Social capital and postnatal depression among South Asian women

How culture defines how people will experience the symptoms of "postnatal depression"?

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My approach in this paper derived from the work of Gananath Obeyesekere (1985) who says of Sinhala of Sri Lanka, that this phenomenal world is considered as cycles of suffering, hopelessness and sorrow, which are a rational response to life as experienced. Obeyesekere makes this point in regard to Buddhism, the religion of the majority Sinhalas when people talk about sorrow they connect it to the Buddhist ideology. He points out that Sinhala people cannot separate suffering or sorrow from their life, just as people cannot avoid old age, loss and death arising out of life conditions. Obeyesekere argues that the socio cultural-psychological conditions, which produce these affects, are anchored to an ideology in Buddhist Sri Lanka. Here I say that this may be part of a more widespread worldview that is not limited just to Buddhism, but is also shared by adherents of Hinduism, Christianism and Islam, in the region of South Asia.

My method includes interviews with a sample of fifteen South Asian women who were born in and migrated from either Bangladesh or India and living in Western Australia. At the time of the interviews their age range was between 24 and 37 years, and most had graduated from university in their home country. The interviewees were from three different religious groups: Muslim (5), Hindu (5) and Christian (5). I interviewed these women between their two and twelve months postnatal period, in order to see how these women locate themselves with regard to issues of economic insufficiency, lack of supportive rites and rituals surrounding childbirth, having little or no community support and isolation from family. I explore the social capital factors of postnatal depression through an analysis of the in depth interviews.

On the basis of interviewing those women I will start this paper with a story I call 'the voice of a migrant woman', to let you know the difficulties are possibly faced by a migrant woman, who gives birth in an entirely new society and without any relatives to support her.

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, 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 spend lots of time taking care of my children. 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 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.

Discussion of story

This is the story of Mina, who is a woman facing all the difficulties a new migrant mother possibly does. Mina could come from anywhere around the world, that is why I have not given her an identity, or a country. However, she is not a figment of my imagination. On the basis of my work and experience with migrant women, and the knowledge I gathered through my research on postnatal depression (PND), I would say that Mina could easily represent thousands of other women in a similar situation.

Medical and anthropological literature suggests that socio-cultural factors are important contributors to high rated of PND. These possible socio-cultural factors which are related to PND are (1) cultural recognition 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) assistance with tasks, mostly from other women; (6) social recognition of the new status for the mother through rituals, gifts, or other means (7) financial situation, (8) sick baby (9) relationship with partner. The literature argues that the lack or poor of these elements are generally present in the structuring of the postnatal depression.

However, I argue that south-Asian migrant mothers even those with "psychotic symptoms of PND" experience feelings that Westerners might label depressive, at the same time learn to function more or less effectively in the society. Western medicine identifies the symptoms of "classic depression" as crying, despondency, and feeling of hopelessness, acute anxiety, panic and feelings of physical illness (Pitts 1995:68:4). However, my contention is that a constellation of symptoms which are defined as depression in Western societies as an illness, are seen as part of life by South Asian people, because their cultural system or social capital understands and interprets those symptoms differently. I argue that symptoms are not the sum total of an experience; rather a significant contribution to experience comes from socio-cultural capitals that both contribute to the symptoms and interact with them.

Before I describe about South Asian culture and it's socio-cultural capital, I would like to explain schema theory, (Strauss and Quinn) which I use to analyse my informants psychological understanding about PND.

Schema theory assists in identifying culture as a mental construct. It recognises that individuals make sense of their day-to-day experiences through schema. The schema is based on associative learning, which means when we experience two things together it comes to have an association in our mind. When we first see a dog and it barks then we know that dogs bark. Then if we just hear a barking we can recognise that it is a dog - this is because of the association. Similarly when we see a woman wearing a sari and that woman is from South Asia (SA) then we associate that women in SA wear saris. Later if we see a sari, our South Asian schema is activated and we will be able to associate sari and woman and SA.

People are supposed to have common schemas when they share common experiences. However, people are different thus their schemas are different though they may have schemas that are some extent similar. This related to my second point I made earlier. For example, many people watch the T.V. show 'The Simpsons' in the world. In a way many people share a same experience or share a same culture i.e. The Simpsons culture. However, if someone with the schema, which developed with extended family, watches The Simpsons, and others watch through the schema developed with nuclear family, each will understand The Simpsons differently. Another example, in a Western society a 'family schema' is father, mother and children whereas in SA a 'family schema' is father, mother, children, uncle, aunty, cousins, grandmother and grandfather. Thus schema is an internal understanding of how we see the world. Schema helps us to see and understand the world and interact with it.

The interrelationship between the extrapersonal (culture/world structure) and intrapersonal (mental structures) is particularly significant to my study in understanding culture and human behaviour. In relation to the women who participated in my study cultural schemas inform how at the intrapersonal level they self-re-construct and self-represent their mental condition under difficulties they experienced after migration and giving birth.

To illustrate this argument let me provide ethnographic information of Shonali, a participant to my study. "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 nurses were right—I was depressed. But it is not the point. What could a psychologist or a doctor do if I went to them? This is not a disease. I 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 the nurses in the public sphere differ significantly to Shonali's self-representation of depressed in the private sphere. Even though Shonali recognises that she was depressed as the nurses told her, she felt this was not a disease. The word 'depression' and the associated 'symptom' remain but the meaning is changed. The schema of suffering, Shonali developed from her childhood experience differed from the nurse's schema of suffering or depression.

Let me provide some more description about women's status in SA as a background of how women feel about their emotions. This is what I call socio-cultural capital. This will give you a better understanding of how South Asian women perceive PND. Women's upbringing in that society socialized their experience of PND. I will now discuss the *purda* system and how

purda modifies their emotion through out their life. The way women are socialized and treated in that society has a great impact on how they feel about their feelings.

South Asia and the Status of Women

In South Asian society, women's participation in the productive sphere is greatly restricted. Women are generally domestic workers, not employees. Nowadays, however, in Bangladesh an expanded education system has resulted in increased female attendance in secondary and college education and the growing presence of non-government organizations has helped to increase women's participation in the economy, and thus it has given the women opportunities to go out and do work more often than they used to do before (Rozario 2003).

Despite many women being allowed to work towards payment of their dowry or out of economic necessity, but they are required to stop work upon marriage or as soon as the economic necessity is solved. Lack of female participation in the economy is greatly due to the *purda* system. Essentially, this system refers to female seclusion and suggests that women should stay at home. The separation of the worlds of men and women is a major aspect of *purda*. *Purda* is 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. Essentially, *purda* limits women from entering into the economy. These cultural factors can, and do, effect the experience of postnatal depression.

Control over the spatial mobility of women, the norm of purda is maintained through the ideology of lajja or honour, shame and female pollution. A kind of stoical attitude towards femininity is implicated in the values of South Asian society and the socialization of its female children. In this society from childhood women are taught to suppress their emotion and not to express their feelings. Women are expected to be patient in every phase of their life and they are supposed to sacrifice their life on behalf of their families. This attitude is reflected in the training of female children's social behaviour. When a girl grows up alone with her brother she is not supposed to behave like her brother; the maternal attitude towards 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 requires physical activities. Chi is the typical South Asian expression to lower someone's self-esteem. For example a mother's reaction towards her daughter who behaves like a boy is "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. Lajja is "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).

A direct translation of *lajja* might be shame, however, *lajja* is a more complex ideological construct, having both positive and negative connotations. The example I have just given of lajja is in a negative sense. Behaviour in opposition to the social norms brings shames to the family, thereby lowering prestige. Alternatively in a positive connotation, having *lajja* ensures that a person especially woman will conform to the social norms. Thus *lajja* represents self-respect and honour of a woman who follows the cultural values.

South Asian culture stresses the idea of female pollution, in terms of sexuality and childbirth, both are associated with *purda*. Having pure status as a woman is often related to wealth and a good relationship with god. Menstruating, pregnant or a woman has given birth are seen as polluted so sexual contact with her husband is out of the question. She is not even allowed to cook for others and is prohibited from any religious activities during that period. So in this society as a young girl grows up she eventually learns that *chi* and *lajja* are things that would be around throughout her life. She also learns that purda, immobility, modesty, silence and dependency of women are very important qualities, which ensure her sexual purity (Rozario 1992:85). Thus she internalises that she is not someone who gets the priority in the family and

should not express her emotion. Describing her own feelings becomes *lajja* (shame) for her. This socialization process or social capital helps women cope with experiences of what Western call PND. In this society where women have to deal with so many strains they recognise these experience as nothing but another aspect of their social life.

To illustrate my argument let me quote representative statements provided by Rani a participant in my study.

“Don’t take everything serious. 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. More over, in India if you are a female, you are just treated as a 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 is as a layperson, they lean to cope with it and they just learn. It is tuned out of our body and mind. We 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 told myself what am I going to do - set depressed and what? I have to get on with it, go and do best for the children. Having postnatal depression is a luxury to us".