her liver had become enlarged at the end of the pregnancy, resulting in a blood clot which caused kidney failure.

By the ninth day after the birth of her son, Kamrun had begun to recover physically, but not mentally, "I could not recognise my baby when I saw him for the first time since I fainted". She could not even remember that she had given birth. She was taken to see her child who was still in intensive care and given his photograph to help her remember him. However, she felt like she was dying and wanted to see her mother before she did.

Every time she closed her eyes she experienced ferocious visions, and so she became afraid of sleeping. Later she emphasised how selfish she had been because she had been thinking only about herself. “After fifteen days I cried and cried, realising that my son could die too. How could I be so selfish? I can not forgive myself for my attitude”.

Kamrun punished herself for her behaviour by deliberately eating small amounts of food and working as hard as possible for her son. She got released twenty days after the birth, but because there was still a chance that the baby could have an aphonia attack, he was required to stay in the hospital for another four weeks. During that period she went to the hospital every morning and did not come back home until 11 o’clock at night. In the hospital, she tried hard to nurse her child but her milk was not sufficient which made her feel even guiltier. She pumped her breast until her breasts were painful and sore; "I did not have enough milk for the baby. I felt bad that I had to give him a bottle”. Kamrun initially interpreted the insufficient supply of her breast milk as punishment for her indifference to her son. During this time Kamrun was given Edinburgh Postnatal Depression Scale and was diagnosed as depressed. Although she was given medication, did not follow up treatment. She though taking medication would not make her feeling less guilty. Instead, she convinced herself that as a mother she must suffer over her son’s condition in order to gain status and reputation in her community. She was always frightened, anxious and afraid that she was not suffering enough for her child. Thus when her son was released she did not want to bring him home as she was afraid she would not be able to look after her son and he might die if he had an aphonia attack again. Kamrun never complained about inadequate obstetrical treatment for herself. Moreover, she was grateful to those medical practitioners who saved her son’s life. Kamrun, like Parul, did not want to have any more children.

4.4 “I did not want him to get angry”

> “I knew it would be a girl. My husband was not with me when I had the ultrasound. I did not tell him or anyone in his family”. Why, I asked her half facetiously, did you keep it a secret? The answer was expected: “Because I knew everybody would be upset with the news that I was going to have a girl. My husband behaves badly if things do not work out his own way. I used to hate him. I wanted to have a baby because I thought once a baby

> comes into the family everything would be changed for the good. Thus I did not want him to get angry, and kept my mouth shut and waited for him to find out".

Sonia has had a hard life, but she is an exceptionally intelligent and resourceful woman. She is career minded and had found a job as a schoolteacher within one year of arriving in Australia. She has a good economic sense which helped her buy a big new house. She went to hospital by herself to give birth alone. She loves her daughter and is so acutely conscious of her well being that she took a year off work to look after her. She told me that the best time she has ever had was after the child was born.

To understand Sonia's postnatal experience more fully, let me detail her life after marriage and after migration to Perth. Her parents arranged a marriage for her with a radio operator eleven years older than she was, who worked on oilrigs. After her marriage decision was confirmed, she communicated with him either by phone or by mail because he was in Australia at the time. When she first came to Perth they both stayed with his sister's family because he did not have a job. Sonia did not like staying with her sister in-law's family; "I was very stressed after I came to Australia. My family was not here and I did not know my husband very well. We were staying with his sister's family. His sister married my husband's best friend, so they all were very close and treated me as an outsider". She could not join in on their conversation, share their experiences, or enjoy their jokes. They were always trying to make her perfect according to Australian standards, and criticized her Indian manners. Her husband liked to discuss with his sister and her husband everything that happened between them. Moreover, she found her husband had a bad temper, and yelled and screamed if he did not like something "I just thought, 'Oh God! What a hell!' I did not have any personal life. Everything was eating me up. I just cried all the time".

Soon after she migrated, she managed to get a job and insisted her husband buy a house. By that time, her husband had a job so they bought a house together. After moving into her own house she found privacy and freedom. However, her husband did not change at all. The job he was doing required him to go to Port Headland for a couple of months at a time. Whenever he came home after these long trips he would spend time with his sister's family and she continued to stay home alone. They used to have severe arguments, which caused her to leave home a couple of times, staying with her distant

cousin who lived far away from her place. Then she decided to have a child “I thought that everything would change for the good. My mother and my sister also told me that it would be OK once a baby was born. I also wanted to enjoy motherhood. I thought I was just wasting time being alone, so it was time to become pregnant”.

Sonia did not tell anyone except her sister that she was going to have a daughter. Here she applied her common sense from her previous experiences, knowing that in India giving birth to a female child is not something to celebrate. In South Asian society, a male child is considered insurance against economic risk for the family, while the female child is considered a liability to parents (Miller 1981:161, Kakar 1978:58). Both Miller and Kakar in their studies show that the preference for sons over daughters in South Asian society is because a son contributes to the family income whereas a daughter drains the family property as she requires a dowry upon her marriage. A son is also seen as a form of old age security for his parents as he carries the family name and looks after his parents in their old age, whereas a daughter usually takes her husband’s name after marriage and leaves her parent’s home to join her husband’s family. Moreover, the son is necessary for performing rituals especially upon the parents’ death, while the daughter is not allowed to perform the rituals.

Sonia mentioned to me that her husband was the only son out of the six children his parents had. She believed they would be disappointed if anyone in the family gave birth to a girl child. She also has more sisters than brothers in her family of origin. However, neither she nor her sister were worried about her having a baby girl because Sonia just wanted to have a child to banish her loneliness and change her husband’s attitude towards her. She mentioned that after she became pregnant her husband changed. “My husband changed so much. He used to question me about every dollar I spent but after I became pregnant he did not bother about what I bought or how I spent money”. Thus she did not want to spoil her husband’s mood by letting him know about the sex of the baby which she was afraid might make him angry again.

Sonia knew she was going to have a caesarean delivery and thus the date of the baby’s birth was fixed. It was arranged that way so that her mother in-law could come before the due date and her husband did not have to take leave from work. However, the plan did not work. Her mother in-law could not arrive at the planned time due to visa difficulties. Her sister in-law offered to take her to hospital but she refused which was

quite understandable as they did not like each other. The operation was set for six o'clock in the morning. Sonia got up at four in the morning to get ready. Before she left she rang her mother and suddenly she felt nervous. "I do not know why, but suddenly I felt shaking and got very nervous. I was very strong physically and emotionally before I talked to her. But during our conversation with her I felt that I needed her desperately. I started crying. She kept asking me why I was crying and assured me that everything would be all right. I wanted my mum to be with me".

Sonia took a taxi to hospital and the baby was delivered. Her mother in-law finally arrived in Perth, visited Sonia while she was in hospital, and brought her home with the help of Sonia's sister in-law. I asked her if her mother in-law had been helpful and whether they had a good relationship. "She was nice but she was not my mother, was she? I couldn't take her for granted. My mother wouldn't mind if I just slept and did nothing, but my mother in-law would. So, I did all the washing, cleaning and also bathing the baby. She cooked meals but I could not ask if I wanted to eat something special. My mother would cook for me with love and affection. I also could not share my feelings with my mother in-law".

Let's examine how Sonia felt. She is a woman in an arranged and loveless marriage, who risked changing her family life by having a child, as an expectant mother she hid the news of the sex of the baby because she did not want to disappoint anyone in her husband's family. She took herself to hospital and gave birth without any family support. It is almost unimaginable how much pressure she had to bear. However, her husband had changed. She knew that motherhood would be a solution for many of the difficulties she had experienced in her family. Kakar (1978:76) shows that in South Asia woman's low social status results in harsh and often humiliating treatment by her husband and his family. She is also likely to experience an unfulfilled sexual life even feel an abhorrence to her husband's sexual advances. The psychological impact of her treatment is increasing low self-esteem which Kakar argues only begins to lessen with approaching motherhood.

"I was fine. I was excited after my child was born and she was healthy. I like this change. I have had the best time ever", she replied to me when I asked about her feelings. Her married life was important to her. Whenever she compared her experiences with her husband before the baby was born to the improved situation

afterwards, her other difficulties such as delivering alone and missing her own mother became less important to her.

4.5 "I feel guilty that my fantasy has not come true"

> I feel very off. I had a fantasy that once a baby was born the relationship between husband and wife would be closer. We were very close and he used to take care of me very much. But he has changed since he has been out of a job. He is stressed, anxious, worried and always irritated, and so am I. It affects not only my love towards my husband but also my love towards my baby. Of course I love my baby, but it was not the feeling I read about or watched in the movies. Then I feel guilty that my fantasy has not come true. I feel I am not a good mother. I guess the economy has destroyed my confidence and broken the backbone of our relationship.

My purpose in including Mumtaz's story here is to elaborate the economic difficulties a new migrant mother can face. She represents the many South Asian women who suffer from economic hardship.

Mumtaz was an engineer working in Bangladesh before she came to Australia with her husband who was a geologist and had been working in Perth for six months before he went back to Bangladesh to marry Mumtaz. Before they came to Australia they had decided that they would try for a child after they arrived in Australia. However, like some other women, Mumtaz looked for a job upon arrival here. Because her Bangladeshi degrees were not recognised in Australia, her applications were unsuccessful. Within eight months Mumtaz became pregnant and stopped job searching. Meanwhile her husband lost his job when Mumtaz was four months pregnant. They became panicky and did not know what to do. They did not have many savings and they were not yet eligible to receive social security.

Her husband tried hard to find another job, got frustrated, and felt great pressure to earn money as their baby was coming soon. Then he decided to get a taxi licence and drive taxis which would provide a good income. Driving a taxi has become a popular source of income among these people from South Asia. Although taxi driving provided them

with some financial security, it did not provide them with mental satisfaction. Therefore, her husband started studying part time besides driving a taxi soon after the baby was born.

According to Mumtaz she received maximum care from her husband until he lost his first job.

> He was very supportive. Because I had severe morning sickness and nausea he used to do all the cooking and housework, and kept asking if I needed anything special. Most of all he tried to understand how I felt. Being the only child in my family, I missed my mother very much, and my husband tried his best to compensate for this gap.

Mumtaz's changed financial situation turned her life "upside down". She constantly worried about money and the growing expenses kept her awake at night. She tried to understand that her husband, who was working and studying, was too tired to help her with the housework and the baby. Her husband was also worried, anxious and upset about his career. Mumtaz's husband was often irritated and argued with her frequently, something he usually did not do. Her husband's behaviour disheartened her. "I know he is worried about money, getting a job and he is tired, but I am tired too. I have gone through all the trauma, delivery and birth that he did not. He should not be as tired as I am. I also miss my mother whose support and company I need". She admitted that she also got angry and used to argue fiercely with her husband all the time.

She complained that she became so upset that she could not feel very much towards her baby and that feeling made her feel guilty about not being a good mother. During the interview she continuously broke down and wept. She described her condition as "severe baby blues and postnatal distress" as it was defined by health practitioners. I asked her how she coped with the baby blues and postnatal distress. She said,

> Now I do understand that my husband is stressed. He is a first time father and does not know what to do. He does not have a proper job but there are increasing expenses, and he has a big responsibility. Therefore he is nervous and tense. Moreover I behave badly too. So his mood is off all the time.

Mumtaz has convinced herself that they will get over these hardships once their economic situation is more settled and her husband has a professional job.

4.6 "The Work of Culture" and Discourse

Out of fifteen South Asian migrant women I interviewed, these four women, I think, had the worse experiences during their postnatal periods. These women had been through social isolation, a lack of physical and emotional support, financial insecurity, medical conditions for either themselves or baby, and insufficient rest. These are the difficulties that are understood to be the causes of "postnatal depression". Due to their experienced difficulties, their mental condition could be easily labelled as "postnatal depression" in the West. However, I argue that the South Asian women and their understanding of suffering is "the work of culture" (Obeyesekere 1985:1990). These women who appear to suffer what Westerners call 'postnatal depression' because of their vulnerability after childbirth, despite their experiences, do not see themselves as ill or their condition as an illness.

In the next chapter, I will explore the sociocultural context for women in South Asia. The chapter will help the reader understand how and why South Asian migrant women do not recognise their postnatal negative feelings as an illness. I will examine the institution of *purda* (veil) and how the concept and practice of *purda* makes women inferior in the eye of the society. *Purda* incorporates the notions and practices of female seclusion, purity, pollution, honour, shame, power and suffering, through which *purda* ensures female subordinations. I argue that these ideas of female virtue and power are internalised and help women cope with what in Western society might be described as postnatal depression.

5 INTERNAL CULTURE, EXTERNAL CULTURE AND POSTNATAL DEPRESSION

> Don’t take everything seriously. You have to learn to laugh, otherwise you can’t survive. You have to go on with your life. I came from a third world country where we used to be under a lot of strain during our lifetime. We have so many situations we have to cope with. Moreover, in India if you are a female, you are just treated as second class; you are not a person who gets the priority. Even husbands treat their wives badly. And that is the situation we face and we have to learn to deal with it from very early ages. Because in India people do not know what PND (postnatal depression) is as a layperson, they learn to cope with it and they just learn. It is tuned out of our body and mind. We are supposed to endure hardship and we look for the solution in ourself. We work hard for the family four times more than men, but what reward do we get? I asked myself, ‘what am I going to do -- get depressed, and what? I have to get on with it, go and do the best for the children’. Having postnatal depression is a luxury to us.

The above comment is from Rani, a nurse aged 35, who was working part time when I interviewed her. She had three children aged seven, two and three months. I went to her place at ten o’clock in the morning, her best time to talk to me as she mentioned, because her baby took a nap at that time and her second child watched television and her oldest child was in school. Rani was talking to me while she was washing bottles and getting them ready to be used when her baby woke up. During our interview session she told me that after her first child was born in Europe she had a very hard time. At that time her husband was doing higher studies in medicine, and had to do part time work. She was not working because her baby was sick. They had to struggle with finances. They could not afford to buy a car, or a washing machine. According to her she was very tired of thinking of their economic situation and their future as well, and she had ‘depression’. I asked her how she coped with her ‘depression’ then. She said “ I did not know at that time that I had a severe depression until I talked about my situation to my colleague after I came to Perth”.

I begin this chapter by addressing two issues: how people internalise cultural conceptions, and how the same symptom is experienced by different people differently depending on their cultural background. To address these two issues I will explain schema theory, which I use to analyse my informants' psychological understanding about postnatal depression. I will examine the internalisation process by looking at the South Asian convention of restrictions on female behaviour, since I believe women's upbringing in that society socializes their experience of postnatal depression. The way women are socialized and treated in that society has a great impact on how they feel about their feelings.

Throughout my fieldwork and thesis writing I have brought my life experience and knowledge of South Asian culture. My commonality with South Asian women, who are my informants, is not only that I am a same generation migrant woman who gave birth in a new society, but as I worked with them, I become aware that I also share a culture that I have inhabited from my birth. From childhood through to womanhood in South Asia, I shared with these women a common language, and common symbols and structures of emotion. Now I am living in Perth, I share many of the common difficulties of being a migrant and a mother. Because I share their culture and have been through many of the same experiences myself, I feel that I have a better understanding of their emotional conventions. "If the story is in our heads before we arrive at the field site, and if it is already known by the peoples we study, then we enter the ethnographic dialogue with a shared schema" (Gergen and Gergen 1997:275).

In this chapter I use my commonality with the South Asian migrant women in Perth, Western Australia in order to present their experience of postnatal feelings. A study of this kind is known as autoethnography (Buzard 2003:61). Cloke et al. (1999:333) offer a specific definition of autoethnography which they understand as "the process by which the researcher chooses to make explicit use of [his/her] own positionality, involvements and experiences as an integral part of ethnographic research".

In their discussion of autoethnography, Butz and Besio (2004:351) argue that it provides important epistemological, methodological and political insights into both postcolonial and cross-cultural research. Berger (2001:505) further draws attention to the benefits of the autoethnographic method commenting that it not only enriches rapport between her and her participants; but also strengths the interaction between the reader and text. I

believe that the application of the autoethnographic method in my research enables me to gain the trust of my informants and thus obtain richer data.

The key aim of this chapter is to explain how South Asian women internalise social experience and cope with their postnatal negative feelings. In South Asia a woman is socialised to value and abide by South Asian female ideology, and must always be on guard to maintain the honour of her family and relatives. To examine women's socialisation process, I discuss the South Asian institution of *purda* which keeps women away from the productive sphere. The patriarchal philosophy of *purda* leads to notions of female seclusion, purity, pollution, *lajja*, *sakti*, sacrifice and suffering, which posit women as vulnerable and does not recognise their contribution to society. I also review childbirth practices at which *purda*, purity, pollution *lajja*, *sakti* and suffering are implemented. An examination of these issues makes it possible to understand how South Asian migrant women manage their mental states throughout their life.

5.1 Schema and Recognition of Postnatal Depression

> The essence of schema theory in the cognitive sciences is that in large measure information processing is mediated by learned or innate mental structures that organize related pieces of our knowledge. . . . Schemas, . . . are not distinct things but rather collections of elements that work together to process information at a given time. (Strauss and Quinn 1997:49)

Cognitive anthropologists Strauss and Quinn (1997) introduce schema theory to assist in our understanding culture as a mental construct. According to them, culture is learned at the same time as the individual's experience comes to be associated in schema. According to schema theory, individuals make sense of their day-to-day experiences through schema. When we first see a dog and it barks then we know that dogs bark. Then later if we just hear barking we can recognise that it is a dog — this is because of the schema. Similarly, when we see a woman wearing a sari and learn that woman is from South Asia then we associate women in South Asia with saris. Later if we see a sari, our South Asian schema is activated and we may assume a woman wearing a sari is from South Asia.

People are supposed to have common schemas when they share common experiences. However, because people are different for examples, each individual has unique experiences of the world, their schemas are different though they may have schemas that are to some extent similar. Let us relate this to my point about difference in the experience of the same symptoms. Many people in the world watch the T.V. show 'The Simpsons'. In a way, many people share the same experience or share the same culture, that is, 'The Simpson culture'. However, if someone with the schema, which developed within an extended family, watches 'The Simpsons', and others watch through a schema developed within a nuclear family, each will understand 'The Simpsons' somewhat differently accordingly to their original 'family' schema. For example, in most Western societies a 'family schema' is father, mother and children whereas in South Asia a 'family schema' is father, mother, children, uncle, aunt, cousins, grandmother and grandfather. Schema helps us to see and understand the world and interact with it. Schema as a concept helps us understand internalisation.

The interrelationship between the extrapersonal (culture/world structure) and intrapersonal (mental structures) is particularly significant to my study in understanding culture and human experience. In relation to the women who participated in my study, the idea of cultural schemas helps me understand how at the intrapersonal level they self-reconstruct and self-represent their feelings while experiencing difficulties after migration and birth. To illustrate this, let me provide ethnographic information about Shonali, aged 26 and mother of a two month old child. Shonali's story is similar to many of my participants whose husbands are geologists, but who have now had to turn to taxi driving to provide an income for their families.

> When Shonali was six years old, she lost her mother, followed by her father four years later. Since then Shonali and her sister, who was not more than five years older, were raised by their uncle and educated in a boarding school. Shonali came to Australia three days after she finished her undergraduate degree to join her husband who is a geologist who migrated here three years before he married Shonali.
>
> Shonali used to stay at home alone when her husband had to go far away for his work at the mining site. Sometimes he was away for twenty days or more. When Shonali became pregnant, her husband tried to find a job in the

> city but could not get one. So he quit his job and started driving a taxi, so that he could be near his wife when she needed him. However, since her husband worked at night Shonali was left at home alone during the night. She missed being able to share her feelings with her sister. After her baby was born she also wanted to have her sister who could help her with the baby and the housework, so that she could get the rest she desperately needed.
>
> She did not get help from her husband as he worked at night and slept during the day. Moreover, she did not get emotional support from her husband because he thought "Shonali did not have any problems with the pregnancy and birth so she must be fine". Shonali said: "I felt miserable when nurses kept telling me that I was going through a problem called postnatal depression and suggested I see a doctor or a psychologist. Yes, I suffered a lot, I was always irritated, feeling bad and could not stand anyone around me. Maybe the nurses were right — I was depressed. But it is not the point. I went to a psychiatrist, but without talking to me enough, or really checking me, he gave me medication. I did not have a disease, so I did not take the medication and did not go to see him again. I only wanted my sister here who could understand me. I convinced myself that my present situation was absolutely nothing compared to the hard time we went through after our parents died. If I could cope with that I could deal with my new situation. If I die, my children will experience the same suffering I suffered and I can't bear that. So I have to be strong to serve their needs.

The cultural constructs of depression as perceived by nurses in the Anglo Australian public sphere differ significantly to Shonali's self-representation of her feelings. Even though Shonali accepted that she was 'depressed' as the nurses told her, she felt this was not a disease. The word 'depression' and the associated 'symptoms' remain but because of the way she represents her condition to herself, the meaning is changed. The schema of suffering Shonali developed from her childhood experience, differed from the nurse's schema of suffering or depression.

Now let me turn to a more specific discussion of women's status in South Asia as a background to how women are socialised. This will give you a better understanding of

how South Asian women perceive postnatal depression and how they feel about their feelings.

5.2 Looking Through the Lenses: *Purda*, and Female Virtue

In South Asian society, a woman's identity is entirely defined by her relationship to others: first she is a daughter to her parents; second, she is a daughter-in-law to her husband's parents and wife to him; and third, she is a mother to her sons and daughters (Kakar 1978:56-57). In this society, female participation in the economic, social and political realms of power is greatly restricted. Women are generally domestic workers, not employees. However, Rozario (2003:121) makes the point that the present day expanded education system has increased female attendance in secondary and college education and that there is a growing number of non-government organizations which are helping to increase women's participation in the economy, and giving women more opportunities to go to out and to work more regularly than ever before. Rozario also reports that many women in Bangladesh are only working to help pay for their dowry or out of economic necessity, and they are required to stop work upon marriage or as soon as their economic necessity has lessened. This pattern is essentially the same in Pakistan where Mumtaz and Shaheed (1987) did their study on women's status in that society. They say that in Pakistan,

> the attitude towards women as inferior beings is visible from the birth of a girl, which is greeted with guilt or despair on the part of the mother, shame or anger on the part of the father, and the general concern and commiseration of the entire circle of friends and family. . . . The embryonic woman is seen by all classes and in all regions in Pakistan as a liability and social burden. A woman's assets are calculated only in terms of their power of reproduction, and as an object of sexual satisfaction" (Mumtaz and Shaheed 1987: 23).

In Pakistani society women are considered "useless" because the women do not contribute to the family's economy (1987: 28). Mumtaz and Shaheed argue that the key element which makes them 'useless' is *purda* which not only prevents women from getting an eduction and employment, but also restricts them from seeking health

practitioners. They report *purda* as constructing women in such a way that they are seen as being less valuable than men and their sicknesses having less of a priority.

5.3 *Purda* and Femininity

This section provides a way of understanding the schema of *purda*, and describes how this schema shapes women's mental states in South Asian society. One method of excluding South Asian females from economic, social and political spheres has been through the institution of *purda*. *Purda*, literally means curtain, and refers to the practice of female seclusion. It suggests that women should stay at home. In Rozario's (1992) ethnographic research on women's status and social change in Bangladesh, she says, "In the strictest sense [*purda*] involves keeping women confined within the home and covering them in veils whenever they venture out of the home . . ." (1992:88). She observes that the separation of the worlds of men and women is a major aspect of *purda*. *Purda* represents as an honour for women in South Asian culture although the degree of *purda* observed by a woman is determined by her age, class, culture and religious background. In wealthier households, women tend to be in stricter *purda* than women in poorer households. Muslim women tend to live in much stricter *purda* than Hindu and Christian women. *Purda* is a sphere of validation for women, providing a base of power from and within which they can act. However, the women's position and power (the institution of *purda*) is still contained within a patriarchal system. The apparent contradiction between *purda* as both female seclusion and female honour reflects a broader feminist sociology (Martin 1986:245) which argues that the domestic sphere is both the source of female power as well as a cage that restricts women's power.

High illiteracy is associated with female labour participation in the economic sphere. In their study of North Indian societies Jeffery, Jeffery and Lyon (1989) reported that because girls are brought up for inevitable marriage and therefore destined to perform housework, school attendance has less relevance for them. Girls' schooling stops as they reach puberty. In contrast, boys are encouraged to continue their schooling. The net result has been to further limit the options open to women in terms of job opportunities. Because women have such low levels of education, it is nearly impossible for them to be employed. If they get a chance to do some paid work their lack of education results in them being employed in the least satisfying, least well paid and least upwardly

mobile jobs. Jeffery and Jeffery (1998:131) found that in wealthier families, girls are educated to perform their domestic obligations perfectly and to raise their children correctly, therefore, wealthier families prefer girls to attend school, but no one expects schooling to prepare girls for employment; girls are educated for marriage, not for job chances.

A small number of studies have attempted to analyse the changing gender roles among South Asian women before and after migration. Baluja (2003:49) finds that migration does not necessarily remove the traditional gender roles, and earning money does not necessarily give woman autonomy. She writes, "Migration may move a woman from the private female sphere to the public male sphere. However, after migration, . . . women may be required to maintain their traditional, private roles as mothers, wives and household workers even though they may now work outside the home" (2003:49) a situation not unlike that of many Western women (Lorber 1994). In her study of Bangladeshi immigrants in the United States of America, Baluja observes that women have traditional, conservative attitudes towards themselves. For example, her female participants acknowledged the value of female virtue and that housework was a female's duty. Baluja's participants also believed that women's mobility should be curtailed to protect her honour and reputation (Baluja 2003:135).

My findings are similar to Baluja's study. Working outside does not necessarily involve a reduction in the household work expected of women. People in the Perth South Asian community still believe that the social interactions of women should be limited and act on this belief. In this community a mother, especially one whose daughter is approaching adolescence, becomes worried that her daughter might be too 'Aussie' (a colloquial term for Australian) and will break the cultural norms. Thus she tends to get her married as soon as possible to a boy from her home country. Though migration has affected the kind of clothing South Asian migrants wear, it does not necessarily remove the notion of *purda*. While many South Asian men wear shorts, many women continue to veil to protect their honour and their reputation. However, the notion of *purda* is not restricted to only covering women's body, but it is also manifested through how they talk, how they behave, even what they eat, what they believe, whom they marry and so on. Drinking alcohol is disgraceful for many South Asian women while it does not dishonour South Asian men's reputation.

5.4 Female Pollution

Pollution which is associated also with *purda* is a major topic in the sociology of South Asian society. South Asian culture stresses the idea of pollution in terms of female sexuality. There is much debate in the anthropological literature on South Asia about the nature of the relationship between the conceptual axes of purity/pollution and auspiciousness/inauspiciousness (see Madan 1991 for the debate). It is not my intent to look into the details of these debates here. Rather, what is interesting to me is that it is assumed (Madan 1991) that the notion of female purity and pollution comes from pan-Hindu ideology. I argue however, that the conception of purity and pollution is expressed, experienced and practised with little variation by all female populations in South Asia regardless of religion. I believe that the obsession with female sexual purity is a manifestation of masculine control over female sexuality and that it can be found in every human society (Dickemann 1981:422).

In South Asian society, sacred creeds are used to justify and emphasize female subordination through *purda* and feminine modesty. For example, in the Quran it is said that men are in charge of women as Allah has made men superior to women, and so good women are obedient (Ali 1973:199 and Pickthall 1954:83). According to Gupta (1988:43), Hindu law considers women as the weaker sex, and physically, temporally, morally, spiritually and religiously incompetent. Hindu women never seem to have had equal status with men. The concepts of female sexual purity may derive from a Hindu idea, but the concept and the practice of *purda* comes from Islam. The Quran tells women to "lower their gaze and restrain their sexual passions, and not [to] display their adornment except what appears thereof" (Ali 1973:685). Their head-coverings should cover their bosoms (Ali 1973:685). In South Asian society, Hindus and Muslims share and practise this ideology and Christians are influenced by this concept.

On the basis of fieldwork in Bangladesh, Rozario (1992:184) argues that the Bible highly values women's virginity before marriage and fidelity afterwards which indicates that similar ideas about female sexuality are not foreign to Christian thought. According to Rozario, the notion of purity and pollution play an important role in legitimising and maintaining Bangladeshi Hindu, Muslim and Christian gender and status hierarchies. She mentioned that having a pure status as a woman is often related to wealth and a good relationship with god. Menstruating, pregnant or recently postnatal women are seen as so polluted that they are not permitted to have sexual contact with their

husbands. Rozario found that postnatal women are not allowed to cook for others and are prohibited from any religious activities during that period. Female purity and pollution are integral to *purda*, which controls female sexuality and insures the protection of female virtue.

Childbirth and pollution

> I shaved my baby's head when he was forty days old. This is dirty. Baby's fingernails and hair that he has brought from inside his mother's tummy are not clean. So on the fortieth day I shaved his head and cut his fingernails.

This statement is from Marufa who believes that a baby's birth hair and nails are polluted and who considers that the forty days after delivery are a polluted period. Although I have not found any literature talking about shaving a baby's head, many scholars mentioned birth pollution in South Asia. Hollen (2003:194) did note, however, that a mother's and her baby's first head bath is undertaken within a certain period after delivery.

The way in which childbirth is managed in rural South Asian society whether Hindu, Muslim or Christian, is similar, though there are small varieties depending on religion, region and class. The typical South Asian pattern includes strict rules regarding confinement and diet. As Rozario (1998:151) pointed out, postnatal Hindu women in Bangladesh are supposed to be confined for thirty days, whereas for Muslims it is five days in the case of a female child and six to seven days in the case of a male child. Christian women experience a fifteen days confinement period, after which the baby is baptised. During this confinement period, postnatal mothers are not allowed to go out especially at night time; nor are they allowed to cook or do any rituals. These practices do, however, vary from class to class. Poor women and women in nuclear families find it difficult to follow these rules and they tend to go back to their normal routine much earlier than they are supposed to. We can see a similar pattern in Hollen's (2003:194) study in Tamil Nadu, India, where Christian and Hindu women have thirteen days of confinement following delivery, but Muslim women's postnatal confinement does not come to an end until the fortieth day. Again it is a slightly different among poor families.

Rozario (1998:151) suggests that confinement is due to the idea of birth pollution. She notes that Hindus build a separate hut for delivery due to pollution and although

Muslims and Christians do not build a separate hut, they try to give birth in a separate room. Jeffery et al. **(**1989:106**)** who study in parts of North India find a similar idea of pollution:

> Childbirth pollution is the most severe pollution of all, far greater than menstruation, sexual intercourse, defecation or death. Consequently, touching the amniotic sac, placenta and umbilical cord . . . and delivering the baby, cutting the cord and cleaning up the blood are considered the most disgusting of tasks.

In contrast to Jeffery et at, but similar to Hollen (2003), Kalpana Ram (1998) found among Christian fishing communities in Tamil Nadu, India, that pollution is of less significance in childbirth. Ram mentions that pollution is associated with birth, menstruation and death, and that the blood of birth is considered as polluting as the postnatal period and menstrual blood. Hollen emphasises a mother's vulnerability. She found that a Tamil mother is considered to be vulnerable for as long as she bleeds heavily, therefore her postnatal rest and diet is given a greater emphasis than a concern about impurity. Hollen observes that in Tamil Nadu, the end of the postnatal blood flow is marked by a ceremony where the mother and baby are given their first head-baths. When the ceremony is held depends on religion and class. She says, "It becomes clear that the meaning of the ceremony and of the [removal of pollution] was more concerned with a rite of passage out of a state of extreme vulnerability of the mother and newborn's health than with the vulnerability of [the] . . . space" (Hollen 2003:196).

Many women in my study have experienced confinement as a matter of pollution. However, as immigrant mothers they could not afford to be confined and rest for a certain period according to their custom. They could not stay away from cooking or doing other household duties since they did not have any other relatives to do it for them. However, many mothers stopped themselves from going to church, mosque or temple, and/or engaging any other religious activities for a certain period after delivery. They reported that to do such religious activities after delivery would mean they were not following their custom and hence would be dishonourable. They believed they were not clean enough to do any ritual or even touch their religious holy books. Some women even celebrated the end of pollution by shaving their baby's head or by taking their

babies to a temple to do a special worship. By not doing religious activities for a certain period after delivery these women maintained their honour and *purda*.

Dai, the pollution remover

Birth generally takes place at home in rural South Asia and is attended by female relatives who provide physical and emotional support to the mother through sharing knowledge and experiences of traditional birth. The participation of a *dai*, the traditional midwife, in the delivery is also crucial. Women's preference to be attended by a *dai* rather than going to the hospital during childbirth is due, I believe, to the cultural notion of *purda* and pollution. My belief is supported by Islam's (1989) work in Bangladesh in which she argues that homebirth attended by a *dai* is preferable to going to hospital because of *purda*. Islam describes an incident when a *dai*, in spite of using all the techniques she knew, failed to deliver the baby. By the time the village doctor was called the mother was unconscious. The doctor said that because the baby was dead he would have to cut it out of the woman's body. Islam noted that the family members agreed because "this was still better than taking the woman to the urban hospital where violation of the *purda* was inevitable" (1989:233). Islam mentioned that it took four days from the time the *dai* arrived until the baby was removed from the mother. The family were prepared to go though this ordeal because both the mother's life and the family's reputations were saved.

While conducting her ethnographic study of birthing conventions in a rural Bangladeshi village, Afsana (2003) found that Bangladeshi women are expected to remain silent during birth. Silence is regarded as an essential criterion related to their notions of *purda*, and help maintain physical and mental strength. Afsana says "mind/body unification and embodied experience" play an important role, providing a woman with the sense of being an active participant in her own labour event (2003:10). The reason why the attendance of a traditional midwife is essential for rural Bangladeshi mothers is, as Afsana (2003) explains, because the birthing mother and her family trust the *dai* and depend on her to maintain *purda*, provide traditional birthing skills and play a supportive role in facilitating the birth process. Afsana and other researchers such as Jeffery et al. (1989), Rozario (1998) and Hollen (2003) have observed that hospital is not only seen as expensive for poor people, but also medical practitioners are regarded as being insulting and arrogant towards rural people in South Asia. Hospital is where

violation of *purda* is inevitable. The unfamiliar environment of the hospital makes birthing mothers feel insecure. The authoritative stance of Western trained obstetricians, which predominates in the hospitals in Bangladesh, makes birthing mothers feel inactive and unimportant. Moreover, the doctors seem to have little regard for the mother's achievement. Afsana claims that health professionals fail to understand the cultural norms or meet the expectations of rural Bangladeshi women. Therefore, most of them remain distant and adhere to cultural birth practices.

Although, *dai*s lack expertise in Western medicine and there is a high rate of maternal and infant mortality when the traditional birth system is followed, the *dai*'s presence means that the birthing family can maintain *purda* and are not fearful of losing their honour. The *dai*'s participation is also important because as Jeffery et al. (1989:108) and Rozario (1992:149) point out, the *dai*'s function is centrally concerned with the removal of defilement. As a delivering woman is considered polluted, her family needs someone like the *dai* to cut the umbilical cord and to clean up the mother's blood so that they are not polluted by direct contact with her.

5.5 The Postnatal Mother and Strict Dietary Rules

In addition to confinement for a certain period of time, the ideology of birth pollution puts restrictions on the postnatal mother's diet. There are similarities in postnatal dietary practices between rural Bangladeshi and South Indian women. It is believed that the umbilical cord of the baby remains raw for some months and therefore breastfeeding Bangladeshi mothers are instructed to be very careful about what they eat (Rozario 1989:154). Similarly South Indian mothers are also expected to follow strict dietary rules to ensure a steady flow of 'dirty' post partum blood (Hollen 2003:169).

Hollen (2003) found that rural South Indian mothers are not supposed to eat at all for the first three days following delivery. After the three day fast, mothers are slowly introduced to certain kind of foods which are believed to enhance mother's milk. This food is basically made out of rice since rice is a highly valued food in South Asian culture. Fish, meat and some kinds of vegetables and fruit are proscribed as it is believed that bones and seeds will pass through the mother's milk into the baby's stomach and make them sick. Thus fish, meat, vegetables and fruit with seeds are excluded from the mother's diet. Like South Indian mothers, Bangladeshi mothers also

avoid fish and meat and their diet is also concentrated on rice products. The dietary rule is essentially the same for the rural North Indian mothers (Jeffery et al. 1989). Ironically, in taking careful and proper care of the new mothers, their families are inadvertently make women during pregnancy and immediately after childbirth poorly nourished at least in rural poor families.

5.6 *Lajja* and Internalising Cultural Values

"[*Lajja*] is a state of consciousness that has been baptised in South Asia as a supreme virtue, especially for women, and it is routinely exhibited in everyday life" (Shweder 1993:426). South Asian *lajja* may appear at first glance to be similar to Anglo-Western 'shame' or 'embarrassment'. However, the manifestation of *lajja* might better be said to resemble the way Anglo-Westerns show 'gratitude' or 'loyalty'. A direct translation of *lajja* might be shame, however, *lajja* is a more complex ideological construct, having both positive and negative association. Some scholars have chosen to use the term *izzat* or *ijjat* (Islam 1989:233; Rozario 1992) to refer to the honour/shame unification, which is seen as an important component of *purda*. *Purda* controls the spatial mobility of women and the norm of *purda* is maintained through the ideology of *lajja*. This aspect of femininity is implicated in the values of South Asian society and the socialization of its female children. The idea of *lajja* is reflected in the training of a female child's social behaviour, as little girls slowly internalise the model adult behaviour of their women elders.

When a girl grows up, say, with a single brother, she is not supposed to behave like her brother; the maternal attitude towards a daughter's behaviour is different. A girl is taught not to talk loudly, not to climb a tree like her brother and not to play "boy's sports" like football that require physical activity. *Chi* is the typical South Asian expression used to describe the lowering of someone's self-esteem. For example, a mother's reaction towards her daughter who behaves like a boy is to say '*chi*'. She would say, "*Chi*, you are a woman and you should not play with boys", and then she would add "What a *lajja*," another expression which signifies loss of respect. Her mother dins into her daughter's ears certain ideas such as *lajja*, which make for harmony, at the expense of sacrificing the daughter's will. The internalisation of *lajja* also presupposes that the virtues of self-sacrifice and self-effacement is embedded in the feminine role in South Asia. *Lajja,* "an impression of [a woman's] sexual status is often

formed from her day-to-day behaviour – how she walks, dresses, handles her hair, as well as how she behaves with her family, neighbours etc" (Rozario 1992:85). Obeyesekere (1985) discusses the use of this expression in Sri Lanka. Behaviour in opposition to social customs brings shame to the family, thereby lowering prestige. Alternatively, in a positive connotation, having *lajja* ensures that a person, especially a woman, will conform to social customs. *Lajja* represents the self-management, self-respect and honour of a woman who follows the culture's values.

Self-control, silence and modesty are recognised as very important qualities ensuring female virtue and this forms *sakti*, the female power, which I will discuss in detail later in this chapter. The seed of *lajja* is sown in Indian Hindu ideology where *lajja* represents *sakti*. According to Menon and Shweder (1994:277), in Indian Hindu ideology, woman is the creator of the universe, as well as its destroyer. Hindu ideology recognises woman as having the power within her to sustain or destroy the social order. At the same time, uncontrolled power is destructive and immoral, and therefore, Indian Hindu morality requires self-control and self-regulation. Menon and Shweder demonstrate how this ideology is reconstructed by Indian patriarchal society. Male dominated Hindu culture suggests the most moral way to control one's power is through the emotion of *lajja*. To have a sense of *lajja* is to be conscious of one's duties and responsibilities, to persevere in the performance of social role obligations, to continue commitment to the maintenance of social harmony. *Lajja* is described as an expensive and gorgeous piece of jewellery worn by women. To summarise, *lajja* requires self-control, silence and modesty, important qualities which ensure female virtue and which constitute female power.

Because *lajja* ideology teaches that women rather than men have natural power, it is primarily women who need to exercise control over their power and it is they who have to develop their capacity to experience *lajja*. *Lajja* has the same ". . . linguistic stem [as] a local plant (a touch–me-not) that is so coy that it closes its petals and withdraws into itself at the slightest contact" (Menon and Shweder 1994:278). Every time a woman draws a *purda* across her faces to avoid contact with avoidance relatives, generally her father in-law, husband's elder brother and men with whom she does not have any relationship, she shows *lajja*, evidence of her modesty and obedience to the social norms. Thus *lajja* is both power and virtue.

5.7 *Sakti*, Suffering and Labour Pain

Sakti, female power, is located primarily in women's reproductive capacities. In South Asia, women are said to have inner strength due to their ability to withstand the strain of childbirth. Women's ability to suffer pain is said to be *sakti*. Women are thought to derive their power from the patience and determination required to endure the pain of childbirth and the sacrifices of motherhood.

In her study of a Christian community in Tamil Nadu, Ram (1998) mentions that Hinduism has long been inflected by the notion of love and suffering. In Hinduism, salvation occurs through the path of love and suffering, and by suffering one learns to control one's own ego and desire in order to experience the joy of transcendence or salvation. This Hindu idea of love and suffering, as Ram notes, also helps orientate Tamil Christian women towards the idea of experiencing birth as love through suffering and abjection. She writes,

> . . . women's perception that the pain and suffering of pregnancy and birth are somehow connected intrinsically to the emotional qualities of femininity - patience, endurance and love - links them to the specifically Catholic attributions of the worship of the Virgin Mary (1998:134).

A concept identified as key in some studies of the relationship between *sakti* and suffering in the context of labour pains in South Asia is that of *tapas* (Hollen 2003:119, Egnor 1980:17). As Egnor explains:

> The power acquired through suffering and servitude is a special case of the Hindu theory of tapas, whereby through certain forms of self-denial (called tapas) the individual accumulates a certain internal heat (also called *tapas*). The longer and more harsh the suffering, the greater the heat accumulated. This heat may be used, but unless it is spent in sacrifice, another form of self-denial, it is lost.

So, *tapas* is the bodily experience of internal heat from suffering as well as the *sakti* derived from the heat. This notion of self-inflicted suffering and internal heat can powerfully motivate women to suffer — a performance of their female *sakti*. Some women I met proudly mentioned that, in spite of the insistence of doctors and nurses,

they had not taken any anaesthesia during delivery. Nahar, aged 29, had delivered her first baby a week before I met her and was very eager to tell me about her experiences.

> Shortly after her husband, a geologist, found a job at a mining site far from their home, Nahar became pregnant. They had delayed having children because they wanted to be established financially in Australia first. Nahar, who had been trying to get work, however, found it very hard to get a job because her overseas Bachelor degree was not recognized in Australia and she also could not speak English well. She had taken some childcare courses and had done some unpaid work in a childcare centre. After her husband got a job, they did not want to wait any longer for children because they thought 'they were getting old'.
>
> She began having her first contractions in the afternoon. She rang the hospital and was asked to wait until the pain got severe. Because the pain was getting stronger and stronger, her husband took her to the hospital in the middle of the night, where she was examined and told that she was not sufficiently dilated. She was then sent back home with the suggestion that she take a long hot bath to help her cope with her pain. In the morning because the pain was still severe she returned to the hospital. This time though she was still insufficiently dilated, she was admitted to the hospital. She was offered drugs to reduce the pain but she refused. The next morning she was fully dilated, however, she was too tired to deliver her baby. The doctor told her to have anaesthesia as they were going to do a caesarean. Nahar, instead of taking drugs, gathered 'all her strength and power together' and finally had a 'natural birth' with no anaesthesia. I asked her why she had refused to take any painkillers when she had the option and she said, "There is no credit in giving birth without suffering pain. How can I be a mother if I cannot endure the pain of labour? Being a mother is not an easy task, you have to suffer pain.

Nahar was not the only one who thought that suffering labour pain is something a mother should experience. Another woman explained, "All that pain vanished on seeing my beautiful child. It was worth suffering pain". One women who took an epidural expressed her guilt for not coping with the pain and said:

> What a shame that I am a mother and do not know how severe the pain can be. I could not go through the pain because I was induced and my doctor told me that induced pain is more severe than normal labour pain, thus I was scared. Besides, I had lots of option to relieve it. If I had been in Bangladesh and if I did not have that option I would have experienced the pain. Well, next time I will not have an epidural.

Hollen (2003:121) argues that women in South Asia are often described as "valiant and powerful" but that is not to say that they are always given the respect that such qualities might demand. In fact, these constructions can continue women's subordination. Women themselves are keenly aware of this. In South Asia, men are not permitted to be present during either home births or public hospital births. My findings here are similar to what Hollen (2003:121) found doing research in rural South India. Birth is considered so much the exclusive domain of women that sometimes husbands were not even informed that their wives were is labour and only came to know after the baby had been born. Nahar and Parul appreciated the Western custom, and made their husbands be present during the delivery. They said, "It is very good. Only then husbands can realise how much we suffer to give a birth. Only then they would respect us when they see how much *sakti* we have."

These women obviously did not seem to be worried when they were induced. Their *sakti* was not threatened by drugs, which accelerated labour pain. They did not feel guilty if they were given drugs to increase the pain instead it was only when the drug was used to reduce the pain, the women were scared of losing their female power. I do not want to debate whether or not women should take anaesthesia to reduce their pain when the option is available. I will mention, though, that administrating anaesthesia to reduce pain can be as dangerous as using some other stronger oxytocin drugs to accelerate labour. Hollen (2003:113) reports that no matter how dangerous it is, in hospital births and even in home birth in Tamil Nadu using the drugs such as 'epidocin' and 'sintocin' which accelerate labour is getting more popular.

Intervention by drugs during delivery is an area of biomedicalisation of childbirth into which I do not intend to delve. Instead, what is interesting to me is that, in South Asia, the cultural notion of female power and the local construction of the body have such a strong impact on how South Asian women perceived the administration of drugs. The

invention of techniques to increase labour pain such as herbal medicine, coffee and soda-based drinks (Hollen 2003:124), sanctified water, amulet and homoeopathic medicines (Rozario 1998:145), and soaking the abdomen of birthing women with oil (Islam 1989:233) is becoming more prevalent. These multiple techniques are used to increase labour pain, but techniques for reducing pain were not mentioned.

The following conversion is with Bina, a civil engineer, who thought that she had not fulfilled her requirement to become a good mother because she had had a caesarean delivery.

> Me: How was the delivery?
> Bina: Oh! The delivery was caesarean. I did not feel anything, just lying down. Because they gave me anaesthesia, I could not feel any pain. I even did not feel the cutting of my abdomen.
> Me: Did you like the caesarean delivery?
> Bina: No, not at all. I had been preparing for a normal delivery, and practising all sort of things like breathing and feeling contraction pain. I had a fantasy of a normal delivery. Both my husband and I went to the antenatal classes and practised all the things like contractions, massage and everything. I was expecting a normal delivery, but when they told me I would have to have a caesarean delivery I was crying. It was shocking for me.
> Me: How did you feel about it?
> Bina: As I said, I was shocked and I cried. If I was in India I am sure I would not have got any information about normal delivery. There they don't give any information. I know from my sister in-law's experience. She told that she did not know what was going to happen. She did what doctors told her to do. Here I got all the information about normal delivery and I was preparing for that. I was depressed that I could not go for the normal delivery.
> Me: Why do you think that you were depressed?
> Bina: I cried a lot. Well it happened after three days like crying, feeling down. I was told that it was hormonal and was meant to happen. I was depressed because I could not have a normal delivery. I was ill, could not do

anything and felt helpless to look after the baby properly. I was so depressed that I was not sure if I was a good mother.

Me: How did you cope with it?

Bina: Well I was depressed and cried, but finally I accepted it. What could I do if I was not safe for a normal delivery? At least it was good that both my baby and me were safe and sound.

Nahar's seeming desire to suffer pain derived from her desire to emulate mothers of films and novels who became martyrs through suffering and sacrificing. She mentioned her desire and was thrilled that she was going to experience in actuality what she had only experienced in literature. Nahar felt inadequate and "depressed" because she lost what she saw as her opportunity to experience the sacrifices of motherhood and the feminine values articulated in poetry and many traditional novels. She was also "depressed" because she missed her chance to show solidarity with the fictional women she identified with, and to feel proud of herself by suffering.

5.8 The Poetics and Discourse of Suffering in South Asia

The appeal to female characters in ancient South Asian literature plays an important role on women's acceptance of feminine virtues and feminine roles in their life of suffering. Sadness and suffering are rooted in a vision of the tragic which is articulated in religion and social reality. Hardship and suffering are expressed through traditional rituals, popular beliefs, poetry, films and novels. Through all these channels, South Asian women are taught that enduring suffering and misery is what earns them honour and reputation in the society.

Suffering in religious literature

The role of suffering in the Ramayana, a Hindu sacred text, is influential. Sita, the classic example of wifely devotion, and the heroine of the epic, personifies the ideal woman. Sita, the wife of Prince Rama of Ayodhya, symbolizes sacrifice and suffering. As described in Robinson (1999:91), Sita accompanied Rama who was exiled to the forest at the behest of his stepmother, and was abducted by Ravana, the demon king. Then an epic battle took place. Ravana was killed and Sita was rescued, put through a fire ordeal as a test of her chastity, and brought back to Ayodhya. Some time later,

hearing gossip about taking back his unchaste wife, Rama decided to send Sita into exile. When the exile period was over and when she had to face a second chastity test, an infuriated Sita decided to disappear from the earth forever and did so. By doing so she became a martyr.

In novels, poetry, and especially in women's songs in their everyday life, Sita stands for a symbol of the sacrifice and suffering that is seen to be inextricably linked with womanhood (Sen 1999:218). Sita shows dignity, self-control and infinite forbearance which are seen as woman's greatest virtues. She becomes a glamorous form of suffering and thus a winner even when she loses. Women all over the subcontinent share Sita's life, experience the same values and show a great deal of commonality. "In the women's folk tradition in [South Asia] never mind where you are, which century you belong to or what language you speak, you are all sisters in sorrow" (Sen 1999:201).

In many Muslim societies, grief and suffering are a part of religious belief, and the articulation of tragedy, guilt and grief are tolerated and expected. Pain, suffering and hardship are emphasised as a measure of faith in God. It is said in the Quran:

> We shall certainly try you with something of fear and hunger and loss of property and lives and fruits. And give good news to the patient. Who, when a misfortune befalls them say: 'surely we are Allah's and to Him we shall return (Ali 1973:65-66).

The Quran also states that those who persevere will be rewarded by God - "Only those who persevere will get their reward measureless" (Ali 2001:392).

In my ethnography not many women directly referred to reading about suffering in religious literature, however, many of them respond to their difficult situations by saying "probably that's what God wills", or "there must be a reason behind this and God knows everything". This suggests that the culture of these women, in particular, the religious belief they practiced and internalised, interacts with their birth experiences and affects their response to it.

Good et al. (1985) also examined the interplay of cultural themes and the positive valuation of dysphoria in contemporary Iran, where they say sadness, grief, distress,

tragedy and suffering are anchored to the Iranian ethos. These emotions are integral to Shi'a religious culture and popular literature (1985:395). They begun their research by focusing on the Shi'a popular passion play and the tragedy of Kerbala where Imam Hussein's death at the hands of the Sunnis is the core vision of grief and sacrifice as a religiously motivated emotion. They found:

> The commemorations of this central religious event are associated not only with grief and modulated sadness but also with a paradigmatic cluster of emotions: guilt and repentance, righteous anger, and these fused in identification with the martyred (1985:387).

Like South Asian women, according to Good et al. Iranian people explicitly and positively interpret their experience of loss and sadness in relation to the suffering of the community of martyrs. Thus, weeping for Hussein is perceived as a sign of Muslim sincerity, and the emotional experience marks the height of Iranian Shi'ism.
Good et al. state, "Tragedy, injustice, and martyrdom are central to Iranian political philosophy and historical experience. 'Dysphoric affect' is thus not equated with simple unhappiness in Iranian culture; it has profound religious and personal significance" (1985:384). They have noted that the experience of melancholy, sadness and depression is rooted in two contexts in Iranian culture: one is connected with an understanding of self. The other is associated with an intense Iranian vision of the tragic, expressed in religion, romance, social reality and history. The authors suggest that this vision is articulated through the Islamic tradition of mourning rituals, epics, films and poetry.

In this study, Good et al. have used this understanding of dysphoria in religious discourse as the framework for examining clinical depression among Iranian immigrants in the United States. In talking of 'dysphoric affect', they quote one of their informants: "People in Iran are *ghamgin* [sad]. . . . They cry easier than they laugh. It's because of the culture. . . . We say if people have an easy laugh, it is because they don't understand that life doesn't have a point to it. We understand tragedy better" (1985:397).

Certainly, the preceding section demonstrates the importance of suffering in people's conceptions of life, and we have seen how religion feeds this view. A few of my non-Shi'a Muslim informants explained to me how sadness, tragedy and other

manifestations of suffering were important to them. The ideology of suffering set them apart from non-Muslims. This would be an interesting subject for a comparative study of different religious communities in South Asia, but is not a topic I can pursue here.

Like Iranian emotional conventions, giving social meaning to dysphoria has also been observed among South Asian women in Grima's (1992) ethnography of Paxtun emotional conventions. Studying Afghan and Pakistani women in Pakistan, Grima observed the intensity of woman's suffering through the experience of *gham*: sadness, sorrow, loss and grief (1992:11). According to Grima, Paxtun women's whole identities revolve around *gham*, and their emotional style is that they cannot express any deep feelings publicly, except through *gham*.

Grima shows that Paxtun women use knowledge of *gham* to explain and justify themselves through their cultural expression. "*Gham* is perceived here as an experience of personal depth, a highly valued experience of affect that gives women status and makes them worthy of having their stories listened to" (1992:13). In her research, Paxtun women acknowledge their life as a series of incidents of *gham*, and they willingly offer life stories comprised of suffering. The Paxtun women get rewarded with admiration and respect if they express the suffering as silent sorrow. Full expression of sadness is perceived as a source of honour for a Paxtun woman. Once again, articulations of sadness, grief and suffering (depressive affects) are attached to the ideology of Paxtun women: "*Gham* is an imperative in the feminine world view of Paxto" (Grima 1992:141).

As Grima and Good et al. argue for the Paxtun and Iranian contexts respectively sadness and suffering are associated with social competence as well as personal depth. This is not a case of culture creating a particular emotional response, rather "convention promoting certain emotives over others . . . [and] these emotives strongly influence individual emotion". (Reddy 1997:334). The importance of Reddy's proposition to my thesis is that it helps explain how South Asian women might experience the postnatal anguish differently from Western women.

5.9 Internalising Postnatal Depression

> "Internalised representations are typically not precisely stated rules but are loose associative networks that enable flexible reactions to the particulars of any given event" (Strauss and Quinn 1994:285).

A young girl silently observing her mother and other women in South Asian society, internalises a schema of *lajja*, which articulates purity, faithfulness, self-control and submissiveness as important aspects of femininity, and the appropriate response to most events. And so, by the time her turn comes to perform *lajja*, especially after puberty, marriage and childbirth, the grown female child is socialized, and knows exactly how best to fulfil expectations of her behaviour and attitude. Thus South Asian cultural upbringing and ethical understanding have taught the women in my ethnography not to embrace personal angst or discomfort. These women have developed a sense of self-control which prevents them from asking for sympathy whenever they feel personal angst and stress.

> The generalizations that constitute [the] separate understandings . . . could, in turn, be modelled as patterns of strong connections among units for the sights, sounds, smells, and so on that go together in our experience of each of these, on down to fine-grained features of experience (Strauss and Quinn 1994:286).

The external culture becomes the women's internal culture, they internalises feelings that womanhood is nothing to rejoice in. Their emotive grows more intense with each stage of growth and development until motherhood.

Kakar's (1978:66) use the term "inner world" gives a better understanding of internalised schema and emotive. According to Kakar, an Indian girl gradually incorporates into her inner world ideas and practices associated with being a good woman. He says that an Indian girl, during her puberty, becomes aware that in her culture she is considered inferior to a boy. This discovery may damage her self-esteem. However, Kakar suggests that things such as her mother's training in femininity, popular songs and literature which feature ideal women help mitigate any blows that she may feel to her self-esteem. Kakar further suggests that if suddenly at an early age a

young girl's self-esteem falters, she becomes more submissive, docile and self sacrificing to gain her family's love and approval. "In order to maintain her family's love and approval, the 'narcissistic supplies' necessary for firm self-esteem, the girl tends to conform, and even over-conform, to the prescriptions and expectations of those around her" (1978:62). This is the way she compensates for any feelings of low self-esteem and, according to Kakar, this is an unconscious process.

Thus, I argue that the strong connections between cultural expectation and internalised womanhood results in the South Asian migrant women having experiences of that are called 'postnatal depression' in Western medicine. In South Asian society where women have to deal with so many difficulties, they recognise 'postnatal depression' as nothing but another aspect of life, thus its impact is minimized. In the next chapter, I investigate how South Asian immigrant women articulate their mental states according to the cultural expectation of motherhood and how they express their emotions in their discourse.

6 POSTNATAL DEPRESSION AS AN EMERGENT PHENOMENON

> I did not feel good. My husband was too busy with his study and work to pay attention to me. I desperately needed my mother to be with me. I felt so sad that I could not even love my child as much as I wanted and so I felt guilty about it. One day a child health nurse came to see my child and as she asked me how I was feeling. Suddenly I burst into tears. I couldn't say anything to her. She held me, and comforted me like my mother would do. Then we had a talk and she told me that it was called postnatal depression, which was very common for women after having a baby. I was relieved by her sympathy and by hearing that I was not the only woman who felt like crying and felt guilty about motherhood. Although she asked me to go to a doctor, I did not feel to do so. What could a psychologist or a doctor do if I went to them? (Kabita)

The aim of this chapter is to acknowledge postnatal depression as an emergent product. An emergent product is something that arises out of the interaction between two or more things. For example, a human baby is an emergent product which comes out of the interaction of two essential components: an egg and sperm. However, just looking at an egg and a sperm separately we cannot foresee a human baby. Similarly, postnatal depression emerges out of the interaction of biology and culture. As I have argued before, human mothers are vulnerable after childbirth. Thus, my South Asian participants and Western mothers share one component of postnatal depression which is postnatal vulnerability. They also share the environment where they give birth. But what they do not share is the same cultural notion of womanhood. Therefore, while Western women recognise postnatal depression as an illness, South Asian migrant mothers acknowledge it as "life". In the rest of the chapter, I show how the perception of postnatal depression as "life" is reflected in the discourse of the South Asian mothers I interviewed.

Getting back to the previous quote from thirty year old Kabita, whose eyes were full of tears when she was recalling memories of her experience after childbirth. Throughout my research I met a number of other South Asian women who, like Kabita, came to be

told that they had “postnatal depression” and were advised to see a doctor. Those women, like Kabita, accepted that they had “postnatal depression” and mentioned this to me when I asked them to talk about their emotions about motherhood. They said, “I was depressed after my baby was born”, or “Like women here (in Australia) I also had postnatal depression”.

> “The translation into an emotional code carried out by attention as it formulates and utters an emotional statement can be very far reaching in its consequences for the multivocal thought patterns that are excited or dampened down as attention works” (Reddy 2001:102).

Reddy says that when we hear others speak about their feelings we often ask ourselves whether we would feel the same in similar circumstances. These South Asian migrant women used the idea of “postnatal depression” to express their negative feelings after giving birth. The concept of “postnatal depression” gave them a convenient way to communicate with medical practitioners regarding their emotions.

Reddy (2001:99) recognizes that culture generates, shapes and guides our psychological processes. So, in using the words “postnatal depression” metaphorically Kabita, and the other South Asian women interviewed were able to use an emotive to transform their intense suffering. According to Reddy, emotive is a word or phrase that both describes and modifies our feelings. Thus, although my informants used the word “depression” they were not talking about depression as a Western woman might. Their discourse signals were notably different from those of a Western discourse. Introducing a word like “postnatal depression” might have helped these women to explain their symptoms to others. However, on the basis of my interviews, I think that their use of this term neither represents the same experience as that of many Western women diagnosed with postnatal depression, nor does it represent the same complex of feelings. They labelled their experience as “postnatal depression” but the label did not include the associated meaning of illness.

In the quotation opening this chapter Kabita says: “I felt so sad that I could not even love my child as much as I wanted”. Notice the word ‘sad’ Kabita used to describe her emotion. Sad is a word used to express one’s feeling and this can be used in quite different ways in South Asian languages. For example, a person would be sad if a

family member died, or if a friend betrayed them, but would that depress them? Let me start with a personal anecdote. Around 1990, in Bangladesh, a television commercial confused me. As I recall, it was a nine or ten second TV commercial with a young woman around age 19, sitting on a rocking chair, close to the window, looking very sad. Outside the window the weather was pleasant and birds were singing but the girl was not interested at all in enjoying such beauty in nature. Then the caption appeared on the screen: “Depression is an illness. Consult your doctor.” The caption was in English. Later I notice that some stickers and pamphlets with the same caption were pinned up in doctors’ surgeries.

Sadness or sorrow in its dictionary meaning in south Asian language is *dukkha*. The term *dukkha* has a variety of meanings ranging from ordinary sorrow to suffering. Sorrow is said to arise from misfortune, calamity and destruction, and from “separation from those who are dear, (their) downfall, loss of wealth, death and imprisonment” (Masson and Patwardhan 1970:52). Sorrow is accompanied by other mental states including world-weariness, physical weariness, panic, confusion, lifelessness, sickness and worry. Sorrow “should be acted out by tears, laments, drying up of the mouth, change of color, languor in the limbs, sighs, loss of memory, etc” (Masson and Patwardhan 1970:52). One of the most common terms in the lexicon of sorrow is *bishonnya*, which means grief, dejection or a sense of hopelessness.

Bangladesh Television could not find any Bangla word for depression for that commercial, and therefore the English word depression was used. Later on, the caption was translated into Bangla, and the word *bishonnya* was used in place of depression. It is worth mention that even with the substitution of the word, the commercial was soon taken off the air. At that time I was doing my Bachelor degree. Even as a university student I could not understand why I should see a doctor if I was sad. In fact, I thought ‘depression’ might be the latest term for sadness; the term seemed very fashionable to me and I liked it. But the associated word ‘illness’ struck me. Though I liked the term ‘depression’ as an alternative to sadness, I could not convince myself that if someone were sad or depressed they were ill. The woman in the TV commercial looked sad to me, but she did not seem like someone who should see a doctor. I will point out soon what my informants said about their mood and motherhood.

6.1 Don't Get Sad, Get Mad: Emotion as Self Altering

In this thesis I argue that postnatal depression is an outcome of the interaction of human biology and environment. There is a universal potential to feel susceptible and helpless following birth because vulnerability is deeply rooted in human mothers during labour and delivery, and thus birth is almost everywhere treated as a traumatic life crisis event (Trevathan and McKenna 1994:92). Human experience, however, can never be simply biological. Any human experience must be the outcome of interaction of psychobiological and sociocultural factors. Every human experience must have components of these two areas in it. Thus, the experience of postnatal depression is grounded in biology and culture and emerges out of the interaction of biology and culture (Burbank 2000).

According to Reddy, "Insofar as an emotion claim is self-exploratory, its effects on the self may tend to confirm or disconfirm the claim: insofar as an emotion claim is self altering, its effects on the self may intensify or attenuate the state claimed" (2001:103). Thus, 'putting on a smile'— may change one's mood. One can alter the way one feels inside by altering the outside. I illustrate this argument through an quotation (Isen and Diamond 1989:144, in Reddy 1997:333):

> "We are reminded of the way in which little boys have often been taught to keep from crying by substituting anger for sadness: 'When something bad happens, don't get sad; get mad.' Thus, people may be able to regulate their feelings, through their focus and through changing what they learn in given situations. Similarly, they may be able to change the impact of certain kinds of feelings, again by directing thoughts along certain lines. In this way, problem emotions, even though they feel automatic and uncontrollable, may be alterable".

So 'putting on a smile' may help you feel that smile inside. It is like a physical action to teach one's body to be a certain way. My South Asian participants use the term "postnatal depression", but the use of this expression signals to them something quite different from what it signals to Westerners. Their experiences, which their Western trained medical practitioners refer to as "postnatal depression", provides them with a sense of pride and honour. Here their management of their psychic pain is what Reddy refers to as an emotive.

Another example is the Kung women's experience of menstruation. While women in the United States experience mood disorders, changes in their social behaviour and activity patterns and physical symptoms with the phases of the menstrual cycle and end of menstruation, menstruation and menopause have neither psychological effect nor are they of great importance to African !Kung San women whose traditional means of subsistence is hunting and gathering (Shostak 1983:322&352). Taking blood samples from !Kung women, Shostak found the same basic monthly hormonal pattern as that reported for Western women. However, her interviews with !Kung women showed that though they described physical discomfort during menstruation and in the initial months of menopause, the description of discomfort was not in terms of wider psychological ramifications. Pregnant women experience childbirth without any medical facilities, traditional midwives or even another birth specialist to help. They are expected not to scream or cry out for help but to sit quietly and stay in control throughout the labour in order to show full acceptance of childbearing (1983:180). Shostak argues that it is possible that physical effects for Western and !Kung women are similar but the stoical attitude of the !Kung toward childbirth keeps them from recognising any of the physiological reactions they do have.

6.2 Individual and Shared Understandings of Postnatal Depression

Kabita's understanding of postnatal depression can be explained in part using Strauss and Quinn's (1994) notion of schema. They said that individuals develop unique personal schemas, "the generic versions of experience that remain in memory" (1994:285), over the course of their lifetimes, building up a "network of associations" which can be used to make sense of experience and predict appropriate behaviours (1994:287) or be altered in the face of contrary experience (1994:290). Some schemas, influenced by the mass media and nation-state lifestyles, are widely but not universally shared (1994:293) and constitute cultural understandings.

Kabita developed and internalised her South Asian schema through socialization from her childhood. After coming to Australia and giving birth, Kabita began the process of building a Western schema or adding Western pieces to her pre-existing schema as she interacted with the Australian medical system. However, her conception was regulated and guided by previously learned patterns of association. "Although schemas can change, those built on repeated experiences of a similar sort become relatively stable,

influencing our interpretations of subsequent experiences more than they are altered by them" (Quinn 2005:6). Kabita associated crying, feeling guilty and suffering with motherhood. Therefore she felt good when the nurse told her that these feelings were common for mothers. Being socialised in South Asia she also attached her mental pain to a prior concept of womanhood in which suffering is honoured.

6.3 Postnatal Depression in Discourse

To find "postnatal depression" and its associated meaning in my South Asian participants' discourse, I identified four key concepts: *sakti* (power), suffering, sacrifice, and *lajja* (shame/honour). Identifying key concepts from what my participants said helped me gain a better understanding of their cultural schema. "[Key concepts] are windows into shared knowledge of cultural exemplars, reasoning is an especially good analytic window into the shared structure or cultural schema being used to do it" (Quinn 2005: 41).

Kabita's shared schema, like other women's in this research, has created her sense of what is natural and desirable during the postnatal period. She internalised that *sakti*, suffering, sacrifice and/or *lajja* are essential qualities of a mother. Thus, the *sakti*, suffering, sacrifice and/or *lajja* schemas can be viewed as internalised emotives which regulate the women's psychological processes. Their emotives are given shape by their vulnerability during the postnatal period and are formulated by their understanding of *sakti*, suffering, sacrifice and/or *lajja*, which are derived from their prior enculturation.

<u>*Sakti* and suffering</u>

The following excerpt is from 28 year old Shanti, a doctor, whose story is very similar to Sheila's story whose comments I quoted in chapter three. Both Shanti and Sheila have babies who were required to stay in hospital after the mothers were discharged. In the following excerpt, Shanti talked about not having relatives to look after her child and herself. She also mentioned that she did not have nutritious food, and did not get a chance to get some rest.

> I think I just had to. I think I am a strong person when it comes to a crisis situation. In a small thing, like if I feel lonely on my own, I cry, but in a

> crisis situation I am quite strong, coping. Yes I just cope with it as I just had to. I didn't get a rest that was the only thing I missed. Having a baby in India it would have been in my mother's house, and there I would have been enabling to have a rest. On the other hand, I had to cope with everything on my own here. I missed food. There was nobody to cook nutritious food for me. I ate only sandwiches all the time on the run — that was another thing I missed. There was agony; I was not physically and mentally very well and my child was sick.
>
> However, I didn't really miss all of that. All I missed was not being able to rest and let someone else look after my baby and me. When you are not getting enough rest you are obviously more prone to depression. In the case of the first baby I didn't even have time to think. All I had to do was get up every morning, go to the hospital, look after the baby, and come back in the evening. Every four hours I was expressing milk because I wanted to breast-feed and that was the only way I could do so. I had to keep the milk supply so I did not have time to think if I was getting enough rest or not. I was more concerned about my baby.

She said, "*When you are not getting enough rest you obviously are more prone to depression"*, and the associated comment *"I didn't even have time to think."* From Shanti's description of the postnatal period some key concepts can be identified which address two South Asian complexes of ideas and values: *Sakti* and suffering. Shanti suffered because she "did not have time to think", but had to cope with everything on her own". This comment conveys the meaning of suffering. The suffering gave her power — *sakti* which made her strong enough to serve the child's need. "I am a strong person when it comes to a crisis situation" – in this case, power is articulated in the crisis of motherhood and expressed in the activity of looking after her sick baby.

<u>Sacrifice</u>

I have used Parul's story before, but I see her comments on sacrifice in motherhood as appropriate to use here again.

> I did not enjoy my baby for the first twelve months after he was born because I was obsessed with his condition. He needed lots of activity and motivation. I was busy massaging him, talking to him checking his hands, legs and everything. I did everything I could do to keep him motivated. I did everything a mother can possibly do for her baby when he is sick. I did my best. I was offered a full time position but refused it for my child. I took a part time position instead and put him into a day care for extra interaction with other people and children. The day care was next to my office and instead of giving him a bottle I used to go every two hours to nurse him, so that he would have my skin to touch as well. Obviously I was tired but I did not feel it. All my concentration was on my son. I didn't even feel my severe back pain until he was twelve months old. Until then I could not think of anything but the baby.

Parul said, "I did my best" to convey the expectation that motherhood is a sacrificing arrangement. As a mother, she portrayed herself disposed and ready to sacrifice her own life for her child. We see Parul as a devoted mother who is determined to save her child. "Obviously I was tired but I did not feel it", and "[I] took a part time position instead". Clearly Parul shares the idea with other South Asian women that a child comes first to a mother. She signals her willingness to sacrifice herself when she talks about her part time position and severe back pain.

Lajja

The following passage, provided by twenty six year old Nazneen, reflects ideas about shame, the negative side of *lajja*. Nazneed was working in a government job in Bangladesh.

> Any man can be a father without doing anything. But to be a mother you have to go through a long pregnancy, with nausea, back pain, anxiety. You have to bear the labour pain, stay awake all night, you have to nurse the baby, bath the baby and so on. Then when you are exhausted and hungry, you will not have food to eat, so you need to cook. (With a laugh) I used to dislike babies before my children were born especially, with their nappy changing. My husband has never changed our babies' nappies. I guess it is

> easy for a father not doing it. However, could I say 'No'? — Never. It is not nice for a mother to say 'No'. I couldn't even say to my husband, 'Look I am tired and need a good sleep. So, you will look after the baby tonight and I will sleep'. You know, it sounds ridiculous when you are a mother, you can't say 'No', Can you?

In the two phrases "it is not nice to say 'no' and 'it sounds ridiculous', Nazneen conveyed her shared belief that a mother would be laughable if she said 'no' to any aspect of child rearing. It is *lajja* for a mother to show her unwillingness or inability to take care of her child. It is acceptable for a father to expresses his lack of interest in changing nappies. However, "When you are a mother, you can't say 'No".

Sakti, suffering and *lajja*

Thirty year old Tania incorporated the concepts of *sakti*, suffering and *lajja* in her following description of postnatal experience.

> Don't you feel embarrass to ask your husband to make food for you because you are hungry? I mean, I am not a child who cries for food. My husband should realise that I need some special nutrition when I am breastfeeding. I cannot even complain about my back pain. My husband massaged my back couple of times, but I felt ashamed. Back home, I did not hear any woman complaining about back pain after giving birth. Didn't they have back pain or they just kept quiet like I do and put up with everything. I guess that is the price we have to pay to have children. We have to lose something to get something, and that is the requirement of motherhood. My mother raised her six children and my grandmother had ten of her own. How could they survive with so many children? Didn't they suffer from the back pain – I wonder! They must be extraordinary women.

Three key concepts are represented in her comment. The first, and the one that can be said to be the passage's major theme, is *sakti*. Tania emphasised and was inspired by her mother and grandmother's reproductive capacities and their ability to endure pain. Capacities that she sees as coming from their *sakti* and that makes them extraordinary. Thus, suffering comes into the picture. To claim her *sakti*, Tania put up with everything

and kept quiet. Her mother and grandmother could suffer, so she herself also could suffer.

The third key concept represented in the passage is *lajja*. She felt ashamed to complain about food and back pain, because, 'back home' women did not complain about these things. The idea of complaining about food and pain might weaken her *sakti* and thereby her honour. Thus, she suffered. Her discourse, which includes the three key concepts *sakti*, suffering and *lajja*, point to the high price paid in achieving motherhood.

The four key concepts *sakti*, suffering, sacrifice and *lajja* are implicated in the values of "cultural schemas [which] are built up from experience that has been shared" (Quinn 2005:6). It is likely that giving birth to a child in relative isolation from family in a new country produced a sense of suffering and hopelessness (depressive affects). But these feelings were given cultural meaning in terms of a South Asian schema of motherhood. I found the concept of "sacrifice" in almost every women's discourse. They tried to convey the meaning that they did their best for their child. Twelve women felt guilty thinking that as a mother they should have done more for their child. Through their guilt they conform or even over-conform to the sacrificing element of motherhood.

The concept of *lajja* was directly reflected in six of the women's discourses. They talked about a few other South Asian women in the community who were looking after their children, managing their house, studying and/or working in a fulltime position. These six women mentioned it would be shame for them if they could not take care of both their newborn child and the housework. They also noted that because they had to do everything alone they were overloaded and tired. However, they did not complain, so that they could maintain their good reputation in the eyes of the other women in the community. Eleven women incorporated the concept of *sakti* and suffering, and related it to their postnatal experiences. They frequently told me, "I was strong", "I had to do everything on my own, who would do that for me", "I had to be strong physically and mentally or I would have died".

As I have previously argued, through their socialisation, South Asian women internalise an understanding of what motherhood entails and this understanding is shared. In addition, I have also argued that what they have internalised has a great impact on their emotions and, as the comments above show, this is reflected in the way they speak

(Quinn 2005:16). Although Western medical doctors view “postnatal depression” as an illness, South Asian women experience the suffering of their metaphorical postnatal depression as a source of pride and honour.

7 SOCIALISATION AND INDIVIDUAL PSYCHE

This thesis has explored the significance of South Asian socialisation and culture, and the impact this has had on some South Asian women's perceptions of the negative feelings they have which are associated with the postnatal period. Drawing upon ethnographic interviews, the exploration has taken me in search of the psychosocial foundations of South Asian women's postnatal experiences. I have emphasised the link between psyche and culture throughout this thesis and argued that within a given cultural and social order, particular cultural themes become internalised in the individual psyche.

In this thesis I am moving from the idea that 'everybody feels just like a Westerner' to a concept that recognises that 'culture does make a difference to how people feel'. Western medical practitioners tend to assume that emotions are universal and that all people feel emotions in the same way. It seems that few of them can imagine the possibility that someone may experience emotions differently if they have been socialised in another culture. In contrast, I argue that "postnatal depression" like emotional experience, emerges out of the interaction of the physiobiology and culture. Postnatal experiences entail fluctuations in hormones, perception and behaviour, but women's responses to their postnatal negative feeling depend on their socialization and their internalised notions of motherhood. Thus, I argue that the feelings a Western medical practitioner describes as 'postnatal depression' are very often to a South Asian woman just 'life as it should be'.

The theoretical orientation in this thesis is derived from Obeyesekere's (1985, 1990) idea of the 'work of culture' and Reddy's (1997, 2001) concept of 'emotive'. They both argue for some sense of psychic unity for human beings. However, they acknowledge the impact of cultural difference on emotion. According to Obeyesekere, there is a biological factor in the sorrowful affects that everybody shares, but people have the ability to search into their culture for an appropriate way to express and resolve these negative feelings. The culture itself provides symbols through which its members can express their pain.

Similarly, Reddy brings together biological and cultural approaches of emotions through his idea of 'emotive'. He suggests that feelings are located in our nervous

system and that they interact with a cultural script which both translates our feelings and has the power to alter them. Reddy goes on to say that although the translation method is an unconscious process, people can consciously explore and change their feelings.

I also incorporate into my thesis Quinn's (2005) and Strauss and Quinn's (1997) 'schema' theory to present how people internalise cultural themes and act on them. I examine 'schema' and 'emotive' by looking at the restriction of female behaviour in South Asian society. The significant part of the 'work of culture' in South Asian society is the interpretation of negative feelings as culturally appropriate behaviour. This emotional convention promotes certain emotives which influence an individual's ability to maintain community life.

I used the Edinburgh Postnatal Depression Scale (EPDS), the most widely used depression measuring tool, in my research to find out if the EPDS could reflect the psychological states of South Asian immigrant mothers. I have found that the EPDS measures symptoms which are all about feelings such as, tearfulness, fatigue, feeling guilt and hopelessness. It is true that South Asian immigrant women, like all women, experience these feelings. So the scale does measure people's feelings but I take issue with the jump from feelings to illness; just because the South Asian immigrant mothers have these feelings does not necessarily mean they have a depressive illness. Although the feelings of the EPDS are socially constructed as illness, and the South Asian migrant mother may have this set of feelings the women themselves do not see their "symptoms" as an illness. Rather, very often they view their experiences as appropriate and not abnormal, and linked to their cultural construction of suffering and womanhood. They continue to function effectively. They do not see themselves as having an illness called depression. They see themselves as normal, healthy new mothers.

In order to understand the feeling aspect of the South Asian women's postnatal negative experiences, I focus on their socialisation processes. South Asian migrant women interpret postnatal negative feelings in relation to elements already anchored in the South Asian female ethos: suffering and womanhood. This ethos, which is laid down in early life, acts as shared knowledge and helps South Asian women to cope with postnatal distress. These women appear to perceive crying, despondency and suffering which they experienced both after migration and after childbirth, as a prerequisite for womanhood and motherhood. Negative postnatal affect is largely understood as just

another part of life. The cultural institution which produces and reproduces the practices of *purda* in which hardship and suffering find expression and which are depicted in literary, religious and other genres, is would seem to be fundamental to a female cultural ethos of suffering.

Careful attention to the words and themes the women used to talk about motherhood and postnatal feelings reveal four key concepts: *sakti*, suffering, sacrifice and *lajja*, that are linked to the values which have cultural meaning in terms of a South Asian schema of motherhood. In my argument, while I do not attempt to convey the impression that South Asian migrant mothers are always sad and do not give vent to any expression of joy, I do not deny the existence of a core feeling of sadness. Undoubtedly, there is a biogenetic factor in depression. However, I suggest that it is possible to modify dysphoric affect by altering the meaning of feelings. Cultural variation in the meaning of feelings and the different idioms for articulating negative feelings must be taken into account.

8 BIBLIOGRAPHY

Ali, A. 2001. *Al-Qur'an: A contemporary translation*. Princeton University Press: Princeton.

Ali, M. M. 1973. *The holy Quran*. Specialty Promotions Co. ING: Chicago.

Abou-Saleh, M. T., Ghubash, R., Karim, L., Krymski, M. and Bhai, I. 1998. Hormonal aspects of postpartum depression. *Psychoneuroendocrinology* 23(5): 465-475.

Afsana, K. 2003. Birth in Bangladesh. *Campus Review*, 4(10): 10-11.

Afsar, R. 2004. The Indian Ocean connection: migration from the Indian subcontinent to Western Austalia. In *A changing people: diverse contributions to the state of Western Australia*, edited by R. Wilding and F. Tilbury, 196-209. Department of the Premier and Cabinet, and Office of Multicultural Interests: Perth.

Annual report, 2000. Ishar Multicultural Centre for Women's Health. Mirrabooka: WA.

Baluja, F. K. 2003. *Gender roles at home and abroad: the adaptation of Bangladeshi immigrants*. LFB Scholarly Publishing LLC: New York.

Behrndt, M. 1995. "Voices from within the four walls: a bio-cultural analysis of postpartum depression among first-time mothers in metropolitan Perth. Western Australia". Unpublished PhD. thesis. The University of Western Australia.

Berger, L. 2001. Inside out: narrative autoethnography as a path toward rapport. *Qualitative Inquiry* 7(4): 504-518.

Bruner, E. M. 1984. The opening up of anthropology. In *Text play and story*, edited by E. M. Bruner, 1-16. Waveland Press, INC: IL.

Burbank, V. 2004. "Emotion and self-deception. Paper read at AAS. Plenary: A genuinely moving anthropology requires disengagement". September. Melbourne.

Burbank, V. 2000. The lust to kill and the Arnhemland sorcerer: an exercise in integrative anthropology. *Ethos* 28(3): 410-444.

Butz, D. and Besio, K. 2004. The value of autoethnography for field research in transcultural settings. *The Professional Geographer* 56(3): 350-360.

Buzard, J. 2003. On auto-ethnographic authority. *The Yale Journal of Criticism* 16(1): 61-92

Chun, Y. P. and Yue, D. X. 1999. Postpartum depression and social support: a comparative study in Hongkong. *Psychologia* 42: 111-121.

Cloke, P., Crang, P. and Goodwin, M. 1999. *Introducing human geographies*. Arnold: London.

Copper, P. and Murray, L. 1998. Prediction, detection and treatment of postnatal depression. *Arch Dis Child* 77: 97-99.

Copper, P. and Murray, L. 1998. Postnatal depression: clinical review. *BMJ* 316(20): 1884-1886.

Crouch, M. 1998. The evolutionary context of postnatal depression. *Human Nature* 10(2): 163-182.

Dankner, R., Goldberg, R. P., Fisch, R. Z. and Crum, R. M. 2000. Cultural elements of postpartum depression: a study of 327 Jewish Jerusalem Women. *Journal of Reproductive Medicine* 45(2): 97-104.

Dickemann, M. 1981. Paternal confidence and dowry competition: a biocultural analysis of purdah. In *Natural selection and social behavior: recent research and new theory*, edited by R. D. Alexander and D. W. Tinkle, 417-438. Chiron: New York.

Early, E. 1985. Catharsis and creation: the everyday narratives of Baladi women Cairo. *Anthropological Quarterly* 58(4): 172-181.

Egnor, M. 1980. On the meaning of sakti to women in Tamil Nadu. In *The powers of Tamil women*, edited by S. S. Wadley, 1-34. Syracuse University: Syracuse.

Flyvbjerg, B. 2001. *Making social science matter: why social inquiry fails and how it can succeed again*. Cambridge University Press: Cambridge.

Fuggle, P., Glover, L., Khan, F. and Haydon, K. 2002. Screening for postnatal depression in Bengali women. *Journal of Reproductive and Infant Psychology* 20(2): 71-82.

Gergen, J. K. and Gergen, M. M. 1997. Narratives of the self. In *Memory, identity community: the idea of narrative in the human sciences*, edited by P. L. Hinchman and K. S. Hinchman, 161-184. State University of New York Press: New York.

Good, J. B., Good, D. J. M. and Moradi, R. 1985. The interpretation of Iranian depressive illness and dysphoric affect. In *Culture and depression: studies in the anthropology and cross-cultural psychiatry of affect and disorder*, edited by A. Kleinman and B. Good, 369-428. University of California Press: Berkeley.

Grima, B. 1992. *The performance of emotion among Paxtun women: the misfortunes which have befallen me*. University of Texas Press: Austin.

Gupta, R. R. 1988. Women in Hindu law: their property rights. In *Status of women*, edited by S. Agrawal, 43-58. Printwell Publishers: India.

Harkness, S. 1987. The cultural mediation of postpartum depression. *Medical Anthropology Quarterly* 1(2): 194-209.

Harris, B., Lovett, L., Newcomb, R., Read, G., Walker, R. and Riad-Fahmy, D. 1994. Maternity blues and major endocrine changes: cardiff puerperal mood and hormone study II. *British Medical Journal* 308:949-953.

Hendrick, V., Altshuler, L. and Suri, R. 1998. Hormonal changes in the postpartum and implications for postpartum depression. *Psychosomatics* 39(2): 93-101.

Hiltunen, P. 2003. *Maternal postnatal depression, causes and consequence*. Oulunyliopisto: Oulu.

Hollan, D. 1994. Suffering and the work of culture: a case of magical poisoning in Toraja. *American Ethnologist* 21(1): 74-87.

Hollen, V. C. 2003. *Birth on the threshold: childbirth and modernity in South India*. University of California Press: London.

Hrdy, B. S. 2000. *Mother nature*. Vintage: London.

Isen, A. M. and Diamond, G. A. 1989. Affect and automaticity. In *Unintended thought*, edited by J. S. Uleman and J. A. Bargh, 124-152. Guildford Press: New York.

Islam, S. 1989. Rural women and childbirth in Bangladesh: The social cultural context. In *Gender and the household domain: social and cultural dimensions*, edited by M. Krishnaraj and K. Chanana, 233-254. New Delhi: Sage Publications.

Jeffery, P. and Jeffery, R. 1998. Gender, community, and the local state in Bijnor, India. In *Appropriating gender: women's activism and politicized religion in South Asia*, edited by P. Jeffery and A. Basu, 123-142. Routledge: London.

Jeffery, P., Jeffery, R. and Lyon, A. 1989. *Labour pains and labour power: women and childbearing in India*. Zed Books: London and New Jersey.

Jenkins, H. J., Kleinman, A. and Good B. J. 1991. Cross-cultural studies of depression. In *Psychosocial aspects of depression*, edited by A. Kleinman and J. Becker, 67-99. Lawrence Erlbaum Associates: New Jersey and Hillsdale.

Johnson, L. and Lloyd, J. 2004. *Sentenced to everyday life: feminism and the housewife*. Berg: Oxford, New York.

Kachru, Y. 1994. Self, identity and creativity: women writers in India. In *Self as person in Asian theory and practice*, edited by R. T. Ames, W. Disanayake and T. P. Kasulis, 335-357. University of New York Press: New York.

Kakar, S. 1990. *Intimate Relations: exploring Indian sexuality*. The University of Chicago Press: Chicago.

Kakar, S. 1978. *The inner world: a psycho-analytic study of childhood and society in India*. Oxford University Press: Oxford.

Kleinman, A. and Good B. (eds.) 1985. Introduction. In *Culture and depression: studies in the anthropology and cross-cultural psychiatry of affect and disorder*, 1-33. University of California Press: Berkeley, London.

Kleinman, A. 1978. Culture, illness and care: clinical lessons from anthropologic and cross-cultural research. *Ann. Inter. Med.* 88: 251-258.

Kumar, R. 1994. Postnatal mental illness: a transcultural perspective. *Soc Psychiatry and Psychiatr Epidemiol* 29:250-264.

Lee, C. 1997. Social context, depression and the transition to motherhood. *British Journal of Health Psychology* 2:93-108.

Levy, R. I. and Wellenkamp, J. C. 1980. Methodology in the Anthropological study of emotion. In *The measurement of emotion, vol. 4, Emotion: theory, research and experience*, edited by R. Plutchik and H. Kellerman, 205-232. Academic Press INC: New York.

Linde, C. 1993. *Life stories: the creation of coherence*. Oxford University Press: New York.

Lorber, J. 1994. *Paradoxes of gender*. Yale University Press: New Haven.

Lutz, C. 1985. Depression and the translation of emotional worlds. In *Culture and depression: studies in the anthropology and cross-cultural psychiatry of affect and disorder*, edited by A. Kleinman and B. Good, 63-100. University of California Press: Berkeley and Los Angeles.

Madan, T. N. 1991. Auspiciousness and purity: some reconsiderations. *Contributions to Indian Sociology* 25(2): 287-294.

Martin, J. 1986. Non-English-Speaking migrant women in Australia. In *Australian women: new feminist perspectives*, edited by N. Grieve and A. Burns, 233-247. Oxford University Press: Melbourne.

Masson, J. L. and Patwardhan, M. V. 1970. *Aesthetic rapture: the rasadhyaya of the natyasastra*. Vol. 1. Deccan College: Poona, India.

Maushart, S. 2002. *Wife work: what marriage really means for women.* Bloomsbury: London.

Maushart, S. 2000. *The mask of motherhood: how becoming a mother changes everything and why we pretend it doesn't*. Penguin: New York.

McGuire, M. T. and Troisi, A. 1998. *Darwinian psychiatry*. Oxford University Press: New York.

McGuire, M. T., Troisi, A. and Raleigh, M. M. 1997. Depression in evolutionary context. In *The maladaptive mind: classic readings in evolutionary psychopathology*, edited by B. S. Cohen, 255-282. Psychology Press: Cambridge.

McKenna, P. E. 1997 *When work doesn't work anymore*. Delacorte Press: New York.

Menon, U. and Shweder, A. R. 1994. Kali's tongue: cultural psychology and the power of shame in Orissa, India. In *Emotion and culture: empirical studies of mutual influence*, edited by S. Kitayama and R. H. Markus, 241-284. American Phyc Assoc: Washington DC.

Miller, B. D. 1981. *The endangered sex: neglect of female children in rural north India*. Cornell University Press: Ithaca, NY.

Mumtaz, K. and Shaheed, F. 1987. *Women of Pakistan: two steps forward, one step back*. Zed Books LTD: London and New Jersey.

Najman, J. M., Anderson, W. B., O'Callaghan, M. J. and Williams, G. M. 2000. Postnatal depression – myth and reality: maternal depression before and after the birth of a child. *Soc Psychiatry Psychiatr Epidemiol* 35: 19-27.

Nesse, M. R. 2000. Is depression an Adaptation? *Archives of General Psychiatry* 57(1): 14-20.

Nesse, M. R. 1998. Emotional disorders in evolutionary perspective. *The British Journal of Medical Psychology* 71(4): 397-415.

NHMRC 2003. Tri-Council policy statement: ethical conduct for research involving humans. Article 2.3 Naturalistic observation, [Online], 32-33. Available from: http://www.pre.ethics.gc.ca/english/policystatement/policystatement.cfm

Noh, S. and Chen, X. 1998. Measuring depression in Korean immigrants: assessing validity of the translated Korean version of CES-D scale. *Cross-Cultural Research* 32(4): 358-377.

Obeyesekere, G. 1990. *The work of culture: symbolic transformation in psychoanalysis and anthropology*. The University of Chicago Press: Chiago.

Obeyesekere, G. 1985. Depression, Buddhism, and the work of culture in Sri Lanka. In *Culture and depression: studies in the anthropology and cross-cultural psychiatry of affect and disorder*, edited by A. Kleinman and B. Good, 134-152. University of California Press: Berkeley and Los Angeles.

O'Hara, M. W., Schlechte, J. A. and Lewis, D. A. 1991. Prospective study of postpartum blues. *Archives of General Psychiatry* 48:801-806.

Patel, T. 1994. *Fertility behaviour: population and society in a Rajasthani village*. Oxford University Press: Delhi.

Patel, V. 2002. Letters to the editor. *Am J Psychiatry* 159(8): 1438.

Patel, V., Rodrigues, M. and DeSouza, N. 2002. Gender, poverty and postnatal depression: a study of mothers in Goa, India. *Am J Psychiatry* 159(1): 43-47.

Pedersen, C. A., Stern, R. A., Pate, J. and Senger, M. A. 1993. Thyroid and adrenal measures during late pregnancy and the puerperium in women who have been major depressed or who become dysphoric postpartum. *Journal of Affective Disorders* 29(2-3): 201-211.

Pickthall, M. M. 1954. *The meaning of the glorious koran: an explanatory translation*. New American Library: New York.

Quinn, N. 2005 (in press). How to reconstruct schemas people share from what they say. In *Finding culture in talk: a collection of methods*, edited by N. Quinn, Palgrave Macmillan: New York.

Ram, K. 1998. Maternity and the story of enlightenment in the colonies: Tamil coastal women, South India. In *Maternities and modernities: colonial and postcolonial experiences in Asia and the Pacific*, edited by K. Ram and M. Jolly, 114-142. Cambridge University Press: Cambridge.

Reddy, W. M. 2001. *The navigation of feeling: a framework for the history of emotions*. Cambridge University Press: Cambridge.

Reddy, W. M. 1997 Against constructionism: the historical ethnography of emotions. *Current Anthropology* 38(3): 327-351.

Robinson, A. C. 1999. *Tradition and liberation: the Hindu tradition in the Indian women's movement*. Curzon: Surrey.

Romito, P., Saurel-Cubizolles, M. J. and Lelong, N. 1999. What makes new mothers unhappy: psychological distress one year after birth in Italy and France. *Social Science and Medicine* 49: 1651-1661.

Rosaldo, M. Z. 1984. Toward an anthropology of self and feeling. In *Culture theory: essays on mind, self and emotion*, edited by R. A. Shweder and R. A. LeVine, 137-157. Cambridge University Press: Cambridge.

Rottenberg, J. and Gotlib, H. I. 2004. Socioemotional functioning in depression. In *Mood disorders: a handbook of science and practice*, edited by M. Power, 61-78. John Wiley and Sons: New York.

Rozario, S. 2003. Gender dimensions of rural change. *DFID Livelihood* 121-129. Online: http://www.livelihood.org

Rozario, S. 1992. *Purity and communal boundaries: women and social change in a Bangladeshi village*. Zed: London and New Jersey.

Rozario, S. 1998. The dai and the doctor: discourses on women's reproductive health in rural Bangladesh. In *Maternities and modernities: colonial and postcolonial experiences in Asia and the Pacific*, edited by K. Ram, and M. Jolly, 144-176. Cambridge University Press: Cambridge.

Saravanan, R. 2002. Letters to the editor. *Am J Psychiatry* 159(8): 1438-1439.

Seguin, L., Potvin, L., Denis, St. M. and Loiselle, J. 1999. Depressive symptoms in the late postpartum among low socio-economic status women. *Birth* 26(3): 157-163.

Sen, D. N. 1999. Sisters in sorrow: contemporary Indian women's re-telling of the Rama tale. In *From Independence towards freedom: Indian women since 1947*, edited by B. Ray and A. Basu, 201-220. Oxford University Press: India.

Shostak, M. 1983. *Nisa*. Vintage Books: New York.

Shweder, R. A. 1993. The cultural psychology of the emotions. In *Handbook of emotions*, edited by M. Lewis, and J. M. Haviland, 417-431. The Guildford Press: New York.

Small, R., Brown, S., Lumley, J. and Astbury, J. 1994. Missing voices: what women say and do about depression after childbirth. *Journal of Reproductive and Infant Psychology* 12: 89-103.

Stern, G. and Kruckman, L. 1983. Multidisciplinary perspective on postpartum depression: an anthropological critique. *Social Science and Medicine* 17: 1027-1041.

Stewart, S. and Jambunathan, J. 1996. Hmong women and postpartum depression. *Health Care for Women International* 17: 319-330.

Strauss, C. and Quinn, N. 1997. *A cognitive theory of cultural meaning*. Cambridge University Press: UK.

Strauss, C. and Quinn, N. 1994. A cognitive/cultural anthropology. In *Assessing cultural anthropology*, edited by R. Borofsky, 284-300. McGraw-Hill, Inc: New York.

Stuchbery, M., Matthey, S. and Barnett, B. 1998. Postnatal depression and social supports in Vietnamese, Arabic and Anglo-Celtic mothers. *Social Psychiatry and Psychiatric Epidemiology* 33: 483-490.

Thompson, K. 1997. Detecting postnatal depression in Asian women. *Health Visitor* 70 (6): 226-228.

Thornhill, R. and Thornhill, N. W. 1989. The evolution of psychological pain. In *Sociobiology and the social sciences*, edited by R. Bell and N. Bell, 73-103. Texan Tech University: Lubbock.

Trevathan, R. W. and McKenna, J. J. 1994. Evolutionary environments of human birth and infancy: insights to apply to contemporary life. *Children's Environments* 11(2): 88-104.

Troisi, A. and Mc Guire, M. 2002. Darwinian psychiatry and the concept of mental disorder. *Human Ethology and Evolutionary Psychology* 23 (4): 31-38.

Ugarriza, D. N. 1992. Postpartum affective disorders: incidence and treatment. *Journal of Psychosocial Nursing* 30(5): 29-32.

Watson, J. P. and Andrews, W. P. 2002. Toward a revised evolutionary adaptationist analysis of depression: the social navigation hypothesis. *Journal of Affective Disorders* 72: 1-14.

APPENDIX 1: Questionnaire

1. Date questionnaire completed_____
2. Date of birth _____
3. Occupation _____
4. Name of your suburb _____
5. Marital status: (circle your answers)
   Single married never married remarried
   divorced widowed de-facto relationship
6. Do you work outside the home? Y/N
7. If yes, what do you do? (*Please specify*)
   Business_____ Job_____
   Other_____
8. Are you involved in any community work? e.g. sports, cultural program Y/N
9. If yes, what do you do? _____
10. What is your partner's occupation? _____
11. What is your country of origin?
    India Bangladesh Pakistan Sri Lanka China
    Australia England other_____
12. What languages do you speak?
    English Hindi Bengali Tamil Panjabi
    French Spanish other_____
13. How long have you been in Australia?
    Less than 1 year 1-4 years 4-7 years 7-10 years
    10-13 years 13-16 years 16-19 years 19+ years
14. Are you a citizen in Australia? Y/N
15. If no, what is your resident status in Australia?
    Permanent resident temporary resident visitor other _____
16. What visa category did you have when you came to Australia?
    Permanent resident spouse family reunion
    Refugee other _____
17. Did you want to come to Australia? Y/N
18. Do you want to stay in Australia? Y/N
19. How many of your family live with you in your house? _____
20. How many of your family live nearby? _____
21. Where do they live?

Next door next street same neighbourhood

next suburb other_____

22. Do you have any relatives who support/ help you? Y/N

23. Do you have any friends who support/help you? Y/N

24. What kind of support/help do they give?

Financial emotional house work other _____

25. How many children do you have? _____

26. Are you pregnant now? Y/N

27. When was your first baby born? _____

28. Was/is this your first pregnancy Y/N

29. Did/do you want this pregnancy? Y/N/Not sure

30. Did you plan to become pregnant? Y/N/Not sure

31. Did/do you like being pregnant? Y/N/Not sure

32. Did/do you have any major physical problem during the pregnancy Y/N

33. Did/do you have any major physical problem during the birth Y/N

34. What type of birth did you have? Vaginal/caesarean

35. Did/do you have any preference about the sex of the baby? Y/N

36. Did/does your husband have any preference about the sex of the baby? Y/N

37. Did/do you know the sex of the baby before birth? Y/N

38. Where was your first baby born?

In Australia in the home country at home

in the hospital other_____

39. Was a family member with you when your first baby was born? Y/N

40. If yes, which family member did you have with you when your first baby was born?

Husband mother mother-in-law sister

sister-in-law aunty other_____

41. Where was your last baby born?

In Australia in the home country at home

in the hospital other_____

42. Was a family member with you when your last baby was born? Y/N

43. If yes which family member did you have with you when your last baby was born?

Husband mother mother-in-law sister

sister-in-law aunty other_____

APPENDIX 2: Interview

How did you feel being pregnant?

What did you expect would happen after you had a baby?

What is your birth experience?

What did you experience while in the hospital after birth?

What did you experience after coming home?

Did you feel the same way you expected to before the birth?

How did you feel physically?

How did you feel emotionally?

How did you manage your child?

How did you feel being a mother?

How do you compare your life in Perth to your life in your home country?

What do women do back home after giving birth? What rituals do they follow? What rituals did you do in Perth?

Did you miss your mother? Would you explain how much and why you missed her?

How did you feel about your relationship with your husband?

How would you compare your expectations with the reality of the birth?

How did you deal with the reality?

How did you cope with your feelings?

Do you think your experience would be same/different if you were in your home country? – how/why?

Were you given an EPDS in the hospital? What did you think about it?

How did you feel scoring your mood in the EPDS?

What do you think about postnatal depression?

What do you think women in your home country think about postnatal depression?

Do you think you had postnatal depression?

APPENDIX 3: Edinburgh Postnatal Depression Scale

Cox, Holden and Sagovsky (1987)

The following set of questions are designed to assess how you are feeling. Please **Tick (✓)** the answer which comes closest to how you have felt **OVER THE PAST SEVEN DAYS**, not just how you feel today.

Example: I have felt happy:

0.Yes, all the time
✓1. Yes, most of the time
2. No, not very often
3. No, not at all

This would mean: "I have felt happy most of the time" during the past week.

Please complete the following questions in the same way.

In the past 7 days:

1. **I have been able to laugh and see the funny side of things**
   - 0 As much as I always could
   - 1 Not quite so much now
   - 2 Definitely not so much now
   - 3 Not at all

2. **I have looked forward with enjoyment to things**
   - 0 As much as I ever did
   - 1 Rather less than I used to
   - 2 Definitely less than used to
   - 3 Hardly at all

3. **I have blamed myself unnecessarily when things went wrong**
   - 3 Yes, most of the time
   - 2 Yes, some of the time
   - 1 Not very often
   - 0 No, never

4. **I have been anxious or worried for no good reason**
   - 0 No, not at all
   - 1 Hardly ever
   - 2 Yes, sometimes
   - 3 Yes, very often

5. **I have felt scared or panicky for no very good reason**
   - 3 Yes, quite a lot
   - 2 Yes, sometimes
   - 1 No, not much
   - 0 No, not at all

6. **Things have been getting on top of me**
   - 3 Yes, most of the time I haven't been able to cope at all
   - 2 Yes, sometimes I haven't been coping as well as usual
   - 1 No, most of the time I have coped quite well
   - 0 No, I have been coping as well as ever

7. **I have been so unhappy that I have had difficulty sleeping**
   - 3 Yes, most of the time
   - 2 Yes, sometimes
   - 1 Not very often
   - 0 No, Not at all

8. **I have felt sad or miserable**
   - 3 Yes most of the time
   - 2 Yes, quite often
   - 1 Not very often
   - 0 No, not at all

9. **I have been so unhappy that I have been crying**
   - 3 Yes, most of the time
   - 2 Yes, quite often
   - 1 Only occasionally
   - 0 No, not at all

10. **The thought of harming myself has occurred to me**
    - 3 Yes quite often
    - 2 Sometimes
    - 1 Hardly ever
    - 0 Never