# University of Alberta

The Intersection between Culture and Postpartum Mental Health: An Ethnography of Bhutanese Refugee Women in Edmonton, AB.

by

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## Abstract

This thesis is an ethnography of postpartum mental health outcomes in a group of Bhutanese refugee women living in Edmonton, AB. Previous research has shown that refugee women are at a higher risk of postpartum depression than Canadian-born women. Despite this finding, the postpartum experiences and unique needs of refugee women remain poorly understood. Utilizing an anthropological approach, I aim to fill this gap by investigating women's own perceptions and understandings of their postpartum wellness. I focus on examining and explaining the complex intersections between selfhood, wellness, gender, family and community in Bhutanese women's responses to childbirth and the ways in which those relationships change or persist in the face of migration. I interpret Bhutanese women's resilient and strong postpartum responses through these interconnected cultural variables, establishing the vital role that culture plays in postpartum mental health.



Keywords: Bhutan, Nepal, refugees, culture, postpartum, mental health, gender, social support

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# Chapter One: Introduction

The postpartum period is associated with profound and life-altering changes in the lives of new mothers and their families. Although this stage is frequently accompanied by expectations of happiness and joy, this is not always the outcome. In reality, there are variations in postpartum emotional states and mental health outcomes dependent on a wide range of contextual factors. In recent years, research pertaining to negative changes in postpartum mental health has intensified and postpartum depression (PPD) has been presented as a health issue of global concern. Despite the existence of a considerable amount of research into the matter, the aetiology and worldwide incidence of postpartum depression remains poorly understood and is widely debated within various academic disciplines and medical circles. Anthropologists, cross-cultural psychologists and transcultural psychiatrists have contributed to the body of knowledge on postpartum depression by investigating the relationship between culture and postpartum depression.

Culture can be defined as “the learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular group that guides their thinking, decisions, and actions in patterned ways” (Leininger 2001, 47). Jenkins, Kleinman and Good (1991) have argued 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" (68). Thus, culture is an inherent and irremovable component to the perception, understanding and expression of depressive feelings in individuals and their larger social environments. The need to incorporate cultural factors in understanding postpartum mental health has intensified in recent years, due, in part, to changing social environments characterized by increased movement within and across borders. Refugee and immigrant women in particular have been presented as an especially high-risk group for depressive disorders in pregnancy and the postpartum period (Zelkowitz et al. 2004). Increasing numbers of re-settled immigrant and refugee women in Canada and other countries around the world presents health care workers with the pressing challenge of understanding this increased risk (O'Mahony et al. 2010).

In my thesis, I am concerned with understanding and highlighting the complex relationship that exists between cultural factors and postpartum mental health outcomes in refugee women. My interest in this topic is derived from a conversation that I had with a colleague at the Multicultural Health Brokers Co-operative (MCHB) in Edmonton, Alberta[1]. During a discussion of issues facing

[1] The MCHB was founded and continues to run by immigrant community health workers who bridge the gap between newcomers and health institutions and other essential services in Alberta. There are currently 54 of them representing 22 diverse cultural and linguistic communities in Edmonton. The health brokers offer a wide-range of services to support and educate refugee and immigrant families in areas concerning the whole life span, from pre- and post-natal health to seniors' well-being. They provide holistic family support, community development and system advocacy. Please see www.mchb.org for more information.

immigrant and refugee women in our city, my colleague mentioned postpartum depression as an issue of growing concern. She then shared with me a rather disturbing story regarding a Karen refugee woman from Burma whom she had been asked to help. Recently re-settled in Edmonton, Paw Htoo[2] was pregnant with her first child. After giving birth in a hospital, she began to exhibit behaviors that were deemed abnormal and dangerous by health care workers. She refused to eat or talk to anybody and did not look directly at anyone when they entered the room. Although she was breastfeeding she was also feeding her child water, which was viewed as unusual and harmful for the baby by health care workers. As a result she was deemed a "bad" mother and viewed as a threat to her newborn. On one occasion she screamed, leading the hospital staff to believe that she was becoming violent. Ultimately, she was presumed to be "crazy", placed in a straightjacket and isolated in a room away from her husband and newborn baby.

But Paw Htoo was not crazy. After a mental health care worker recommended that Paw Htoo be released from her isolated state and be sent home after one week, my cultural broker colleague visited her to follow-up. During this visit, it became abundantly clear that Paw Htoo's behavior could be explained by looking at her individual experiences and cultural background.

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[2] Name has been changed to protect this woman's privacy.

Firstly, her negative postpartum feelings could be explained by the fear, isolation and lack of social support that she experienced during and after her pregnancy. As a recent immigrant, Paw Htoo knew only her husband and had not connected with anyone that looked like her or spoke her native languages of Burmese and Karen. While in labour, she could not understand the people around her or what was happening. This resulted in fear and apprehension, as she did not know where she was being taken or what medications were being administered to her. In the days after she gave birth, she was visited by strangers with binders and suitcases. She explained that she felt that she was being interrogated because she was in trouble with the law.

Secondly, the postpartum behaviors deemed "abnormal" by health care workers were also explained by her cultural background. Paw Htoo did not speak to anyone because she *couldn't*. Although she did, in fact, understand and speak English, the doctors and nurses spoke far too quickly for her to comprehend. When she spoke English she was also misunderstood, resulting in embarrassment and the decision not to attempt to speak English at all. Being misunderstood and ignored also resulted in considerable frustration, resulting in her sudden outburst. She was not eating because the food she was offered did not adhere to the Karen traditional postpartum diet (e.g. avoidance of cold food). Furthermore, in her culture it is common practice to give newborn babies small amounts of water in conjunction with breastfeeding. After being investigated from a compassionate and culturally-relevant perspective, Paw

Htoo's postpartum state appeared not to be connected with any biological or psychological changes commonly associated with postpartum depression in Western contexts. Rather, her negative postpartum experiences were a result of multiple, interconnected cultural factors that could have been mediated much earlier.

The issues raised from this situation indicate the vital importance of culture in understanding refugee women's postpartum responses. They also highlight the crucial need for cross-cultural research into cases of PPD as well the need to consider women's own unique understandings of their postpartum mental health. Through my research with Bhutanese refugee women in Edmonton, AB, I seek to contribute to the body of knowledge concerning cultural factors and postpartum mental health outcomes. The objective of this thesis is to explain and understand the complex intersections between selfhood, health, gender, family and community in women's culturally-mediated responses to childbirth and the ways in which those relationships change or persist in the face of migration.

In my thesis I show that the majority of Bhutanese refugee women that participated in my study did not perceive illness in themselves following childbirth, instead exhibiting a positive, resilient response in the postpartum period. When women did mention feelings of postpartum tension, this was not perceived as illness or depression, as it might be in Western medicine. To explain

this finding I interpret Bhutanese women's postpartum experiences through three interwoven cultural factors: cultural constructions of illness, the gendered self, and sociocultural support. Throughout each discussion I add a consideration of the effects of migration in order to show generational changes and consider future implications.

Before proceeding into the discussions surrounding these three cultural factors, it is necessary to provide an introduction to the subject matter and theoretical background from which my work is founded upon. In this chapter I present background information regarding postpartum depression and the risk factors among refuge women. First, I describe the Western, biomedical conceptualizations of postpartum depression and current biological, psychological, evolutionary, feminist and sociocultural theories concerning its origination. Next, I introduce ideas surrounding refugee women's mental health, establishing the background information needed to understand the interpretations made throughout this thesis. I then outline my position and the approach to the study of refugee women's postpartum mental health that I utilize throughout this thesis. Finally, I provide a brief outline of the content of the thesis.

### *Understanding Postpartum Depression*

Postpartum depression (PPD), also known as postnatal depression, is a serious and complex condition that causes high levels of morbidity in women of

childbearing age. Worldwide, women face their greatest lifetime risk of developing depression, or another mood disorder during their childbearing years (Templeton et al. 2003). In 2000, major depressive disorders were estimated to be second only to HIV/AIDS in terms of total disability among women aged 15-44 years (for men of the same age group, they were third) (WHO 2001). The worldwide prevalence of PPD is widely cited to be 10-15% (Goodman 2007) although this number has been contested due to a paucity of research concerning cross-cultural diversity in rates of PPD (Halbreich and Karkun 2006). Statistics and information regarding the universality, classification, expression and complications of PPD comes largely from Western biomedical research. However, it must be noted that prevalence and definitions of PPD can vary widely based on cultural and social variables such as understandings of illness, expectations of women and social responses in the postpartum period.

PPD is currently grouped with other mood and affective disorders in the two main classification systems used within psychiatry: The American Psychiatric Association's Diagnostic & Statistical Manual of Mental Disorders (now in its fifth edition) and the International Classification of Diseases (currently on its tenth version) (Robertson et al. 2003). The criteria for clinical diagnosis under these classifications is essentially the same as for a major depressive disorder, except for the ''postpartum onset'' specifier that is applied if the episode begins within 4 weeks of childbirth (O'Hara 2009). The symptoms and expression of postpartum mental illness can vary based on severity, onset and resolution time.

In the literature, conditions of PPD may occur anytime within a year postpartum and, depending on severity, can be characterized as one of three forms: the "baby blues," postpartum depression or postnatal psychosis. The mildest form, the so-called baby or postpartum "blues" are common and often resolve within a few days without any intervention (O'Hara 2009). Symptoms arise within the first week to ten days and include "mood liability, irritability, interpersonal hypersensitivity, insomnia, anxiety, tearfulness, and sometimes elation" (O'Hara 2009). The most serious and least common form, postnatal psychosis, is characterized by severely depressed mood, delirium, delusions, psychotic thoughts, hallucinations and insomnia (O'Hara 2009; Halbreich and Karkun 2006). Individuals with this condition have extreme complications, including thoughts of self-harm or suicide and, rarely, infanticide (Templeton et al. 2003). Such was the case with Andrea Yates, a mother convicted of drowning her five children, who was later revealed to have suffered severe postpartum depression and postpartum psychosis (McLellan 2006).

The majority of research on postpartum mental health issues has focused on the intermediate form known simply as postpartum depression. Less grave than postpartum psychosis and more intense than the "blues," PPD generally occurs within four to six weeks after giving birth (Halbreich and Karkun 2006). Symptoms are wide-ranging and can include insomnia, loss of appetite, irritability, anxiety, guilt, low self-esteem, lack of concentration, agitation,

tearfulness and anxiety (Templeton et al. 2003, O'Hara 2009). Throughout this thesis, references made to PPD will refer to this intermediate form.

PPD can impact women, their children and their families in negative and sometimes devastating ways. A number of studies have shown that women suffering from PPD experience significant changes in health and overall life satisfaction. They may experience impaired cognitive ability and increased marital difficulties (Brummelte and Galea 2010) and have an increased risk for continuing or recurrent depression (Halbreich and Karkun 2006). A new mother's depression has been shown to affect spouses as well, as the partners of women with PPD are more likely to become depressed themselves (Halbreich and Karkun 2006; Lovestone and Kumar 1993).

In addition to the negative impact that PPD has on a woman and her partner, a significant body of literature has shown that children of depressed mothers are especially sensitive to its effects. The negative impact of maternal depression on offspring starts *in utero* and extends into infancy and beyond (Goodman and Brand 2008). Maternal depression creates an adverse environment that can affect a developing physical and mental development as well as safety and future life outcomes. Depressed mothers are more likely to suffer anxiety disorders and substance abuse (O'Hara 2009) as well as be less likely to interact and engage with their children and be attuned to their needs (Halbreich and Karkun 2006). As a result of poor mother-child interactions,

infants may suffer adverse cognitive, behavioural and emotional outcomes and have an increased risk of developing depression and emotional and antisocial disorders in adolescence (Brummelte and Galea 2010; Klainin and Arthur 2009). Furthermore, a lack of attentive care may result in malnutrition and poor physical health (Halbreich and Karkun 2006). Even when mothers recover, the effects of PPD can be recognized in development issues and behavioural problems later in life, including having an increased propensity for violence (Hay et al. 2003). Unfortunately, some evidence has shown that these effects may not be mitigated by the presence of other caretakers. According to a study by Goodman (2008), partners of depressed women demonstrate less optimal interactions with their infants, indicating that their presence does not compensate for negative effects of PPD on children (624). The far-reaching complications that PPD can have on a mother, her child and her family, make the study of PPD a pressing global health issue.

***Cross-Cultural Prevalence***

In recent years, the prevalence of PPD across cultures has been the subject of considerable debate and scrutiny. The current body of research has produced conflicting results, with some research showing certain geographical areas, cultures and ethnicities to have higher symptomatology (Onozawa et al. 2003; Affonso et al. 2000) while others maintain that cross-cultural comparisons show negligible differences in prevalence (Robertson et al. 2003; Kumar 1994).

Furthermore, although some researchers have proposed that PPD is a culturally-bound syndrome, found infrequently or absent altogether in non-Western cultures (Stern and Kruckman 1983), the most recent research has found evidence of PPD as being a transcultural phenomenon (Zubaran et al. 2010). The inconsistencies regarding the universality and prevalence of PPD across cultures can be attributed to issues with current study tools and methods as well as the various ways in which postpartum mental health is understood and presented across cultures.

Recent research has brought issues with PPD diagnosis to the forefront and has offered a possible explanation for variations in PPD cross-cultural rates. Researchers have called attention to the two main assessment tools used in diagnosing PPD: the Edinburgh Postnatal Depression Scale (EPDS) (Cox et al. 1987) and the Beck Depression Inventory (BDI) (Beck et al. 1961). Both screening tools have been developed by Western clinical researchers, reflecting the beliefs of Eurocentric psychiatry (Brummelte and Galea 2010, Barry and Beitel 2009). Furthermore, the fact that all assessment tools for PPD have been developed using the English language "generates complications of cultural relevance, semantics, sensitivity, concepts and constructs" (Zubaran et al. 2010, 363). As such, the use of standardized diagnostic tools in transcultural research should be avoided in favour of culturally-sensitive tools developed specifically with and for specific cultures.

In addition to issues with diagnostic tools, anthropologists have considered the role cross-cultural equivalencies of depression in reported rates and risk (Zubaran et al. 2010). As I will show in Chapter Four, cultures vary greatly in their understandings and classifications of illness, views of acceptable ways to express distress and norms regarding disclosure of mental illness. In their review of 143 studies on PPD, Halbreich and Karkun (2006) found a wide range of reported prevalence, from almost 0% to almost 60%, which they attributed to cross-cultural variables, differences in perception of mental health and its stigma, differences in socio-economic environments and biological vulnerability factors. These variables have been implicated by others, such as Zubaran and colleagues (2010) who noted that "the prevalence of PDD in a given society appears to be influenced by a myriad of local and environmental factors, including cultural and folklore elements, religious practices, socioeconomic deprivation, lack of health care infrastructure and poor public health indicators" (362). Overall, it is important for researchers of PPD to remain mindful of the cultural limitations of study methods and diagnostic tools, and the implications that culture has on the global incidence of PPD.

### *Refugee Women and Postpartum Mental Health*

Although PPD can affect and has been recognized in all groups of women regardless of background, refugee and immigrant women have been recognized as a particularly high-risk group (Dennis et al. 2004; Miszkurka et al. 2010; Collins

et al. 2011; Kirmayer et al. 2011; Schininà et al. 2011; Davey et al. 2008; O'Mahony et al. 2013; Foss et al. 2004). In their literature review, Collins and colleagues (2011) found that nearly all of the reviewed studies found that probable rates of PPD were higher in immigrant women (including refugees) than in their native-born counterparts. This has been found to be true within a Canadian context, with refugee women being shown to have a significantly higher risk of developing PPD than Canadian-born women and other immigrant women (Dennis et al. 2004; Stewart et al. 2008). The ever-increasing number of refugee groups settling in Canada presents health care workers with the pressing challenge of understanding the factors contributing to this increased risk.

Refugees - who can be defined as individuals who moved to a new country to escape persecution, torture, or cruel and unusual punishment (O'Mahony et al. 2013) - experience unique stressors over the course of migration that can negatively impact their mental health outcomes. In the pre-migration stage, refugee women are likely to encounter violence and trauma resulting from the events that precipitated their migration. Instances involving war, persecution and/or political and military instability often coincide with gender-based violence and discrimination, including acts of sexual violence and rape. Refugee women may directly experience or witness such horrors, which put them at a significant risk for mental health issues. During the migration process, stressful life events may continue or amplify, as refugee women are subjected to conditions of uncertainty within refugee camps. Economic difficulty,

food scarcity, separation from family members (especially their own children) coupled with an ongoing threat of sexual violence, trafficking, and discrimination are challenges faced by refugee women following their initial flight. These experiences may result in episodes of depression that continue throughout a woman's pregnancy into the postnatal period or re-emerge as PPD following birth (Collins et al. 2011).

In addition to the challenges faced by women before and during migration, transitions associated with the post-migration period may contribute to refugees being at a higher risk for PPD (Zelkowitz et al. 2004). Following re-settlement, refugee women must re-adapt to new social, economic, and cultural systems, a process that has been recognized as being extremely stressful (Collins et al. 2011). Women may experience significant stress as a result of financial worries, social isolation, separation from family language barriers, discrimination and racism, which can in turn affect their emotional and mental well-being (Collins et al. 2011). Pregnant women and new mothers may be especially sensitive to the stresses associated with migration, as they must simultaneously make the major and stressful transition from ‘woman’ to ‘mother’ and 'local' to 'immigrant' (Barclay and Kent 1998).

It is perhaps unsurprising that refugee women, with their backgrounds of traumatic life events and stressful acculturation and adaptation challenges, emerge as a high-risk group for PPD. Psychosocial risk factors that have been

associated with PPD, such as low levels of social support, previous history of depression, antenatal depression, and traumatic life events are common in refugee women (Collins et al. 2011). Furthermore, women may be further predisposed to develop PPD when the multiple demands of motherhood are coupled with negative adaptation outcomes (such as low socioeconomic status, financial worries and isolation). It is important to consider the unique challenges faced by refugee women in understanding their elevated risk for PPD and responding to their maternal mental health needs. However, as my study will show, not all refugee women experience PPD symptoms despite traumatic and difficult life events, and it is equally important to understand the underlying reasons for lack of PPD in vulnerable populations such as the Bhutanese.

### *Approaches to the Study of Postpartum Depression*

Although the expression and complications of PPD are well-defined and accepted in Western medicine, the nature and aetiology of PPD continues to confound mental health workers and researchers. The current body of research on PPD includes a wide range of hypotheses and perspectives regarding factors contributing to postpartum mental health issues. Five emergent perspectives that I have reviewed in the literature include: biological, psychological, evolutionary, feminist and sociocultural. In this section, I will give a brief overview of each, indicating their strengths and weaknesses in explaining the phenomenon of PPD as well as their relationship to my own research. While

each perspective is discussed individually here, it is important to remember that they are not mutually exclusive and there is growing agreement among researchers that the postpartum depression arises due to a combination of intersecting risk factors.

*Biological Perspective*

In Western nations, much research has been dedicated to finding links between PPD and human physiology. Proponents of the biological perspective believe that PPD arises due to abnormal or changing biological components during and after pregnancy. During pregnancy, women's bodies undergo significant hormonal changes and experience equally pronounced hormonal changes following birth. These significant and abrupt changes, coupled with the fact that PPD symptoms have been found in a range of countries and cultures, would seem to indicate a biological cause (Zubaran et al. 2010).

Interest in biologically-based explanations for postpartum mental illness has a long history, dating back 2000 years when Hippocrates first suggested that PPD was caused by milk being diverted from the breast to the brain (Thurtle 1995). Contemporary researchers pursuing a biological explanation have pointed to several biological factors including: nutritional deficiencies and/or metabolic imbalance, iron-deficiency anaemia, hormonal changes and fluctuations, abnormality in biopterin or neopterin levels, alterations in hypothalamic–pituitary–adenocortical mechanism, and alterations in neurotransmitter levels

(Klainin and Arthur 2009). There have been several studies focusing on the biological dimensions Asian cultures specifically. In a literature review concerning PPD in Asian cultures, Klainin and Arthur (2009) found 12 studies that documented an association between physical/biological factors and PPD (1366). The factors uncovered in these studies included a history of medical conditions and premenstrual symptoms, poor physical health, and difficulty carrying out physical activities (1366).

Despite significant research focusing on biological factors, no strong and consistent associations have been made (Brummelte and Galea 2010; Gale and Harlow 2003; Robertson et al. 2003; Steiner et al. 2003; Hayes et al. 2000). Although biological factors have been popular among Western researchers in explaining the onset of PPD, studies have been to very limited success in establishing definitive evidence or reliable results. Many studies have been unsuccessful due to methodological problems such as non-accurate hormone level readings and inappropriate blood sampling techniques (Robertson et al. 2003) while others were simply unable to demonstrate the clear connections needed to support their hypotheses.

Although the biological perspective may factor into the multidimensional nature of PPD, the lack of evidence to prove or disprove theories has left me unconvinced and I will not pursue them in this thesis. Although the women in my study underwent the same biological changes as any pregnant woman, the

majority did not perceive any postpartum emotional changes in themselves, indicating the importance of other factors in interpreting and mediating any biological changes that arise postpartum. Although biological factors may certainly precipitate postpartum mental changes, women's sociocultural environment fundamentally shapes the ways in which any maternal distress is manifested (Zubaran et al. 2010).

*Psychological Perspective*

The psychological perspective emphasizes the role of cognition, psychological factors and individual behavioural characteristics in causing PPD. Proposed factors include a previous history of mental illness, and/or having a poor mood, anxiety, depression or neuroticism during pregnancy (Robertson et al. 2003). Several psychological models have also been constructed to explain the emergence of PPD, including the cognitive, behavioural, learned helplessness and self-control models. According to the cognitive model, depressed women have negative views of themselves, the world and their futures, which in turn contribute to poor mental health (Klainin and Arthur 2009). The behavioural model hypothesizes that women are predisposed to depressive symptoms following diminished levels of response contingent positive reinforcements (Klainin and Arthur 2009). The learned helplessness model posits that a history of negative events leads to expectations of future failure, which contributes to feelings of lack of control and depressive symptomatology (Klainin and Arthur

2009). Finally, the self-control model postulates that depression occurs when self-control processes such as self-monitoring, self-evaluation, and self-reinforcement are disrupted (Klainin and Arthur 2009). Current research has found a greater deal of support for psychological factors and constructs in the aetiology of PPD than for biological factors. Studies have successfully shown that both a history of mental illness, dysphoric mood during pregnancy and poor cognitive constructs can results in continuity of mental disturbance following pregnancy (Robertson et al. 2003) indicating a role in PPD.

In Klainin and Arthur's (2009) review of PPD studies in Asian cultures, psychological factors were found to have been investigated in 43 studies. Factors included: "Depressive symptoms during pregnancy, antenatal anxiety, past psychiatric history, premenstrual dysphoric disorder, stressful life events, child care stress, negative affect, low self-esteem, poor self-image, insecure attachment style, and negative attitude toward employment" (1367). These components were described as being strong risk factors, indicating the need to include psychological factors in studies on Bhutanese postpartum mental health.

Although most current psychological perspectives focus on the role between psychological states and developing PPD, psychological constructs can also have a positive mediating role. Throughout my thesis I will touch on the psychological perspective by focusing on how women's psychological factors can have a positive effect on the way they view and manage postpartum mental

health. In Chapter Five in particular, I discuss how women's cognitive schemas informed by gendered experiences and understandings of suffering can protect against PPD.

*Evolutionary Perspectives*

In Darwinian, or evolutionary psychiatry, PPD is viewed as an evolved, adaptive response to childbirth rather than a pathological or harmful condition. Evolutionary perspectives challenge the Western, biomedical beliefs that classify PPD as an illness, contending that postpartum mental changes are beneficial in certain contexts. In this framework, PPD is representative of individual fitness; the process by which individuals with a genetic tendency to successfully cope with challenges experience increased reproductive success. Proponents of the evolutionary perspective view PPD as an evolved adaptation that functions to increase the fitness of an individual as well as her offspring.

Crouch (1999) provides a concise argument regarding the ways in which maternal distress acts as an adaptive response. According to Crouch, PPD "is an adaptive aspect of maternal responsiveness that has evolved through natural selection in a context where some environmental (including social) factors can challenge the mother's capacity to provide continuing care for the infant" (1999, 170). In her hypothesis, Crouch maintains that maternal distress signifies a woman's inability to provide and attend to her infant adequately, which in turn attracts support for herself and by extension, her child. She notes that in

ancestral patterns, social groups would have been small and tight-knit, and support would be prompt, personal, and direct. Today's world, however, is substantially different from the conditions that allowed PPD to function as an adaptive response. According to Crouch, it is this changing environment that accounts for the view of postnatal distress responses as inappropriate and representative of illness rather than as a positive adaptation (1999, 170).

As part of her argument, Crouch also contends that postpartum cultural practices evolved along with responses to PPD in our ancestral past and survived long-term in most societies, acting as stress-reducing mechanisms. Postpartum rituals which prescribe rest and social support as well as giving enhanced status to a new mother may have arose due to expressions of maternal distress. Again, Crouch argues that this pattern would have evolved due to fitness advantage in small, ancestral conditions but may have lost its function in today's world. She notes that " in a complex social setting far removed from the conditions under which the response pattern evolved, the painful emotional state and its overt manifestations are counterproductive and compound the difficulties that have precipitated them" (1999, 170) indicating that PPD may have lost its original purpose and effectiveness.

Although it has interesting arguments, I do not wish to pursue the evolutionary perspective in explaining the postpartum mental health responses of Bhutanese women. According to this perspective, PPD is an adaptive response

that elicits additional support to offset stressors. However, as Ghosh (1991) has noted, when immigrant women experience a multitude of stressors - from economic difficulties to language barriers to lack of cultural recognition - they do not necessarily exhibit depressive symptoms as some Neo-Darwinists might expect (17). This indicates the importance of reviewing other factors that affect women's responses to postpartum stressors. The aspect of evolutionary accounts that is most useful within my interpretive framework is the suggestion that postpartum cultural practices and ingrained support systems evolved as protective mechanisms. In my research, the importance of sociocultural support was very apparent and will be elaborated upon in Chapter Six.

*Feminist Perspectives*

As in the evolutionary perspective, advocates of the feminist perspective do not view PPD as being representative of a physiologically or psychologically-based illness. Rather, feminist analyses of PPD seek to critique the medicalization of postpartum depression, provide a broad analysis concerning distress that can arise from women's roles in patriarchal society and advocate for the deconstruction and reconstruction of institutionalized motherhood (Berggren-Clive 1998). According to these analyses, PPD arises due to incongruities between androcentric expectations of new mothers and a woman's ability to perform them, resulting in feelings of inadequacy. In the most extreme views,

feminists ascertain that PPD is a construction that emerged from male patriarchies, designed to oppress women.

In order to further illustrate the feminist perspective on PPD, I will summarize qualitative research conducted by Berggren-Clive (1998) that focused on 8 women who had recovered from PPD (unfortunately, she does not indicate the ethnic or cultural backgrounds of the women). According to Berggren-Clive, "postpartum depression is not a pathological disease but a natural response to the myths of motherhood constructed in a patriarchal society" (1998, 105). In her interviews, Berggren-Clive focused on how the women themselves made sense of their experiences with PPD. Their responses supported feminist perspectives on PPD, showing that the women themselves implicated stresses associated with the transition to motherhood and the contradictions inherent in the myths of motherhood in understanding the PPD they had suffered (1998, 114). Therefore, PPD can be viewed as a normal reaction to the stresses and inherent incongruities associated with motherhood. This study made strong use of the feminist perspective in order to show how social and androcentric expectations can be connected to postpartum mental illness.

Although I do not utilize all aspects of the feminist perspective, one that I appreciate and have used in my own research is the practice of giving a voice to women and understanding PPD based on their own responses. In her work, Berggren-Clive strived to "create a new discourse on postpartum depression by

conducting qualitative research utilizing feminist principles that gives voice to women and validates their own realities of their experiences with postpartum depression" (1998, 105). My own research relates to this goal, as I aimed to conduct my research for women, rather than on women. Furthermore, it was important for me to give Bhutanese women a voice and understand how they themselves define their identity and postpartum health, rather than implicate the beliefs and expectations of others (including myself). Overall, I strongly believe that the focus on women's own responses and understandings is a fundamental strength of the feminist perspective on PPD.

*Sociocultural Perspectives*

The final approach to PPD that I discuss here is the sociocultural perspective. According to this perspective, PPD arises due to the social and cultural environment of an individual. As Halbreich and Karkun (2006) have noted, the cross-cultural variances in PPD prevalence rates may be accounted for by sociocultural variables (108). These can include religious customs, levels of social support, socioeconomic status, adverse life events, attitudes regarding pregnancy and motherhood, gender roles, and stigma surrounding mental disease (Halbreich and Karkun 2006; Robertson et al. 2003; Kumar 1994). With the exception of social class, which has been consistently shown to be a non-predictor of PPD (Kumar 1994), the majority of proposed sociocultural factors have well-established connections to the emergence of PPD.

Cultural components may predispose women to higher risks of PPD while others may function as protective factors. Predisposing factors can include stigmatization of mental illness, restrictions on emotional expression (Halbreich and Karkun 2006) and expectations surrounding the gender of a child (Templeton et al. 2003). On the other hand, protective factors can be present in religious or cultural traditions. In many non-Western cultures, elaborate postpartum rituals give status and importance to a new mother and can increase self-esteem and clarify social status (Templeton et al. 2003). In addition to rituals, some cultures place a high emphasis on social and practical support for a new mother. Increased guidance, social support and domestic assistance can decrease physical and mental burdens as a mother adapts to her new role (Oates et al. 2004; Halbreich and Karkun 2006) and may thus act as protection from PPD (Robertson et al. 2003). For immigrant and refugee women, migration may result in loss of support networks and cultural traditions, resulting in increased PPD risk.

Social support has emerged from the literature of one of the strongest predictors of PPD. Support can come from a partner, friends, relatives or members of a common community. It can be received in the form of informational support (advice and guidance), instrumental support (practical support, such as assistance with tasks) and emotional support (expressions of love, caring and respect) (Robertson et al. 2003). Studies have consistently

shown a negative correlation between postpartum depression and instrumental and emotional support in particular (Robertson et al. 2003).

In addition to low levels of social support and performance of cultural traditions, low socioeconomic status has been consistently shown to be a strong predictor of PPD. Research has shown that women of a lower socioeconomic standing experience PPD significantly more than more affluent women (Segre et al. 2007; Rich-Edwards et al. 2006; Abrams and Curran 2009; Goyal et al. 2010; Beeghly et al. 2003). Socioeconomic (SES) factors including social adversity, low education, low income, and being unemployed increase the risk of developing postpartum depressive symptoms (Abrams and Curran 2009; Rich-Edwards et al. 2006; Goyal et al. 2006). Low socioeconomic status may lead to increased risk of PPD because financially poor women may experience more chronic stressors. Furthermore, the birth of a child may exacerbate an already stressful economic situation, leading to, or worsening a woman's emotional state. One explanatory framework using psychological constructs that has been offered to explain this relationship is the social stress process model. According to this model, financially poor women are exposed to increased stress and decreased coping responses and resources, which in turn, lead to depression. In support of this theory, researchers have described women of lower SES as indeed having poorer coping styles for stress, greater exposure to stressful environments and lower social support (Segre et al. 2007).

Finally, the relationship between adverse life events and the onset of depression has been well-established in the literature (Robertson et al. 2003). The effect of negative events such as the loss of a loved one or unemployment may exacerbate the stresses already associated with pregnancy and trigger depressive episodes (Robertson et al. 2003). Marital disharmony as an adverse life event has also been correlated with PPD (O'Hara 2009; Robertson et al. 2003).

In my opinion, the current research considering sociocultural components as factors protecting or predisposing women to developing PPD is among the most convincing. The strength to theories that implicate sociocultural factors is that they can harmoniously incorporate other variables, including those from perspectives discussed above. Most importantly, the sociocultural perspective has emerged as being the most influential in my research with Bhutanese refugee women. In Chapter Six, I expand upon current research regarding sociocultural dimensions of PPD in refugee and South Asian communities as well as focus on the sociocultural aspects that I have found to be of great significance.

### *Utilizing Psychological Anthropology*

My approach to the study of mental health is grounded on the fundamental aspects of psychological anthropology, the sub-field of medical anthropology which "undertakes the cross-cultural study of social, political, and

cultural-historical constitution of the self; it also analyzes the manner in which human identity is variously disintegrated and reintegrated, conceptualized and realized, in diverse cultural and temporal settings" (Lindholm 2007, 10). My background in anthropology has led to a strong conviction that culture is interwoven into all aspects of a person's life, including the ways that they construct their identity, conceptualize emotions, and view and experience the world. This belief fits harmoniously with the fundamental claim of psychological anthropology; that individuals exist only within social and cultural contexts (Lindholm 2007).

One of the most contemporary of academic disciplines, psychological thrived in the 1930s and 1940s following the innovative work of Margaret Mead, Ruth Benedict and others (Lindholm 2007). The work of Francis Hsu (1948, 1961) was also fundamental in developing the discipline. Following this initial development, the field saw a resurgence and further development in the 1970s and 1980s following the investigations of academics such as Kleinman (1978; 1980; 1988). Kleinman's work has been particularly useful in uniting the fields of medicine, psychiatry and anthropology, and forming the sub-field of psychiatric anthropology. Recently, the anthropological study of emotion and identity has re-emerged among contemporary academics. According to Lindholm (2007), this renewed interest is due to major shifts in the world's social and cultural landscapes:

> Considered historically, a renewed interest in psychological anthropology makes good sense, since the discipline addresses fundamental questions about the nature of humanity that have becomes especially pressing in the present era of multiculturalism and globalization, as taken-for-granted, everyday realities have been challenged within a fluid and dynamic world. Today, perhaps more than ever, people want to know to what degree their perceptions, emotions, beliefs, values, and even their experiences of themselves may be shaped and changed by shifts in culture and context. (vii)

The methods and subjects of inquiry found in psychological anthropology are uniquely positioned to investigate the issues that can arise due to increasing global movement, exchange of information, and resulting shifts in cultural and social contexts. For instance, increasing immigration presents psychiatrists with the challenge of understanding diverse cultures in order to effectively mitigate and treat mental illness. Within very recent years, academics are demonstrating the importance role of psychological anthropology in understanding and improving the mental health of re-settled groups of people (Chase 2011).

My own work utilizes several schools of thought in psychological anthropology as well as aspects of feminist and sociocultural perspectives in order to holistically understand the postpartum wellness of re-settled refugee women. Due to the fact that culture is multi-dimensional and complicated in nature, I found it necessary to incorporate aspects of several approaches. As my work is concerned with experiences of mental health and illness more-so than understanding psychological constructs in general, my investigation is positioned within psychiatric anthropology. The foundation of my work is grounded in this

field, as I seek to uncover and understand the complex connections between culture and mental illness in the postpartum period.

In order to determine how Bhutanese cultural constructs of identity and health influence their postpartum responses, I incorporate ethnopsychology. As defined by Kohrt and colleagues (2012) "ethnopsychology is the study of emotions, suffering, the self, and social relationships from a cultural perspective" (88). Building upon the Bhutanese ethnopsychology established by Kohrt and colleagues (2012), I investigate women's postpartum mental health by considering the various ways in which Bhutanese women conceptualize and understand themselves in addition to wellness, illness and depression. By using ethnopsychology, I was able to interpret women's postpartum experiences based on their local cultural conceptualizations. Lastly, in order to interpret the ways in which women's socialization and experiences influence their responses to the postpartum period, I utilize cognitive anthropology's concept of schema. In Chapter Five, my arguments are based on the idea that women's experiences are internalized as cognitive schemas which direct their future expectations and actions.

Situated within the discipline of psychological anthropology, my work draws upon several sub-fields in order to investigate the issue of postpartum depression from a diverse, multi-factored approach. While somewhat complicated in nature, I found it necessary to draw upon several theoretical

schools in order to establish the multiple yet interconnected ways that culture influences postpartum mental health. As discussed in the previous sections, I incorporate an overarching feminist perspective and discrete sociocultural factors within my anthropological approach by striving to represent women's own words and show the importance of sociocultural determinants of health. While it is impossible to investigate postpartum depression from every angle, I have attempted to establish an approach that considers multiple psychological, social and cultural variables.

***Thesis Overview***

In Chapter Two of this thesis, I introduce a background of the Bhutanese people whom this thesis is dedicated. I provide information regarding the plight of the Bhutanese refugees and their experiences with migration and life in Nepal's refugee camps. I also provide an overview of Bhutanese migration to both Canada and Edmonton specifically, including information regarding the current status of the community as well as challenges that they face in their new environment. Lastly, I review the current mental health studies on Bhutanese refugees, indicating their elevated risk of mental health issues.

In Chapter Three, I outline the methodology that was used in my research. I provide a discussion of the community-based participatory research (CBPR), ethnography, phenomenology, and interpretive anthropology approaches that were utilized in conjunction with one another for my research

study in Edmonton. I provide a description of the location that I completed my fieldwork, as well as an overview of my participants' demographic information. I also outline the data collection and analyses procedures that I used to form the content of this thesis. Lastly, I review ethical considerations as well as personal reflections on the ethnographic process.

In Chapter Four, Situating cultural constructions of wellness, illness, and depression in the postpartum period, I begin my first discussion and analyses of Bhutanese women's postpartum mental health. In this chapter, I situate women's responses to the postpartum period within their cultural constructions of self, wellness and depression. Synthesizing my findings with the literature on culture and depression and the work of Kleinman (1977; 1980; 1988) and Kohrt and colleagues (2012), I present women's lack of perceived and expressed distress through the lens of their sociocentric conceptualizations of health and cultural taboos. I end with a discussion concerning the role of migration and generational differences on conceptualization of health and expression of distress.

Chapter Five, Schemas of womanhood, engenders women's postpartum responses, situating them within gender-specific determinants of mental wellness. In this chapter I consider the role that women's socialization and experiences with discrimination have had on their internalized, cognitive responses to the postpartum period. Guided by Strauss and Quinn's schema

theory (1997), I interpret women's lack of perceived and expressed distress through their gendered cognitive frameworks. This chapter concludes with a discussion on the impact that migration has had on gender roles and relations, as well as a consideration of how these changes may influence postpartum mental health.

Chapter Six, Postpartum sociocultural support, will provide a third and final consideration of the influence that cultural factors have on Bhutanese women's postpartum mental health. Utilizing Stern and Kruckman's (1983) hypothesis, I present Bhutanese traditional postpartum components through a discussion of the structuring of the postpartum period, rituals reflecting the presumed vulnerability and pollution, seclusion and rest, social support, and social recognition. I discuss the relationship that each of these sociocultural components has on women's perceptions in the postpartum period. Again, I end with a discussion of the impact that migration has had on women's traditional postpartum structuring and

In the concluding chapter, I provide an overview of the main arguments made throughout this thesis. I bring the three descriptive chapters together, presenting the ways in which cultural conceptualizations of health, gendered experiences, and sociocultural support interconnect and interplay with one another to influence women's postpartum responses. I show that Bhutanese women's lack of perceived and/or expressed distress can be understood through

these complex intersections and highlight the pervasive nature and far-reaching implications of culture on the understanding of women's perceptions of their own mental health in the postpartum period.

## Chapter 2: Bhutanese Migration Experiences

> "I was pregnant when I was coming to Nepal. Eight months pregnant with third baby. On the way I felt like she already died because she was not moving for one week." – Ranju

Ranju is a Bhutanese refugee. She was pregnant when she was forced to leave her home, fleeing the violence and discrimination occurring in her home country of Bhutan. Although both she and her child survived, Ranju faced considerable difficulty as a forced migrant and mother. Despite being a very recent event, the protracted situation experienced by Ranju and rest of the Bhutanese people is rarely discussed in the media. In what has been called one of the world's most neglected humanitarian crises (Mills et al. 2008), the plight of the Bhutanese people has gone largely ignored on the world stage. Although limited in scope, the current research regarding the mental health status of Bhutanese refugees suggests that they may be especially vulnerable to mental illness as a result of their forced migration experiences and this risk is especially pronounced following re-settlement. Understanding the history of the Bhutanese people and the pre- and post-migration factors influencing their mental health is thus an important contribution to understanding PPD experiences and, in turn, supporting health promotion efforts in their new home countries.

In this chapter, I provide a brief overview of the background of the Bhutanese people in order to contextualize women's postpartum experiences in

the context of forced migration and resettlement. I then discuss Bhutanese migration experiences specifically within the Canadian context, focusing on the community in Edmonton, AB. I finish by presenting the current studies on Bhutanese mental health issues, which highlight the vulnerable nature of the community. Throughout my thesis I make considerations based on women's migration experiences and generational changes. As such, this chapter provides important contextual background for interpreting women's post-migration mental wellness.

### *The Plight of the Bhutanese Refugees*

The Nepali-speaking Bhutanese people (or Lhotshampas) are an ethnic group originating from Bhutan, a small country located in South Asia between the Tibetan region of China and India (see Figure 1). The Lhotshampas resided in the mountainous, forested Southern part of Bhutan where most practiced agriculture for income and subsistence. They are predominantly Hindu, although some are practicing Buddhists and Animists. The Lhotshampa society is multi-ethnic in nature, with other groups such as the Rais, Limbus, Gurungs, and Tamangs represented amongst them (Evans 2010). In addition, many belong to caste groups, such as Brahmins, Chhetris or Dalits (Evans 2010). Outside of this section of the paper, I will refer to the southern-dwelling Nepali-speaking group simply as Bhutanese, a choice that reflects the local community's own desires.

In the 1990s, the government of Bhutan and its hereditary monarch, King Jigme Singye Wangchuck, began instituting a repressive series of laws that would precipitate the Nepali-speaking Bhutanese refugee crisis. In 1977 and 1985, marriage and citizenship acts were employed that resulted in a mass denationalization of the Lhotshampas (Mills et al. 2008). Following these acts, the 1989 *driglamnamja* (or one nation, one people) policy further suppressed the Nepal-speaking Bhutanese by favouring the dominant Drukpa Buddhist culture while outlawing the Nepali-speaking Bhutanese people's language, religion, dress and customs (Evans 2010). In response, the Lhotshampas protested and formed political groups to protect their unique culture, language and way of life within Bhutan (Evans 2010). The Government's suppressed these protests, resulting in widespread violence and the forcible removal of over 80,000 Bhutanese people. [3]

Since the early 1990s, over 100,000 Bhutanese refugees have languished in the seven refugee camps in Nepal monitored by the United Nations High Commissioner for Refugees (UNHCR) (see Figure 2) with an estimated 50,000 others scattered throughout Nepal and India (Giri 2005). This number represents roughly one-sixth of Bhutan's population, making the Nepali-speaking Bhutanese the largest refugee population originating from one country in the world (Mills et

[3] For an extensive overview of the history of the Bhutanese people and their plight, please see Evans 2010.

al. 2008). The conditions within the refugee camps have been said to be exceptional due to the quality of basic services (with good water, food distribution and sanitation systems), a school system (which offers free education until grade ten), integration with the local communities, and the involvement and leadership of refugees in daily administration and politics (Schininà et al. 2011, HRW 2003). Nonetheless, refugees struggle to supplement food rations and are frustrated by their inability to seek outside employment and higher education, own land or leave the camps (HRW 2003, Evans 2010). Due to the uncertainty of their future, many Bhutanese refugees have now resorted to accepting third-country resettlement opportunities to establish permanent lives.

***Bhutanese in Canada***

In 2007, following seventeen years of unsuccessful repatriation efforts between Nepal and Bhutan, all Bhutanese refugees in Nepal became eligible for resettlement to a third country (Schininà et al. 2011). The eight countries involved in the resettlement program are Australia, Denmark, the Netherlands, New Zealand, Norway, the United States, the United Kingdom and Canada. Canada committed to re-settle 5,000 refugees by 2012 and later increased that number by 1,500 (CIC 2013). Refugees arriving in Canada were re-settled across the country into more than 21 communities including Edmonton, Charlottetown, Fredericton, St. John's, Saint-Jérôme, Quebec City, Laval, Ottawa, Toronto, London, Windsor, Hamilton, Winnipeg, Saskatoon, Lethbridge and Vancouver

(CIC 2013). The first refugees to be re-settled in Canada included women at risk, survivors of torture and violence, and those with medical needs such as speech and hearing impairments (CIC 2013). As such, a high concentration of refugees may have pre-existing mental health issues, disabilities and/or be especially sensitive to post-migration stressors.

In 2009, the first group of 80 individuals began to arrive in Edmonton, and the community has grown only marginally since then. The community has faced considerable hardship with respect to language barriers, employment, and financial difficulty in addition to their pre-migration suffering. Lack of English proficiency is the number one concern among community members, especially among women who are illiterate in their own native language as well. Language issues were commonly brought up during my interviews, and appeared to cause significant tension for some women. Related to communication barriers are a lack of employment opportunities, financial concerns, and potential isolation, especially among older generations.

Despite facing the aforementioned post-migration challenges in Edmonton, I found that the community is largely thriving due to social assistance programs, a focus on togetherness, and their desire to succeed and integrate into Canadian society. Upon arrival, the Bhutanese settlement counselor ensured that the community members were established within close proximity to one another, which helped lessen isolation and culture shock. Alberta Works has

temporarily assisted families with living costs and finding employment. Non-profit organizations such as the Multicultural Health Brokers Co-operative, Catholic Social Services and The Edmonton Mennonite Center for Newcomers have further helped families with the transition to Canadian life and accessing culturally-sensitive support. The community was warmly received into their community in South Edmonton and given free membership and access to the local Community Hall in return for volunteering their time. With the use of this hall, the community is able to hold meetings and special cultural events, allowing them to share concerns and problems, as well as preserve and promote their culture. Given their history with cultural discrimination and human rights violations, the ability for the Bhutanese people to have a voice and practice their cultural traditions in Canada has been especially important.

During my research I recognized that although the community is concerned about language barriers, they are also making a considerable and focused effort to learn English and integrate into Canadian society while maintaining their cultural identity. As Gita told me: "[Our community] they want to learn here culture, Canadian culture. They don't want to be the Canadian, but they want to be like Canadian. They want to know Canadian culture. Some of our community people don't know English and they want to know English." During a community meeting in 2012 at which the Minister of Citizenship and Immigration Jason Kenney was in attendance, community leaders discussed their commitment to being active, responsible contributors to Canadian society. The

community has certainly succeeded in this commitment and all members have displayed courage and incredible strength and resiliency following migration.

As I will show throughout this thesis, post-migration experiences and generational changes in the Bhutanese community have implications for understanding their mental health in Canada. Although my thesis focuses on mental wellness of postpartum women specifically, health promotion for all re-settled Bhutanese is an important consideration for third-country locations. This need is made clear when reviewing the current literature on mental health in Bhutanese Diasporas.

***Current Mental Health Studies***

Although there are no current studies regarding the mental health of pregnant or postpartum Bhutanese women, several studies on incidences of mental health problems in this population have been completed. Studies focusing on refugees in Nepal's refugee camps have determined the population to suffer from high levels of mental illness as well as an increased rate of suicide. In their review, Mills and colleagues (2008) looked at six studies conducted from 1998-2008 focusing on the mental health of Bhutanese refugees in Nepal. All of the studies that were reviewed reported dramatically high incidences of mental illness including depression, anxiety and post-traumatic stress disorder, indicating an overall elevated prevalence of serious mental illness within the refugees (Mills et al. 2008). The UNHCR and health care workers within the

camps have also recognized the increased incidences of mental health issues such as depression and anxiety, particularly among women (HRW 2003).

In addition to elevated incidences and risks of mental health issues, Bhutanese refugees appear to have higher risks of suicidal behaviours. The rates of attempted and completed suicide among Bhutanese refugees in Nepal's refugee camps and the US are significantly higher than in neighbouring Nepali areas, the US, and the world (Ao et al. 2012; Schininà et al. 2011; HRW 2003a). An investigation into this trend by the IOM (Schininà et al. 2011) determined the community to suffer from high levels of distress both within Nepal and in areas of third-country resettlement. Risk appeared to be highest in the elders and providers within a family and was elevated during the re-settlement process (17). Although gender was not a significant predictor of suicide, victims of gender based violence were determined to be among the most vulnerable to mental health issues and suicide (22).

Overall, the studies conducted on Bhutanese refugees in Nepal and in re-settled countries have established that the population has elevated incidences of psychiatric disorders and suicide risk. To my knowledge, no studies have looked at the mental health of Bhutanese refugees re-settled in Canada and none have focused specifically on the mental health of Bhutanese women. That being said, the studies conducted so far have indicated that all members of this community

may be at an elevated risk of having or developing mental health issues such as PTSD, depression and anxiety.

### *Conclusions*

The Bhutanese refugees in Canada represent a vulnerable group as they have been shown to have both high levels of mental illness and risk of suicide in Nepal and their countries of re-settlement. The Bhutanese community in Canada may be at a considerable risk for mental health issues due to their past experiences as well as Canada's re-settlement selection process. As forced migrants, the Bhutanese people have faced undeniable struggle and adversity along their migration to Canada, resulting in a predisposition to health problems such as depression, anxiety and post-traumatic stress disorder. In addition, the fact that women at risk, survivors of torture and violence and individuals with disabilities were the first to re-settle indicates that many may have pre-existing mental illness or be at an increased susceptibility. It was essential for me to remain mindful of these migration experiences and mental health vulnerabilities when carrying out my research, which will be discussed in detail in the next chapter.

## Chapter Three: In the Field

In this chapter I will be outlining the research methodology that was implemented in this research project as well as discussing site location and participants, data collection and analysis procedures, ethical considerations, and personal reflections on this research process. This study would not have been possible without the assistance of my community partners at the Multicultural Health Brokers Co-operative and in Edmonton's Bhutanese community. By engaging in a community-based participatory research (CBPR) project I was able to connect with the Bhutanese people in a way that would not have been possible through an investigator driven design. In addition to CBPR I used an ethnographic approach and engaged with phenomenology and interpretive anthropology - two methodologies that heavily impacted not only the data collection but the subsequent data analysis. My research design and methodology is interrelated to my approach grounded in psychological anthropology. As mentioned in Chapter One, my research particularly utilizes aspects of ethnopsychology and cognitive anthropology, as well as incorporates feminist and sociocultural perspectives in order to holistically investigate postpartum wellness

In my research I did not want to impose my own biomedical, cultural understandings on a community whose culture I was still unfamiliar with. Indeed, women who had lived most of their lives in Bhutan had little exposure to

Western medicine and concepts regarding mental illness. Instead, I approached the investigation of the subject from a culturally-relative, holistic and feminist angle, focusing on women's own unique words and sociocultural contexts. In my interviews with twelve Bhutanese women, I chose to discuss their culture and experiences with pregnancy and migration rather than asking direct questions influenced by clinical medicine and psychology. By understanding the women on their own terms - rather than implementing Western-based terminology or diagnostic tools (such as the Edinburgh Postnatal Depression Scale)[4] - I was able to gain insight into the ways in which women experience and conceptualize the postpartum period. Using this as a basis for understanding, I integrated aspects of cultural constructions of health, gender construction and internalization, and sociocultural factors in order to explain the lack of postpartum depressive symptoms in this community.

***Methodology***

In this study, I utilized a community-based participatory research approach, and ethnographic methods informed by phenomenology and interpretive anthropology in order to understand Bhutanese culture and gain insight into women's lives and experiences with pregnancy. The first methodological approach that I used is known as community-based participatory

[4] See Cox et al. 1987.

research (CBPR)[5]. Israel et al. (1998) define CBPR as a "collaborative approach to research that equitably involves...community members, organizational representatives, and researchers in all aspects of the research process" (177). Unlike in traditional investigator-driven research, CBPR begins with a topic chosen by or with a community and continues to involve community members and other stakeholders throughout the research process, from beginning to end (Minkler and Wallerstein 2010). The partnership resulting from the integration of both nonacademic participants' real-world knowledge and experiences and the researchers' theoretical and methodological expertise is a fundamental strength to this process (Cargo and Mercer 2008).

This project has been a collaborative effort from conception to completion between me, the Bhutanese Community and Yvonne Chiu. As I noted in the introductory chapter, the problem of postpartum depression in refugee communities was first introduced to me by a colleague at the Multicultural Health Brokers Co-operative in Edmonton. After researching and finally settling on the topic for my Master's thesis, director Yvonne Chiu kindly invited me to speak at a meeting in order to gain community support. It was at this meeting that I was approached by Shiva Chapagain and Govin Timsina, two men that are from and work for the Bhutanese community in Edmonton. After expressing

[5] For a comprehensive background and discussion of CBPR (including criticisms) please see Minkler and Wallerstein 2010.

their interest in my proposed work, we began a CBPR research effort along with Yvonne. Two Bhutanese women, Keshabi Adhikari and Barsha Khadka later joined our effort to act as translators and provide much-needed women's perspectives throughout the project.

In addition to helping choose a topic to investigate, my community partners were involved in the research design, execution and verification. In our first focus group meeting, we discussed the community background, interview topics and, most importantly, the outcomes that the community itself wanted to see as a result of the research. At a second focus group, I discussed the research findings, my interpretations and my thesis outline. My community partners proved to be sources of invaluable support and guidance, giving me honest feedback as well as supplementing information that was lacking from the final summaries. We focused on areas of particular sensitivity and ensured that my work would accurately depict the Bhutanese people to readers. Some of my community partners found my first draft of Chapter Five to be particularly problematic as they felt that it did not fully capture the diversity in gender relations and roles among families, and the contextual variables that women's responses were situated within. They also expressed concerns over protecting women's anonymity as I had originally included women's ages and number of children. To address these concerns, I omitted all women's ages from the final copy and re-worked Chapter Five to include additional considerations of gender issues and highlight the complexity and diversity represented in the community.

Following completion of my thesis, my community partners and I are committed to presenting our findings to the Bhutanese community in order to attain our original goals: to promote mental health following pregnancy and migration, and foster increased male involvement within the family and enhance gender equality.

My experiences with this study have confirmed for me the strength and undeniable usefulness of CBPR. By collaborating with the MCHB and members of the Bhutanese community, I was able to gain invaluable insight into the Bhutanese culture and foster a trusting, friendly environment with participants. Rather than being an independent investigator looking for answers to my own questions, I was part of a team exploring issues that were important to people in my home city. This relates to the feminist perspective, as I aim to conduct my research *for* women, rather than *on* them. By integrating my anthropological background with the first-hand knowledge of my Bhutanese partners and Yvonne, I was able to holistically investigate the issue of postpartum mental health and complete a research project of use and importance to the participants and their community.

In addition to CBPR, my research relied heavily on the use of ethnography. Ethnography - the descriptive study of human groups and cultures (see Fetterman 2010) - involves fieldwork methods such as participant observation and interviews in order to better understand a specific cultural and

social environment. A fundamental strength of ethnography lies in the potential to gain intimate and close access to a community and observe life events as they really are. Through this methodology, I was able to interact with and observe the entire Bhutanese community in a range of capacities. Before, during and following my research, I was invited to community members' homes for casual conversations, meetings addressing the current state and needs of the community and to special celebrations such as Teej and Diwali. Before events I was invited to women's homes, where I was lucky enough to be dressed in a traditional sari and jewelry. This exposure to the community allowed me to interact and form sincere relationships with the Bhutanese people while simultaneously observing their daily lives and special events in order to supplement and better interpret my interview data. Furthermore, my presence allowed the community to get to know me personally so that I became a familiar face and was known to the women before starting the interview process.

Throughout the ethnographic process, I drew upon two additional methodological approaches that were used in conjunction with one another in order to facilitate the collection and understanding of information. The first of these methodological approaches was phenomenology[6], the "study of phenomena as they appear to the consciousnesses of an individual or a group of

[6] For a review of the history, uses and criticisms of phenomenology in anthropology see Desjarlais and Throop 2011.

people" (Desjarlais and Throop 2011). This approach has been effective in its exploration of the subjective experiences of reality and the constituents of the human as a whole. The phenomenological approach "can get at the richness of people's lives, concerns, and engagements in direct and incisive terms" (Desjarlais and Throop 2011, 97), which makes it a harmonious addition to my holistic framework. As this study was deeply concerned with subjective experiences and understandings of the body and wellness, the phenomenological approach provided a means by which to uncover the complicated networks that make up the reality of a Bhutanese woman. It also allowed me to access women's individual perspectives on their postpartum wellness and capture experiential diversity.

The second methodological approach that was used within my ethnographic work was interpretive anthropology. First introduced by Clifford Geertz (1973), interpretive anthropology treats culture as a set of meaningful symbols that structure the lives of a particular society. According to Geertz's approach, the analysis of culture is "not an experimental science in search of law but an interpretive one in search of meaning" (Geertz 1973, 145). Although this approach has been criticized (see Martin 1993 and White 2007), I find it useful due to my belief that culture is implicit in all aspects of a person's life and must be investigated as intimately as possible in order to capture meaning. Without holistically exploring aspects of the Bhutanese culture and interpreting the ways in which women's cultural beliefs and actions related to their responses to

pregnancy, I feel I would have failed to understand and represent the women's embodied experiences. I believe that my work accurately represented the Bhutanese culture as my findings incorporate both women's own "insider" understandings of their culture and my "outsider" interpretations and perspectives. Furthermore, my results were reviewed and verified by my Bhutanese community partners.

The successful application of interpretive anthropology to other contemporary ethnographies provides additional support for my own approach. For instance, the interpretive approach has been expertly employed by Theresa O'Nell (1996) in her research concerning depression among the Flathead Indian Community in the United States. In her work, O'Nell interprets experiences of depression by first investigating and understanding a complex network of underlying historical factors and cultural ideas about self, family, ethnicity and emotions. Incorporating the Flathead Indian people's own points of view, O'Nell presents the phenomenological experiences of depression among this community as being due to conceptualizations of morality as well as histories with colonial oppression and domination. Work such as this provides support for the use of interpretation in medical anthropology.

***Site and Participants***

During the summer of 2012, I began ethnographic work (observation and interviews) with the Bhutanese community in Edmonton, AB. The decision to

have Edmonton as the site of my work was due to my connection with the city (where I was born and raised) and my previous volunteer work with the Multicultural Health Brokers Co-operative. Through volunteering at the organization, I developed a passion for understanding and assisting refugee and immigrant groups in my home city, and made connections which greatly assisted me in accessing potential participants. As noted earlier, it was through my volunteer endeavors that I conceived of this project and was welcomed into the Bhutanese community.

All of the ethnographic work presented in this paper was conducted within the urban landscape of Edmonton. The majority of the community was, at the time, living in close proximity to one another in apartment buildings located in the South side of the city. The majority of families and extended families resided in one apartment, or in the same building. I was able to conduct several of my interviews within the same home or by walking just a couple doors down. Community events and meetings were held at a local community hall, also located within a close distance to most of the community members' homes.

My sample consisted of twelve Bhutanese women; the community as a whole numbered only 93 individuals at the time. All of the women in the study self-identified as Hindu, were born in Bhutan and migrated to Canada directly from Nepal. All were recent immigrants, arriving in Canada only within the past three years. They ranged in age from 23-70, with an average age of 41.7. All

were married except for one, who was widowed. The majority of the women were unemployed, although three held jobs in the business, health care and service industries. The unemployed women were homemakers and the majority of women were also students taking English classes and/or training for employment. Eight women were illiterate in their own language, able to read and write only simple words in Nepali. Several castes were represented among the women, although I chose not to discuss this[7]. The sample was diverse concerning gravida, parity, number of children and country in which they gave birth. Gravida and parity both ranged from 1-8, with an average of 4. Number of surviving children ranged from 1-6, with an average of 3.1. Four women had given birth only in Bhutan, three in Bhutan and Nepal, two only in Nepal, two only in Canada, and one gave birth in each three locations. Thus, the sample was purposively selected to capture a range of pregnancy, birth, and postpartum experiences.

***Data Collection***

The data used and discussed in this research was collected through participant observation of daily life and special events, as well as through semi-structured interviews. Although I had engaged with the Bhutanese community previously, I began official participant observation in July 2012 following ethics

[7] The decision not to consider caste was due to my unfamiliarity on the subject and abolition of the caste system following migration to Canada. As Shiva put it "the caste system is completely eradicated in Canada."

approval. Participant observation included being present at community meetings, casual discussions in homes, and participating in special events and celebrations. I was fortunate enough to take part in several Bhutanese festivals including Diwali, Teej, Tihar and Dashain. During my observation I made an effort to get to know people and take in my surroundings as opposed to viewing the experience as a scientific endeavor. On occasion, I discreetly made field notes in order to remember something important or of interest, which later assisted me in the data analysis process.

In order to collect specific information from the Bhutanese women themselves, I conducted semi-structured interviews beginning late July 2012. The women who participated in this study were recruited by my Bhutanese community partners. Recognized as natural leaders within the Bhutanese community, my partners were known to everybody in the community and were able to easily contact potential participants. Participants were recruited only on the basis of their reproductive history (all had to have birthing experiences), although my community partners made a significant effort to recruit women who had given birth in different locations and were of varying ages. Women who were known to be suffering from diagnosed mental illness such as posttraumatic stress disorder or major depression were not asked to participate in an effort to

reduce harm[8]. The women were first informed of the purpose and details of the study and only if they so chose, consented to have an interview time with me set up by my translators.

In order to ensure their comfort, I allowed women to decide where the interview would take place. All twelve interviews took place in women's own homes. On occasion, children and other female relatives were in the room. To begin, each read (if able) or were read the information letter verbally in Nepali, which outlined the study's purpose, procedures, potential benefits and risks as well as information regarding confidentiality and voluntary participation. Each interview was recorded with consent from each participant. Time was then spent going through a verbal consent form (with the assistance of a Nepali translator). Verbal consent was required for each question asked before moving on to the interview process. Next, I moved onto interviews utilizing a semi-structured interview guide developed with the assistance of my community partners. This format structured the interview while leaving room for the participants to move the discussion into areas that were important to them. In particular, the question concerning the women's experiences with pregnancy allowed them to present their subjective experiences in as little or as much detail as they felt comfortable. Most chose to express their experiences in a life-history format

[8] This may have impacted my findings as a history of depression or maternal depression has an impact on risk of PPD. However, all of the women that gave birth within the past year were able to take part in the study.

which proved to be enjoyable for all of us. Throughout each interview I was able to adjust my interview questions as necessary and probe deeper into certain areas based on the emerging information. After each interview, I recorded field notes in order to provide context for each interview and note important non-verbal information such as body language. [9]

***Data Analysis***

After each interview I wrote field notes in order to provide context and/or record additional observations or specificities. Interviews were then transcribed line-by-line by me without the use of transcription programming, giving me the opportunity to become intimately familiar with each interview's content. In accordance with the concept of grounded theory (Glaser and Strauss 1967), I went through each transcript carefully, letting themes emerge naturally from women's words alone rather than from existing research, previous assumptions or theoretical frameworks. Using Atlast.ti qualitative data analysis (version 7.0.85) I created discrete codes based on emergent themes as well as my own understanding and interpretation of the texts. My resultant code list included a wide range of codes relating to gender construction and roles, the self, religion, wellness, illness, depression, family, community, pregnancy, migration and stressors. These codes were organizing into families in Atlas.ti,

[9] Body language is an important aspect of Nepali communication and there are some notable differences from Western body language. For example, Bhutanese people may shake their head from side-to-side to indicate “yes” or “maybe” rather than “no” as it does for Westerners.

which allowed me to view co-occurring codes and connections between different variables. Finally, I copied and pasted particularly insightful passages into their respective themes in Microsoft Word. This process helped me to further organize and support themes, as well as observe exceptions to general findings.

My analysis and interpretations were later verified by my community partners in our second focus group. Despite this support, I remain conscious that my interpretations are ultimately interwoven with my own biases and expectations. Data analysis is a work of constant interpretation (Coffey and Atkinson, 1996) and as such, hypotheses emerging from data analysis ultimately reflect the impressions and knowledge of the researcher. Consequently, it is vital to practice reflexivity and acknowledge the effect that our positions as researchers have on the production of knowledge.

***Reflections***

After reflecting upon the research process, I have become aware of two issues and possible limitations of my work. The first issue that I noted early on was the inherent differences between myself and the Bhutanese participants. Although I am a woman, I am also very young, unwed and have never been pregnant. Born in Canada into a white middle-class family, I have lived a relatively problem-free and privileged life which has afforded me good health, education and employment. I have never been hungry, lived in poverty, experienced overt discrimination, faced the threat of ethnic cleansing or been

forcibly removed from my home and loved ones. In these ways, I am worlds apart from the women with whom I worked with and spoke to during this project.

The differences between us were perhaps never more apparent than when I found out that one of my translators and a participant were the same age as me. I could not help but feel incredibly juvenile when comparing myself to these strong women who had raised children, supported their families and households and ultimately survived through inconceivable violence and hardship. Although I always felt warmly accepted and welcome by the community, I cannot help but question whether my lack of commonalities with the women resulted in a dynamic that was overlooked. On the other hand, I am comforted by the alternative implications that being an "outsider" can have on the research process. My lack of commonality with the women may have also been beneficial, as my position allowed me to view the culture from an objective position and recognize linkages that my "insider" Bhutanese community members may have not.[10]

The second issue that was encountered was the complications of using a translator. As I do not speak Nepali, I relied upon two translators for all but two of the interviews. Although I trained both of my translators in depth on the study

[10] For a discussion of the benefits of conducting research as an outsider see Tinker and Armstrong 2008.

procedures and my requirements and we discussed word equivalents, I found it very difficult at times to conduct the interviews as fluidly as I had hoped. One problem that I frequently encountered was misunderstanding, potentially indicating issues with conceptual equivalency and comparability of meaning (Temple 1997). Some questions, or words in particular, were difficult to translate from English to Nepali and the woman being interviewed would misunderstand the original question. In several instances, the participant would repeat information from an earlier question or simply not be able to answer a question at all. The most difficult questions were those concerning the construction of the self, as the concept itself is quite abstract in nature and difficult to ascertain without confounding language barriers.

In addition to misunderstandings, I found that using a translator hindered my ability to create a natural conversation as well as gain a full response. When conducting interviews, I attempt to have them flow into a natural, relaxed conversation rather than a straight-forward questions and responses as I find that it produces better results. By using a translator, I found it difficult to achieve this and the conversation was often choppy and laborious. Furthermore, although I had asked my translators to repeat the participants' responses as closely as possible, this proved to be very difficult as the women often had to be cut off mid-sentence so that my translator could try and relay the information accurately. This also complicated my ability to successfully probe into the complexities of a response. Overall, this experience has provided me with

significant insight into the difficulties that can accompany ethnography and considerations that must be made during the research process.

### *Ethical Considerations*

Before beginning any research activities, I completed the University of Alberta's research and ethics training and underwent the Human Ethics Research Ethics (HERO) review process. Ethics approval for this study was granted by the University of Alberta Research Ethics Board I on June 6, 2012 and later renewed on June 17, 2013. While the risks of this study were not high, I remained conscious of potential psychological, emotional, social and cultural risks and discomforts. In working with a newly-settled refugee community, I was sensitive to their vulnerabilities and made every effort to minimize harm. In the initial focus group with my community partners, we discussed topics and terms that should be avoided in order to eliminate discomfort or stress. As noted earlier, women that were known or thought to be suffering from any mental distress were not asked to participate in the study in order to further minimize harm.

Despite these protective measures, there remained some potential for the women in my study to experience emotional and/or psychological distress as a result of the interview process. In the information letter, I indicated that there was potential for the interview to bring up emotional memories. Participants were told that if any emotional or other problems arose, the interview would cease and that there were several services that they could be referred to if they

consented. Some of my questions required interviewees to recall past memories involving forced migration, life in a refugee camp, gender discrimination and inequality, and challenging postpartum experiences. To this end, I entered into difficult discussions with sensitivity and did not continue to probe if the interviewee showed signs of discomfort. There was one instance where a woman appeared uncomfortable when talking about difficulties that she experienced postpartum related to lack of social support and conditions of poverty. After telling me a little about her hardships she said that she could not say any more. After ensuring that she was ok to proceed, we continued onto much less sensitive topics. Perhaps due to their experiences with pre- and post-migration screening, or their resilient nature described in this thesis, the vast majority of the respondents were self-aware and comfortable throughout our discussion.

I also took protective measures to ensure that the women who participated understood the purpose of the research and were freely and voluntarily consenting to participate. As eight of the women were illiterate, I ensured that all materials were read in full to them and that research activities did not begin until they understood each section and any questions were answered. As participants were recruited by people that they knew, there was also the potential for participants to feel compelled to take part in the study. To this end, I ensured that participants recognized that their participation was

voluntary and that they would not be penalized should they choose to end the interview or withdraw at any time before submitting my thesis.

Lastly, there was a risk that women's reputations and status could be affected should their words be recognized by others in the community. These risks were especially high given the small community size. In my research, women divulged personal information about themselves as well as their relationships with others such as their husbands and in-laws. Women also shared sensitive information regarding their gendered experiences. These issues may be considered private and sensitive, and the recognition of women's names could have placed women at risk. I mediated this potential risk by ensuring the anonymity of all of my respondents. Unless otherwise chosen by participants, interviews took place in the presence of only myself and a translator. The list of participants is known only to myself and my community partners. I have decided not to include women's ages or the number of children that they have given birth to, as well as use pseudonyms in place of women's real names. This prevents readers from associating quotes with a particular person and further ensures their privacy. In making the decision to use pseudonyms I acknowledge the accompanying sacrifices; Bhutanese names indicate a great deal of information about a person, including their familial relationships and caste. Furthermore, as I intend on giving Bhutanese women a voice through my work and presenting them as real people rather than anonymous refugees, it is somewhat ironic and problematic that I also take their names and identifiers

away (Oleschuk 2011). Nevertheless, the drawbacks to using pseudonyms are overshadowed by their important role in ensuring the safety of my participants.

### *Conclusions*

The methodologies implemented in this research study are intermingled with and complementary to the theoretical approach underpinning my thesis. As explained in Chapter One, my work is grounded on theory developed using aspects of psychological/psychiatric anthropology, ethnopsychology and cognitive anthropology as well as feminist and sociocultural perspectives. My methodology has complemented my theoretical approach by allowing me to successfully investigate diverse aspects of the Bhutanese culture and women's lived experiences and subsequently make informed connections and interpretations. By using community-based participatory research (CBPR) and ethnography, I was able to access and immerse myself into the Bhutanese community and gain first-hand accounts of cultural information from Bhutanese women while also making my own observations. My ethnographic approach was enhanced by phenomenology and interpretive anthropology, which allowed me to capture women's subjective experiences and conceptualizations of depression as well as discover meanings within their narratives.

These methodologies have allowed me to understand and establish connections regarding the ways in which Bhutanese culture influences women's construction of self and wellness, internalization of gendered experiences, and

views concerning postpartum sociocultural support. I will now move on to several discussions in the following chapters concerning these connections, and present women's own words and perspectives.

# Chapter Four: Situating Cultural Constructions of Wellness, Illness, and Depression in the Postpartum Period

Although the physiology and underlying biological processes of childbirth are universal from Canada to Bhutan, women's responses to changes that occur within themselves and their lives during the postpartum period are highly variable. As was mentioned in Chapter One, the cross-cultural variance in prevalence of PPD may be explained in part by women's differential understandings of what constitutes depression as well as in culturally-acceptable means of expressing distress. Cultures vary considerably with respect to the ways that the body and its processes are understood, as well as in the ways that illness is constructed, perceived and coped with. In order to understand and interpret women's responses to childbirth it is vital to first consider the culturally-determined frameworks of health and healing that form the foundation of their experiences. In this chapter I situate Bhutanese women's embodied experiences within their sociocultural frameworks of health in order to understand their perceptions of their own postpartum mental wellness.

Before proceeding, it is worthwhile to distinguish disease from illness, two terms that are often used synonymously. In his work, Kleinman (1980) makes an important distinction between the two, noting: "*Disease* refers to a malfunctioning of biological and/or psychological processes, while the term *illness* refers to the psychosocial experience and meaning of perceived disease"

(72). Whereas disease is recognized only within individuals, illness is intermingled with one's larger social and cultural environments. I utilize Kleinman's definition of illness in order to emphasize the role of an individual's sociocultural environment and subjective understandings found in wellness and illness narratives.

In order to uncover Bhutanese women's beliefs regarding health, I relied on an approach informed by the theoretical perspectives and foundational work of Arthur Kleinman (1977; 1980; 1988) as well as the Nepali ethnopsychological model developed by Kohrt and colleagues (2012). This approach incorporates emic accounts garnered from my ethnographic work; these are descriptions and beliefs regarding health collected from individuals in the culture being studied rather than described by an outsider. Emic study does not exclude interpretation by anthropologists (Ohnuki-Tierney 1981), but focuses on cultural and phenomenological information from community members themselves in order to accurately represent cultural beliefs.

By investigating the relationship between culture and mental illness throughout his career, Kleinman has highlighted the importance of cultural factors in understanding and diagnosing mental distress. As Kleinman (1988) explicates:

> Because language, illness beliefs, personal significance of pain and suffering, and socially learned ways of behaving when ill are part of that process of mediation, the experience of illness (or distress) is always a

> culturally shaped phenomenon (like style of dress, table etiquette, idioms for expressing emotion, and aesthetic judgements). (7)

Kleinman's approach implicates the role of culture in every stage of illness, from recognition to expression to treatment. Kleinman posits that individuals utilize explanatory models shaped by their unique social and cultural knowledge which function to explain the aetiology of sickness, onset and timing of symptoms, pathology, course and severity of illness, and treatment options (Kleinman 1980). These explanatory models can be uncovered and constructed from understanding individuals' personal beliefs regarding a particular illness (Kleinman et al. 1987). In this chapter I utilize Kleinman's explanatory model concept by uncovering the ways that Bhutanese women's social and cultural knowledge affects their understandings of health, and ultimately their own perceptions of postpartum mental wellness.

In order to better situate my understandings of Bhutanese self and wellness, I also draw upon the work of Kohrt and colleagues (2012). Using ethnographic data collected among various Nepali ethnic groups, Kohrt and colleagues have developed a Nepali ethnopsychology, or a cultural model of "understanding emotions, the self, social connections, perception, and cognition" (2012, 91) which can be used to understand Bhutanese refugees' cultural conceptions of mental health. Their work uncovers and highlights the complex and interrelated nature of Bhutanese concepts of self, wellness and illness. Within the several divisions of self that Kohrt and colleagues present, of

particular interest to me are the two elements of self known as *man* (heart-mind) and *dimaag* (brain-mind), as they have significance in understanding Bhutanese perceptions of mental wellness and social stigma. By synthesizing their findings with my own, I aim to further explore Bhutanese ethnopsychology and explain women's postpartum experiences.

I begin this chapter with a review of the literature on culture and mental distress in order to show the importance of cultural knowledge in understanding and interpreting postpartum mental health. Next, I discuss my findings concerning Bhutanese constructions of self, wellness, illness and depression in the context of the literature. I then establish the relationship between these cultural constructions and women's postpartum experiences. Lastly, I discuss the effects of migration and intergenerational differences on Bhutanese women's postpartum mental wellbeing. Thus, I will demonstrate the role of cultural environments on Bhutanese women's perceptions and understanding of their postpartum health, and interpret the reported lack of postpartum depression as being due to women's conceptualizations of self and wellness and cultural taboos on expressing distress. Within the context of migration, these concepts and taboos may shift, resulting in an enhanced focus on the individual and varying methods of expressing distress.

### *Culture and Mental Distress in the Literature*

While biomedical paradigms focus primarily on the role of the individual and biological and physiological processes in illness, anthropological research has demonstrated the importance of considering cultural factors. Cross-cultural studies have advanced basic knowledge concerning the differences that exist in cultural perceptions of the body, mind and health (Kleinman and Good 1985; Kleinman 1988). These cross-cultural variants have implications for the way that issues concerning mental health are perceived, understood and coped with. A review of the literature on cross-cultural research and ethnographic evidence of cultural variations in understanding and expressing depressive illness are well established. This research has indicated the important role of culture in researching postpartum depression in diverse sociocultural environments.

At the most basic level, cultures differ in their understandings of individual bodies and physiology. As Scheper-Hughes and Lock have noted, "...the constituent parts of the body – mind, matter, psyche, soul, self, etc – and their relations to each other, and the ways in which the body is received and experienced in health and sickness are, of course, highly variable" (2006, 297). Although humans are incredibly similar in their biological and physiological makeup, there is considerable heterogeneity in the way that cultures define and understand the body and its relationships. This has implications for the way that illness is experienced. For instance, Western science and clinical medicine are

guided by the Cartesian dualism: the separation of mind and body. This dualism has led to Western medical practitioners and lay persons alike to "categorize and treat human afflictions as if they were either wholly organic or wholly psychological in origin: "it" is *in* the body, or "it" is *in* the mind" (Scheper-Hughes and Lock 2006, 299). Within this model, an emphasis is placed on the individual while outside environmental factors (such as social, cultural, economic and political factors) are largely absent from consideration. Furthermore, this dualism has led to the tendency for afflictions in the body to be perceived as "real" whereas issues arising in the mind are typically less accepted as being “true” illness (Kohrt and Harper 2008).

Although aspects of Western culture's epistemology are common in other cultures, with mind-body divisions being observed from West Africa to the Indian subcontinent (Kohrt et al. 2012) alternatives and variations do continue to exist. Traditional Chinese medicine, for example, is characterized by holism rather than dualism. Under this system "the health of individuals depends on a balance in the natural world, while the health of each organ depends on its relationship to all other organs" (Lock and Scheper-Hughes 2006, 301). According to this construction, illness could arise from factors outside and/or within the body, affecting the entire system as a whole. In terms of mental distress, issues affecting one's mind would not be understood without respect to the rest of the body and its environment.

In addition to affecting the way that the body and its constituents are understood and described, culture influences the ways in which individuals conceptualize their own wellness and illness. Whether a culture is individualistic or collectivist, for instance, has a considerable bearing on individuals' psychological factors and underlying behaviours (see Hsu 1981). With respect to mental health, extant literature has shown that cultures differ greatly in their concepts of mental wellness, expression of distress, recognition and acceptance of mental illness, and understandings of the cause of mental disorders. Cultural factors do not just affect the superficial appearance of psychological disorders, but influence their genesis, recognition, course, and remedy (Ingleby 2005). As such, culture plays a prominent role at all stages of a mental illness: "in its causation, the way it is construed and experienced, the accessibility of treatment, the response of the professional, the form of treatment given and its effectiveness, and the prognosis for later life" (Ingleby 2005, 18).

One mental illness that has been well-researched within the context of culture is depression. A vast body of literature, including entire volumes (Kleinman and Good 1985), exists dedicated to examining cross-cultural understandings and expression of depressive symptoms and states. Ethnographic and cross-cultural research has established that depression is variable as a both a mood and an illness due in part to cultural variables, and may be understood as a disease, a symptom, or a normal feeling depending on sociocultural context (Kleinman 1988). For example, Obeyesekere (1985) has

shown that in Sri Lanka, symptoms of sadness that would be viewed by Westerners as depression are instead perceived by Buddhists as the onset of wisdom. Furthermore, although a core group of depressive symptoms exists universally, the experience and expression of depression varies across cultures (Lee et al. 2007). For instance, in many non-Western cultures depression is communicated through somatic experiences and embedded in social contexts (Lee et al. 2007). In her work, O'Nell (1996) has demonstrated that Flathead Indians in America experience and discuss depression through morality, rather than feelings. Although a detailed review of the research on culture and depression is outside of the scope of this paper[11], there exists an undeniable and provocative relationship between the two that results in variations of depression across-cultures.

As with depression in general, it has been noted that one of the main issues in studying PPD across cultures is the variability in symptom definition and expression (Halbreich and Karkun 2006). The Western biomedical clinical definition and symptomatology of postpartum depression as described in Chapter One is not universal, and women's perceptions of wellness following childbirth are situated within culturally specific health narratives and behaviours. Culture also dictates socially-acceptable ways of expressing distress. For

[11] See Tsai and Chentsova-Dutton 2010 for an extensive discussion surrounding cultural variation in depression.

instance, while North Americans and Europeans tend to characterize illness in affective terms, Asian cultures often use somatic complaints as a culturally-acceptable way to express distress (Kleinman 1977; Halbreich and Karkun 2006). A North American woman may describe a negative postpartum mental state by disclosing that she feels sad or depressed, while a South Asian woman with the same negative postpartum changes may say that she has been suffering from headaches. Although both women could certainly be suffering from clinical postpartum depression, their culture differentially directs the way in which the distress is expressed and symptoms are manifested.

Although the literature on postpartum mental health and its connection to cultural constructions of wellness is limited, there exists a large body of research dedicated to exploring the relationship between mental illness and culture. This research illuminates the need to consider cross-cultural variants of wellness and illness beliefs, symptom presentation and expression of distress in any discussion of mental health. My own work situates women's postpartum responses within the context of their sociocultural environment in order to interpret and explain their perceived wellness in the postpartum period.

### *Constructions of the Self*

In order to contextualize Bhutanese women's perceptions of wellness, it is important to first establish the ways in which the Bhutanese people construct the self and its constituent parts. By self I refer to the phenomenological sense of

an individual's lived experience and reflections concerning the structure and composition of their being[12]. Although data on Bhutanese constructions of self is limited, ethnographic data gathered from other Nepali-speaking populations can offer some insight. Research conducted by Kohrt and colleagues over the past decade (Kohrt et al. 2005; Kohrt and Harper 2008; Kohrt et al. 2009; Kohrt and Hruschka 2010; Kohrt et al. 2012) has contributed immensely to the literature on Nepali ways of understanding the self. In this body of work, intricate ethnopsychological and ethnophysiological models of Nepali concepts of mind, body and mental illness have been developed. Although the majority of their work focuses on Nepal's ethnic groups in the urban area of Kathmandu and rural districts of Palpa, Kailali, and Jumla, the most recent publication focuses specifically on the Bhutanese refugees.

Kohrt et al. (2012) apply their ethnopsychological and ethnopsychological model that captures Nepali understandings of self to Bhutanese refugees. In discussing their most recent model, I will refer only to "Bhutanese" rather than "Nepali" in general. According to this model, the Bhutanese have multiple divisions of the self, constructed within a mind-body framework:

> The main components are the physical body (Nepali: *jiu* or *saarir*), the heart–mind (*man*), the brain–mind (*dimaag*), the spirit (*saato*), the soul (*atma*), and one's social status (*ijjat*). Other important divisions are the

[12] My definition of the self fits closely with the model of self, individual and person proposed by Harris 1991.

> family (*pariwaar*), which includes the extended family, and the spiritual world, especially connections with one's ancestral deities (*kul devta*). (93)

Much like in Western mind-body dualisms, the Bhutanese concept of self is grounded on a division between mind-body. However, this conceptualization also leaves room for additional divisions of the self through material and immaterial concepts. For the study of mental health, the heart-mind and brain-mind are especially salient parts of the self. The heart-mind is said to be the locus of memory and emotions where worries and anxiety are grounded (Kohrt et al. 2012). In contrast, the brain-mind operates cognition, attention and social regulation and functions to inhibit socially inappropriate desires or actions (Kohrt et al. 2012). In terms of social acceptance, heart-mind problems are viewed as commonplace and are openly shared, whereas brain-mind problems are stigmatized and rarely communicated (Kohrt et al. 2012). The heart-mind and body-mind are interrelated with the rest of the components of self. Of particular relevance to my work is the connection between heart-mind and body-mind with social status (*iijat*) and the social world (*pariwaar* and *samaj*). Issues of social origin can affect all other components of the self, including the body-mind and heart-mind, which demonstrates the significant importance of social environment in constructing individual health.

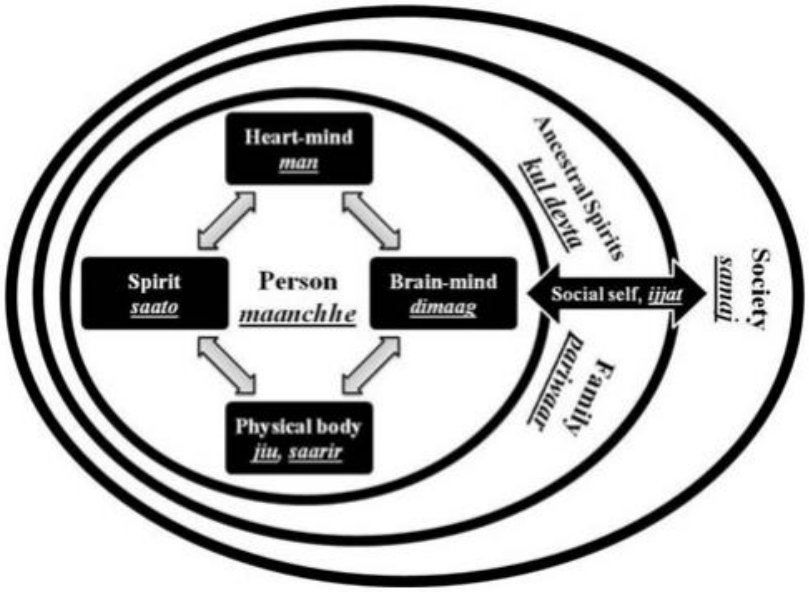


Figure 3. Nepali ethnopsychological model of the self. From Kohrt et al. 2012, 93.

Kohrt et al. recognize that it would be misleading to claim a single ethnopsychology representative of all groups in Nepal and Nepali-speaking Diasporas, but maintain that through their ethnographic work they have found core components of the self that should be incorporated into mental health studies of Nepali-speaking cultures (Kohrt et al. 2012). The accuracy and usefulness of the Nepali ethnopsychological model on understanding Bhutanese health has previously been demonstrated by an anthropologist working with re-settled refugees in the United States (Chase 2011). Furthermore, my interpretations made based on Kohrt and colleagues' ethnopsychological categories were affirmed by my community partners. At the outset of my research I did not intend to use or contribute to the Nepali Bhutanese ethnopsychological model, but nonetheless found Kohrt and colleagues work to be relevant to my own findings as my research progressed. In the following sections I synthesize their findings concerning heart-mind, body-mind, social

status and social world with my own concerning Bhutanese understandings of individual wellness.

As Kohrt and colleagues' ethnopsychological model indicates, Bhutanese concepts of self include various divisions of mind and body and are also deeply interrelated with social environments. Previous research has indeed shown that the Bhutanese construct the self in collectivist or sociocentric ways - meaning that one's personal identity is understood through social relationships and contexts. Through their counseling efforts with torture survivors in Nepal (various Nepali ethnic groups including Bhutanese refugees), Tol and colleagues (2005) have noted that Nepali concepts of self "are more linked with notions of a collectivist identity, in which social relationships define a person to a far larger extent than individual traits" (324). Rather than viewing themselves as autonomous beings, Nepali peoples "perceive their inner selves in a more diffuse manner, linked with social notions" (325). This has clear implications for research on mental wellness, as Bhutanese individuals with sociocentric concepts of self may be unable to practice introspection and scrutinize themselves and their emotional states (324). Furthermore, Bhutanese people may internalize negative mental changes in an attempt to avoid disrupting their social environments.

Although undertaking a comprehensive study into Bhutanese constructions of the body and self was outside of the scope of the present study, my discussions with Bhutanese women did provide some insight into how they

constructed the self. With the exception of two women, whose answers did not articulate the constituents of the self[13], the participants were able to create narratives surrounding their understandings. Consistent with Kohrt and colleagues (2012) model, the self was described as having several divisions within mental and physical realms. Components included their physical body, religious and spiritual components, the soul, the elements (e.g. water, fire), karma, emotions, personality characteristics and social relationships. Although each of these components are relevant to understanding women's concepts of self, the majority were mentioned by only one or two women and cannot be discussed as generalizations. For the purpose of this study I focus on the most common component of self: social relationships.

The most striking and consistent finding was that Bhutanese women described the individual self as inextricable to their social relationships. When women were asked to describe what the self was, or what components made up their individual bodies, six out of ten referenced their place in their families and/or social environment. When asked to describe what made up the "self," Preeti replied: "I am the mother of the family. I am on the top. I have eyes, mouth, hands, legs, but on top of that I am the mom and I am on top." This response was echoed by Gita, who said "Ya now I'm a mom. Ya and then I think

[13] The inability for two of the women to answer the question "what is the self?" may have reflected language barriers, translation issues, and/or cultural differences. The two women responded by saying that were having problems with language in Canada. Although I probed several times, their answers did not change.

wife. And before I am only a daughter, now I have more responsibility to my daughter, my family" and Devika, who said "To this family I'm the mom."

These responses reflect the Nepali sociocentric concepts of self found by Tol and colleagues (2005) and Kohrt and colleagues (2012) ethnopsychological components of social status and family. My findings indicate that Bhutanese women largely construct and understand their individual self through their social environment. They also implicate the role of gender in forming the self, a notion that will be pursued further in Chapter Five. Although Bhutanese women recognize that they are separate beings from others in the world, there is a general lack of an individualized concept of self. Rather, the self and its components are fluid and susceptible to change based on social positioning. This may lead to difficulty in articulating personal feelings, investigating emotional states and/or disclosing negative feelings. While this conceptualization of self was not found homogenously among the group of women that I spoke to (with four not mentioning a social basis of self), it is a meaningful generalization with support from the literature and my Bhutanese community partners. This finding has significant linkages with Bhutanese women's conceptualizations of wellness and illness as well as implications for interpreting women's postpartum health.

***Constructions of Wellness and Illness***

> "To eat and to have wealth is like, I can have today a million dollars, tomorrow I can be the baker, so wealth is like, it's the dust in our hands. We can wash it and it will be gone. But the relation is really important and if I have good relationships with relatives and family that's wellness."

- Janu

So far I have considered the ways in which these Bhutanese women conceptualize their personal identity through multiple divisions of body and mind, as well as through their social environments. These conceptualizations are important to consider in discussions of Bhutanese wellness and illness as they set the foundation for understanding how women determine their own health. Just as the self was described as having physical and mental parts, I found that wellness was described in both physical and mental terms. Three women defined wellness as being the absence of illness, disease and sickness in the body (although only one defined it entirely in these terms), while two others referred to general physical wellbeing. Related to this, two women defined wellness as being able to carry out tasks and live their daily lives as normal. Five women referred specifically to mental health, describing wellness as having a healthy mind, fresh mind, peace of mind and being "emotionally free." Some of the women referred specifically to emotions and personal characteristics, with four including feelings of happiness as wellness, and one emphasizing the role of feeling energetic, bold and brave.

The most important finding in my discussions with Bhutanese women concerned the ways in which they perceive their own personal wellness. In my interviews, I found that seven out of the twelve women understood and described their own physical and/or mental wellness in relation to their social environments. Just as the self is socially constructed, individual health is

determined through social relationships. For instance, when asked "what is wellness?" Janu responded: "If family is happy and if everyone in the family is happy. If there is good relationship with families and relatives and the community people, that’s wellness." In this response, as well as in her quote at the beginning of the chapter, Janu captured the ways in which she and other Bhutanese women conceptualized their own health. Rather than being dependent on individual factors, one's own wellness is determined by the happiness of those around them and by having positive relationships with family and community.

In addition to the influence of family happiness and positive social relationships, wellness was described as being dependent on social cohesion and being able to provide for one's family. The importance of having family and community being together and within close proximity was mentioned by the two eldest women including Bhima, who noted the importance of having her children in the same place: "I have my children with me so that's wellness." Similarly, one's wellness was said to be dependent on one's ability to provide for loved ones, such as being able to take care of them when they are sick or to provide children with good education and attend to their needs. This was indicated by Ranju, whose wellness is dependent on being able to provide for her daughters: "Wellness is if I can take care of my daughters like in nice way. I can give them more facility. And if they become sick I can give the good treatment for them. And I can make nice place to take care of them."

These findings relate to the literature on Bhutanese constructions of self as they indicate the importance of the social component of self in constructing and perceiving individual wellness. As was discussed above, Bhutanese constructions of self are influenced by complex, interrelated components including family (*pariwaar)* and social status *(iijat)*. Given this, it is understandable that one's wellness would be dependent on and influenced by their social environments. These findings are in accord with those found by Chase (2011), who found that Bhutanese individual wellness is related to healthy relations within the community and the strong value placed on cohesion within the family. This finding was certainly evident in my own discussions with Bhutanese women.

Although wellness was predominately socially defined, it was also constructed by some Bhutanese women through socioeconomic factors such as economic success, attainment of education and level of English proficiency. These factors, which reflect post-migration stressors, were mentioned by three women in conjunction with social factors. For example, in her description of wellness Durga mentioned her desire to learn English, attain employment and make money so that she could make a happy life for her family and, in turn, herself. Although her determination of wellness was impacted by socioeconomic factors, it was still inherently dependent on the wellbeing of her family. Social relationships and environments appear to have an intimate and inextricable

relationship to Bhutanese women's conceptualizations of wellness, which has implications for their understandings of illness as well.

The ways in which Bhutanese women conceptualize illness are largely comparable to the ways that they construct wellness. Most of the women's responses to the question "what is illness?" were simply inversions of their descriptions of wellness. As with wellness, illness was recognized as having the potential to affect both physical and mental parts of the self. Four Bhutanese women conceptualized illness in physiological terms as the presence of physical ailments, disease or sickness. One also mentioned the use of medication being a factor in creating illness. Another woman defined illness as the inability to carry out her daily activities. Illness was also described by three women in mental terms such as having an unhealthy mind or negative, pessimistic outlook in life.

Just as wellness is understood as dependent on one's social relationships, illness was described by the majority of Bhutanese women as being socially determined. Of the eleven women that responded to the question "what is illness?," seven mentioned illness resulting from poor social relationships, gossip and rumours, separation from family and community and lack of social support. Interestingly, although socioeconomic and post-migration factors such as employment, money and English proficiency were mentioned as agents in wellness, the opposite was not mentioned for illness. Women that

implicated these factors in their concepts of wellness discussed illness only through social agents.

Many of the women that perceived illness in social terms mentioned a lack of good relationships or cooperation in the family and community as resulting in illness. Dhana described illness as arising "if there is no good cooperation in the family," while Janu mentioned a lack of peace in the family, poor relationships, and family and community members talking about her as resulting in stress and illness: "If there is no good relationship with families, relatives, community and if somebody says “oh, she’s like that,” talk about me and if there is no peace in the family and other family members talk about me and I have some thinking, like some tension, that is not the wellness."

Some of the women also referred to social distance and a lack of social cohesion as contributing to illness. Bhima's response, for example, indicates the role of the absence of family and community in illness: "If the children are not with me, they are far away from me and I can't meet them, and if I don't have any friends around to talk to me. That's illness." Lastly, a lack of social support was considered to be illness, as shown in Nadya's response: "If something happen to my family and if nobody help us I feel like it's illness. Like if nobody helps me and like nobody come to my home, you know, visit me. And if I have some bad incident in my house like maybe something - the kids they're sick sometime and if nobody visits me I think that's the illness."

Although women's responses did vary and included other factors, illness as being socially caused and dependent was a common theme throughout my interviews. Just as wellness is understood through one's social world, illness is perceived largely through the social environment. Scheper-Hughes and Lock (2006) have recognized this pattern in cultures which have sociocentric concepts of self:

> In cultures and societies lacking a highly individualized or articulated conception of the body-self, it should not be surprising that sickness is often explained or attributed to malevolent social relations, to the breaking of social and moral codes, or to disharmony within the family or village community. (302)

Due to their focus on the social environment in creating the self and wellness, it understandably follows that the Bhutanese also attribute illness to social causes. Within this collectivist culture, illness is largely conceptualized in a sociocentric way, meaning that the health of one person must be understood in the context of their social environment. The Bhutanese components of family and social status interrelate to those comprising the mind and body, resulting in wellness or illness depending on quality of social relationships and maintenance of social structure.

Recognizing the differences between the women that I spoke to and their variations in responses, I proceed by focusing on the social dimension of wellness and illness that was woven throughout Bhutanese women's conceptualizations of personal health. Remaining cognisant that other factors

were mentioned in women's responses, I generalize that Bhutanese women conceptualize their own physical and mental wellness through their social environments. This finding has considerable relevancy to Bhutanese understandings of depression, as well as implications for situating women's perceptions

***Understandings of Depression***

> "The depression is like if there is no good relationship between the family members, like mother, husband and wife, sister, child and mom, child and dad. That's the depression. That's the cause of depression." – Devika

While postpartum depression and depression in general appear to be universal conditions, they are viewed differently within and between cultures. The expression, causation, and treatment of depression can vary considerably based on cultural norms and beliefs concerning mental health. In order to understand Bhutanese women's perceptions of their own mental wellness following birth, I sought to first understand their explanatory models concerning depression in general. With the exception of Bhima, who said that she had no idea what depression was, all of my participants were aware of depression as an illness and could explain its symptoms, causes and treatments. Depression was characterized by symptoms such as negative, bad or "deep" thinking, no peace of mind, "breaking" of the mind, feeling "mad," being emotional (i.e. crying for no reason), being unable to live daily life as usual, and avoiding social situations. Some women also indicated that it could be recognized through somatic

symptoms, such as the development of a headache. "Thinking" was an especially salient theme throughout the interviews, as all of the women indicated negative, deep and ruminating thoughts as characteristic of depression. Chase (2011) also found "thinking too much" to be a common idiom of vulnerability.

The majority of my participants (seven out of eleven who responded) explained depression as being caused by social factors. While death and divorce were mentioned by two women, the majority of responses focused on less extreme forms of socially-situated distress. The following narratives exhibit Bhutanese women's understandings of depression:

> "If they don't have any cooperation in the family and if they don't have any like respect and responsibility in the family you know, if the person they don't have any respect and responsibility in the family they feel like they go in the depression." - Dhana

> "If people think like lots of more tension like if they sit and if they think more, more, you know, more for the daughter and for the family problem maybe they're going to be in depression."- Ranju

Just as wellness and illness were perceived based on one's social environment, depression was viewed as being caused by social problems. Issues such as poor social relationships, disrespect within the family, and tension brought on from worry about family members were all mentioned as factors contributing to depression. During one of the interviews, a woman shared with me a current family issue as an example of how a social problem can cause depression. Her daughter had eloped and married a man without parental permission; a

circumstance that she admitted was causing her tension. Although she did not indicate that she was depressed and was carrying on with her life despite her increased tension, this woman shared her experience as an example of a social problem that can cause ruminating, negative thoughts and possibly depression in others.

My findings can be understood with respect to Bhutanese concepts of self and individual wellness. The heart-mind and body-mind concepts of self are deeply interrelated to social status, the link between the individual and the social world (Kohrt and Harper 2008). Any issues of social origin can affect the heart-mind and body-mind, as well as all other components of self (such as the physical body). This explains how a social problem can cause an individual to have emotional changes, somatic complaints (e.g. headaches) and depression. Furthermore, although the heart-mind and body-mind operate differently, they are connected in their operation (Kohrt et al. 2012). As such, a problem within the divisions of the social world and/or social status can cause emotional changes or tension in the heart-mind and in turn affect the brain-mind. In Durga's case, the disrespect and social irresponsibility demonstrated by her daughter could result in a loss of social status and disturbed heart-mind, causing tension that could lead to a mind-body issue like depression if left unresolved.

It is worth noting that four of the women that I spoke with did not mention social problems as causes of depression, instead focusing on the role of

stressors relating to employment, migration and new motherhood. Janu implicated unemployment as causing depression, based on what she had witnessed in others in the community. Sumitra and Sabika both indicated that depression could be caused by language barriers, unemployment and financial difficulty following migration. Although she also incorporated a social aspect of depression, Ranju also implicated these issues in her response. She was especially concerned about learning English, even comparing it to her need to eat: "I don't need to eat food for one week but I want to learn more English." Sumitra, Sabika and Ranju's responses reflected their current situations in Canada, as all three had experienced stress in adjusting to life after migrating to Canada, particularly in their lack of ability to gain employment without proficiency in English.

In her response, Krishna also gave a personal example by situating her understandings of depression in the postpartum period:

> "Well basically you know, once you have baby your entire body structure changes. And the baby's crying constantly, you're a first time mom; you don't know what to do. You have to, you know, frequently wake up at night and you know lack of sleep and you don't think anything is going right. So you know you just go down and down and just look at the negative side of it. Like you know "what happened there, why do you gotta do this, I shouldn't have done this" and instead of looking at the positive side. Looking at the newborn baby like you know how cute they are. I think that basically causes depression and that's basically a part of postpartum depression."

Krishna indicated that depression following birth could possibly be caused by postpartum factors such as physical changes, lack of sleep and unfamiliarity with

motherhood. Her answer does not necessarily reflect her own experience, as she did not consider herself depressed at any time (see section below for her case study). Due to her high level of education and familiarity with biomedicine, it is likely that her answer reflected previous knowledge of postpartum depression rather than her own experiences. Furthermore, the semi-structured nature of my interview format lead her to interpret my question as asking about postpartum depression specifically, just as it lead other women to answer my question based on post-migration stressors. These examples can still be understood within the ethnopsychological framework, as they indicate problems originating in the heart-mind having the potential to subsequently affect the brain-mind.

Throughout my research, I recognized an interesting paradox surrounding depression in the Bhutanese culture. In the first focus group before beginning my interviews, I was told by my community members that depression was not stigmatized in their community but that I should definitely avoid using the term mental illness as it carried negative connotations. In my interviews I found that women openly discussed the concept of depression and never appeared uncomfortable when posed with questions regarding it. Some even gave examples of people they knew that were currently depressed. Furthermore, six out of eleven women indicated that depression was best treated socially by sharing problems and getting advice from others (two mentioned thinking positively, one recommended medication and the other two believed there was

no treatment). In contrast, however, my community partners also mentioned a taboo on discussing negative and/or strong, emotions with family members. As one partner put it, "don't let your family down by mentioning that you are."

This paradox has been noted by others (Chase 2011) and can be explained in part by the ethnopsychological model and sociocentric basis of health. As was noted earlier, the social implications of heart-mind and body-mind problems are variable. Heart-mind issues such as worrying or having tension are socially acceptable to express, whereas issues located in the body-mind such as mental disorders are stigmatized. Situated within Bhutanese frameworks of wellness, this prohibition also relates to the social basis of health. Due to the fact that one's wellness is influenced by and dependent on those around them, the illness of one family member can easily affect the rest. Therefore, it is culturally unacceptable to burden one's family or community with personal issues. Although this may seem counterproductive to the treatment of mental illness, my community partners reminded me that it can actually be helpful. From their point of view, the prohibition on sharing strong, negative emotions can be encouraging for a depressed individual, fostering a resilient nature rather than leading them to dwell on personal woes.

While some women understood depression from alternative angles, the majority of the Bhutanese women that I spoke to implicated social problems in the aetiology of depression. Forms of social distress including interpersonal

conflict, disrespect, lack of cooperation and worry about others, all contribute to the development of depressive behaviour. Given my previous findings concerning the self, wellness and illness, it is unsurprising that depression is similarity understood as being dependent on social factors. Furthermore, depression is paradoxically socially-accepted but viewed as inappropriate to discuss with family members as it can negatively affect them in turn. This knowledge serves as a platform by which to understand and interpret the women's postpartum mental health.

***Postpartum Mental Health in the Social Context of Wellness***

> "After having babies I was happy and I thought that I had more responsibility, like taking care of that baby, raising them and giving education, providing education. Try to swing the right path, not to be like drinking and this and that. Swing right track, providing education, nutritious food, everything. I was happy and I had more responsibility." – Janu

Given the current body of literature on refugee women's increased risk of postpartum depression and the representation of the Bhutanese as vulnerable people (see Chapter Two), I went into my first interview prepared to hear women's stories concerning adverse, traumatic postpartum experiences and feelings. However, interview after interview, I found that Bhutanese women viewed the postpartum period as one of happiness and joy. With the exception of two women (discussed individually as case studies below), none of the mothers indicated negative mental or emotional changes in the postpartum

period. In this section, I discuss women's perceived health following childbirth, relating these findings to those concerning Bhutanese conceptions of self, wellness and depression. I show that Bhutanese women's postpartum mental health is dependent on the social component of self and wellness in two ways: firstly, women's postpartum health is influenced by the health of their newborn child and state of their social environment, and secondly, social restrictions regarding the expression of mental distress influence women's ability to express negative changes. Although mental distress may have certainly arisen for the women, their social and cultural environments resulted in a general lack of perceived and/or expressed postpartum depressive feelings.

Despite being a significant and potentially stressful life event (especially in the context of forced migration), the majority of the Bhutanese women in my study did not perceive any negative mental changes in themselves following childbirth. Even when I probed postpartum feelings and stressors, I found that women spoke of their experiences in overwhelmingly positive terms. After sharing stories with me regarding their experiences of having children, I asked the women how they felt after having their babies[14]. Responses to this question included:

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[14] When asking women to disclose perceived postpartum changes, I did not specify a length of time. Some responses may therefore refer to perceived changes outside of a year following childbirth.

> "I was so happy after my children were born. I was so happy. I was so excited to see when they grow up and when I asked “can you help me to do this?” I was so excited to see that they are helping and they are doing." - Preeti
>
> "I was happy and then I thought I have a responsibility of my children and then the love shared with child. I was happy." - Sumitra
>
> "I was so happy after having a baby and when they are grown up like others I wanted to see grown baby or grown man or grown woman." - Bhima
>
> "I got the girl and I was so happy and I feel like I'm going to give her good education and make her good person." - Gita

The majority of the Bhutanese women interviewed provided answers that reflected the quotes above. Regardless of age or location where they had given birth, ten out of the twelve respondents included feeling increased happiness in their postpartum narratives. This happiness was bodily evident during our conversations, as women's faces lit up with smiles and laughter when talking about their children and recalling their births. Situated within their cultural constructions of wellness, this perceived positive mental change can be understood as reflecting positive social environments. As Bhutanese women's own mental wellness is dependent on the well-being of those around her, no negative mental changes are perceived in the absence of social disruptions. Related to the ethnopsychological model, increased happiness has a positive influence in the heart-mind, while a lack of social problems results in the maintenance of the brain-mind.

Although most women spoke of the postpartum period in positive terms, some also recognized feelings of increased responsibility and worry in themselves. In addition to perceiving increased happiness in the postpartum period, eight respondents also indicated co-occurring feelings of increased responsibility. Women recognized that they could no longer do as they pleased, as they had increased responsibility to their children. As shown in Janu's response at the opening of this section, responsibility was characterized as having to care for and raise children, ensuring proper nutrition, providing good education and ensuring that children become good people and follow the "right track." As I will discuss in more detail in Chapter Five, these responsibilities fall primarily on women rather than being a shared effort. This increased responsibility was not viewed as problematic for one's mental wellness; however Durga's case study below provides an example of how emotional distress can arise from an actual or perceived inability to achieve one's new responsibilities to their children.

Related to the perception of increased responsibility, many women revealed feeling increased worry in the postpartum period. Although worry was not said to have caused mental changes or depression in women, some mentioned it resulting in stress and/or tension. For example, Devika mentioned feeling increased tension resulting from concern over her children's well-being:

> "When I was single, I didn't have to worry about anything. But after having children I have to worry about those children. Maybe something

> will happen, maybe she will be ill, maybe she's hungry, maybe she's crying" like about that I have more responsibility and I got more tension from that."

Even in the absence of actual problems or threats to a baby's well-being, women appeared to be concerned about the health, education and future of their child. The increased feelings of worry and responsibility can be explained by Bhutanese sociocentric frameworks of wellness, as the well-being of others can affect and cause illness within oneself. By worrying about their children, women had increased tension arising in their heart-mind. Although all but one of the women who included worry in their postpartum health narratives did not indicate that their feelings resulted in negative mental changes, prolonged tension in the heart-mind could cause depression in the brain-mind. The potential for worry to cause negative postpartum changes is illustrated in the first case study below.

The first woman to indicate negative postpartum changes was Durga, a mother of children born in each Bhutan, Nepal and Canada. In her narrative, Durga mentioned having tension associated with her children born in Nepal and Bhutan, but not in Canada. Due to poor familial support and difficult living conditions in Bhutan, she felt a great deal of stress after having her children. Her feelings of stress were exacerbated in Nepal, when the arrival of a baby was met with fear of not being able to provide educational opportunities and nutritious food:

> "When I come in refugee camp I got the baby and I feel like "oh why she come here in the Earth, you know, why she come?" And I was thinking "how I gonna give in this place, nothing here" you know, in camp and how am I gonna give education. I was thinking a lot after that. Ya [babies] become lots of sick you know because of no cleanness and lack of health, not lots of health facility in camp you know. No good food, dirty food. And I was so worried about that. And am I gonna get more kids? And what am I gonna do? I think a lot."

Durga mentioned feeling like crying when she reflected on her experiences having babies in Bhutan and Nepal. Three other women in my study had babies in both Bhutan and Nepal although their experiences in both locations were variable. Sabika's situation was similar to Durga's, as she had an unplanned baby in the camp in addition to existing children, and had concerns over her ability to provide within the environment of the refugee camp. Interestingly, Ranju and Sumitra both considered their experiences in Nepal to be better than in Bhutan. Both explained this as being due to having increased support and access to health services, as well as better food.

In comparison to the postpartum stress that Durga suffered in Bhutan and Nepal, her postpartum experiences in Canada were considerably more positive. When asked about postpartum changes following the birth of her child in Canada, Durga indicated feelings of excitement and happiness. In stark contrast to her feelings in Bhutan and Nepal, she was optimistic about the child's future and felt that the environment in Canada was far superior to that of her home country and the refugee camps. Durga's experience illustrates how tension over ability to provide for one's children coupled with worry concerning their

health and well-being can contribute to negative postpartum changes. In her case, prolonged worry and tension over the well-being of her children may have caused a disruption in the functioning of the brain-mind. Durga's last experience, however, shows how positive postpartum changes can result from a desirable social environment. Her story illustrates the importance of social circumstances in the maintenance of the brain-mind and in women's perceptions of their postpartum health.

The second woman whose story I would like to discuss is Krishna, who gave birth only in Canada. Krishna is highly educated and was one of the two women who were fluent in English. Her case was significantly different from the rest of the participants, as her response regarding postpartum wellness incorporated biomedical knowledge previously unseen in discussions with other women. I present her response here in order to show the variations in women's postpartum experiences as well as to show generational differences in constructions of self and wellness. When discussing her postpartum experience, Krishna indicated that although she did not go into depression, she did recognize some postpartum changes in herself. When I probed on this she replied:

> "You know more emotional. I think it's a hormonal change. Like small things would make you cry. And even though you have a higher, you would have developed a higher tolerance of pain by the time the child was born, like you know going through so much. But then once you are breastfeeding you know your breasts are sore and tender just because the child is sucking and you already have so much pain. And you just feel like "I can't take this anymore" you know. Sometimes you do feel that way."

Rather than associating negative postpartum changes to social difficulties, Krishna associated them with hormonal changes and physical pain. Although I have presented Bhutanese culture as having a sociocentric concept of self, Krishna appears to have a more individualistic, biologically-based understanding of both self and wellness. This may reflect her age and/or her education level, as it is evident that she had biomedical knowledge that was absent in narratives of older participants. Although her postpartum experience is presented here as an anomaly, it highlights the importance of recognizing the post-migration, generational differences in Bhutanese women.

Despite the differences shown in Krishna's postpartum health narratives, I found that overall, Bhutanese women's postpartum wellness could be understood through traditional constructions of wellness and illness. Traditional Bhutanese culture focuses on the social contributions to wellness and takes the emphasis off of the individual. As such, in the absence of social concerns, no personal distress is perceived. For Bhutanese women, the postpartum period is characterized by positive changes when accompanied by a positive social environment. However, increased social responsibility and worry about the welfare of children can cause distress if accompanied by difficulty in providing for one's child or the threat of child sickness.

In addition to cultural constructions of wellness, Bhutanese women's postpartum mental wellness can be further interpreted though cultural

understandings of depression and acceptable ways of expressing distress. As discussed earlier, the Bhutanese culture recognizes depression as an illness, but does not sanction the expression of negative emotions around family members. The admission of negative postpartum mental changes may be viewed as socially irresponsible, as one's illness can affect others in turn. Furthermore, heart-mind problems are sanctioned whereas brain-mind issues are not culturally accepted. These cultural prescriptions and prohibitions may have been reflected in women's responses, as the admission of heart-mind issues such as increased responsibility, worry, and tension are acceptable. However, women's lack of perceived mental distress following birth may be reflected by the social taboo on discussing mind-body issues. This may have not only affected what women were willing to tell me, but also affected the ways in which they experienced any mental distress. Mental distress that arose from prolonged negative thinking, tension or worry may not have been perceived or outwardly expressed due to cultural taboos, as well as their culturally constructed perceptions of personal wellness.

### *The Effect of Migration on Conceptualizations of Health*

In closing my discussion of the relationship between Bhutanese cultural constructions of self, wellness and depression and women's postpartum experiences, I assess the role of migration and uncover potential generational differences. Given their background as forced migrants and newly settled

refugees in Canada, it is important to consider the impact of these experiences on the health narratives of Bhutanese women. As such, I discuss my findings concerning the impact of migration on women's understanding of their own health as well as make future predictions regarding the risk of postpartum depression.

Upon migration to Canada, immigrant and refugee groups may undergo a process of acculturation by which they integrate their native cultural beliefs, behaviours, and values with those of the new host culture (Lueck and Wilson 2010). This process can affect their traditional views of the body and wellness. Collectivist cultures such as that of the Bhutanese may shift to more individualistic constructions of self, leading to a higher degree of introspection and less focus on the social determinants of wellness. Understandings of the self and wellness may be further changed upon exposure to Western, biomedical paradigms that place focus on the individual body and biological processes. Changes in these conceptualizations may negatively affect women's postpartum mental health due to increased introspection and recognition of personal distress. However, they may also lead to positive changes if the taboo on the sharing of mind-body issues is lessened in their new environment.

In my research, I did not find a significant link between migration, generational changes and concepts of self and physical and mental wellness. Although some women's responses regarding the self, wellness, illness and

depression deviated from the majority, this was not associated with age or length of residence in Canada. For example, the five women who did not implicate social factors in their descriptions of wellness ranged in age from early 20s to late 40s, indicating the role of other factors such as individual experiences and the semi-structured nature of my interview format. The lack of changes in Bhutanese women's conceptualizations of self and wellness may reflect their desire to uphold traditional culture in Canada (a desire shared by not only the women in my study, but the entire community as a whole) as well as their short length of residence at the time of study.

Although I did not find significant generational differences, one woman noticeably deviated from the rest of the interviewees in her understanding of self and wellness. As noted in the previous section, Krishna indicated postpartum changes that were related to individualistic conceptualizations of self and wellness. In her response regarding the self she was the only woman to include personality characteristics. She was also the only woman to exclude social determinants of health from each of her narratives concerning wellness, illness and depression, and was very candid concerning the negative aspects of her postpartum experience. I interpret these differences as being due to her educational background and exposure to Western beliefs. Krishna was by far the most educated woman in my study having attended post-secondary, and her exposure to Western biomedicine was evident in her responses surrounding health. Krishna may serve as an example of how education and exposure to

Canadian culture may lead to a shift away from collectivist concepts of health, increased introspection and increased ability to express distress.

In addition to having the potential to shift conceptualizations of health, several women indicated stressors on health related to migration during our conversation. In my discussion of Bhutanese conceptualizations of depression, I noted that Sumitra, Sabika and Ranju implicated unemployment, financial difficulties and lack of English proficiency as causes of depression. Post-migration stressors such as these were not mentioned by the women who had recently given birth in Canada, but they certainly carry the potential to cause postpartum worry and tension that develop into depression in new mothers in Canada. Overall, both changing conceptualizations of health and post-migration stressors are important considerations for future investigations of the postpartum mental health of Bhutanese refugees.

***Conclusions***

In this chapter I have shown that Bhutanese women's postpartum wellness can be understood by situating their postpartum mental wellness within their cultural constructions of health. Bhutanese women's general lack of postpartum mental distress can be explained as being due to their socially-determined conceptualizations of self and wellness, as well as cultural taboos on expressing personal distress. Although mental distress may certainly have arisen for the women in my study, Bhutanese conceptualizations of self, wellness, and

depression facilitated their individual responses and lead to the overall lack of perceived and/or expressed postpartum mental distress.

Using Kleinman's explanatory model and theory concerning the role of culture in mental health and Kohrt and colleagues ethnopsychological model as a foundation to my interpretations, I have determined that Bhutanese women's understandings of self, wellness, illness and depression are based largely on social factors. The self is understood as having multiple divisions, including the heart-mind, body-mind, family and social status, which interact with and influence one another. The self is also understood as a sociocentric concept, which leads to the view of the individual self as inextricable to one's social relationships. The majority of the Bhutanese women in my study defined the self as having complex, multiple divisions and being dependent on their place in the social world.

Bhutanese conceptualizations of wellness and illness are also fundamentally social in nature, as both physical and mental wellness are perceived in relation to social environments. For Bhutanese women, wellness is dependent on having good relationships, cooperation within the family, the happiness of others, social cohesion and the ability to provide for others. Illness results from poor social relationships, negative gossip and rumors, a lack of social support, and being separated from family and community. These conceptualizations of health relate to Bhutanese understandings of self, as one's

wellness is dependent on the health of those around them. Any perceived illness arising in the family or as part of one's social status can disrupt the heart-mind and brain-mind divisions of self in turn.

As with self and wellness, depression is understood by Bhutanese women as being caused by social problems. The majority of the women in my study implicated issues such as poor social relationships, disrespect and worry about the wellbeing of family members as contributors to depression. I also noted a paradox between women's beliefs that depression can be socially-treated and a taboo on sharing negative emotions with others. This is also related to the self and constructions of wellness, as women may be less likely to express distress in order to avoid causing social disruptions.

Using the background information on Bhutanese constructions of self, wellness and depression I interpreted women's narratives regarding their own postpartum mental health. I found that overall, Bhutanese women perceived positive changes in themselves in the postpartum period. This was explained as being due to a lack of perceived personal distress in the absence of any social concerns. However, increased social responsibility and worry about a new child appear to cause disruptions in the heart-mind, which can lead to mind-body issues such as depression if accompanied by difficulty in carrying out responsibilities or the threat of child harm or sickness. Furthermore, mental distress arising from mind-body issues may not have been perceived or

expressed due to cultural taboos. These findings appear to have persisted in the face of migration, although Krishna's experience indicates a potential shifts in conceptualization in health. Future research on such possible shifts is required.

Overall, this chapter has implicated the role of cultural constructions of self, wellness and depression in understanding women's perceptions of their own mental health following pregnancy. By approaching the subject of postpartum depression from an anthropological standpoint I was able to explain women's postpartum mental wellness relative to their cultural background. Following Kleinman, I investigated the role of culture in every stage of women's experiences in the postpartum period, from how they conceptualize the self to how distress is perceived. My work has also contributed to the Bhutanese ethnopsychological model by providing evidence for complex Bhutanese divisions of self and advancing knowledge of Bhutanese understandings of wellness and depression. It is evident that the social context of health has an impact on women's culturally-situated responses to childbirth and should be considered in understanding Bhutanese postpartum wellness.

# Chapter 5: Schemas of Womanhood

Gender is an inextricable component of one's identity that affects all aspects of a person's life, including their mental health across the lifespan. A complex relationship exists between gender and one's roles, experiences, opportunities, behaviours and expectations in life. With respect to mental health, gender can affect one's vulnerability to mental illness and have implications for one's ability to disclose negative emotions or feelings, one's ability to seek or access care, and even perceptions of and responses to trauma. Social constructions of gender vary significantly across cultures and as such, gendered determinants of mental health are also variable. In order to better understand women's postpartum experiences, it is essential to consider the ways in which cultural constructions and lived experiences of gender influence health. In this chapter I discuss Bhutanese constructions of gender and women's associated experiences and developed schemas. By understanding these relationships I strive to uncover the ways in which women's gendered experiences affect their postpartum mental health.

For the purpose of this chapter I refer to gender as the socially constructed roles, responsibilities and behaviours deemed appropriate for men and women in a culture. This term is used in contrast to sex, which refers to the socially-defined biological and physiological criteria for classifying men and women. In making this distinction I wish to also acknowledge the considerable

debate surrounding the definitions and concepts of sex and gender, as well as the criticisms surrounding the sex-gender dichotomy itself (see Butler 1990). While both sex and gender are concepts far more complex than I have just presented them and additional categories can accompany them (i.e. gender identity, sexual orientation), for the purpose of this thesis I wish to refer only to gender as it is defined above. This term is sufficient for my work, which deals with a culture with a clear gender binary. Unlike other South Asian cultures which recognize more than two genders (Nanda 1998; Bochenek and Knight 2012), the Bhutanese community that I work with recognizes only "man" and "woman." I focus here only on the cultural and social aspects of these two gender categories and the way that they relate to mental schemas.

The social construction of gender is now a well-established and pervasive notion, at least within the social sciences. According to this view, gender is socially constructed rather than biologically determined, meaning that roles and behaviours deemed acceptable for men and women are constructed and regulated within their respective society and culture. As Simone de Beauvoir famously asserted: "One is not born, but rather becomes, a woman" (1989, 267). In declaring this, De Beauvoir made the distinction between biological destiny and social construction, and suggested that gender is acquired through experience. Rather than being innate knowledge, meanings attached to being a woman or man are learned from a young age through social interactions and are subsequently internalized and enacted by individuals.

In this chapter I utilize Strauss and Quinn's (1997) schema theory in order to uncover the ways in which the socialization and experiences of Bhutanese women lead to an internalization of culture. In cognitive science, schemas are frameworks in the mind that work to organize and make sense of the world. Schemas are developed through lived experiences and exist as preconceived ideas that guide future perceptions and expectations. This concept has been adopted into cognitive anthropology, implemented as way to understand how individuals frame experience. As Strauss and Quinn (1997) explicate:

> 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. (49)

According to schema theory, cultural meanings are internalized and used to guide future perceptions and behaviours. With respect to mental wellness following pregnancy, I propose that Bhutanese women utilize shared schemas of womanhood in their responses to the postpartum period. These schemas influence not only how women understand the postpartum period, but also how they perceive and cope with any negative feelings or challenges that occur within it.

In using the term "shared schemas" I do not wish to oversimplify women's experiences, as there were certainly exceptions to my general findings. As Quinn and Strauss (1997) explain:

> Meanings generated by schemas, in connectionist models, are mental states but are shaped by the learner's specific life experiences and are sensitive to activity in a particular context. While often similar from person to person, context to context, and one period of time to another, they can vary and change. (50)

As women in the same culture undergo largely similar processes of socialization and have comparable experiences, their schemas of the world can be relatively consistent. However, Bhutanese women's individual schemas can differ due to a range of factors such as caste, socioeconomic status, age, individual life experiences, and family composition and beliefs. As Lindholm has explicated: "Not all schemas are accepted equally by everybody, as a result of variations in the learning environment, including the degree of emotional intensity surrounding the learning of a schema" (2007, 259). Throughout this chapter I will present exceptions to my general interpretations in order to be true to the complex realities of these women's lives.

I begin this chapter with a brief overview of the literature on gender and postpartum depression in order to show how the roles, status and socialization of women can influence their susceptibility to mental illness. I then discuss Bhutanese women's gendered identities and experiences and show how their prior socialization and experiences with suffering influence their schemas of womanhood. I interpret Bhutanese women's responses to pregnancy within these schemas, showing that women are expected to become mothers and endure any associated challenges without complaint. In addition, women view

suffering as a part of life and perceive distress as normal. In closing, I present inter-generational changes related to migration, considering how changing gender roles may influence postpartum outcomes in the future. Overall, I demonstrate that women's postpartum mental health outcomes are influenced by Bhutanese schemas of womanhood, which view childbearing as a necessary component to womanhood and struggle and adversity as a normal part of life.

### *Gender and Mental Health in the Literature*

Gender has been firmly established as one of the main factors in issues concerning worldwide health disparities, including differential rates of mental illness. Across countries, women are consistently shown to have a twofold risk of major depression compared to men (Kessler and Bromet 2013). Women's rates of depression double those of men in their childbearing years (Stewart et al. 2006) and although it can and does affect men (Veskrna 2010), depression occurring in the postpartum period is also considerably more represented among women. Many reasons for women's increased prevalence of depression have been offered, including biological and psychological differences between males and females (McMullen and Stoppard 2006; WHO 2001), as well as diagnostic bias among practitioners (Veskrna 2011). In this review, I focus on the relationship between gender status, roles and expectations in understanding women's vulnerability to mental illness. The growing literature on these connections indicates that the inferior status and multiple roles of women may

differentially place them at a higher risk of mental illness such as PPD. In addition, the culturally-dependent socialization and experiences of women direct their attitudes toward pregnancy and motherhood in ways that can negatively or positively influence their postpartum mental health.

Emerging research has indicated that women's status and related social and economic disadvantages put them at an increased risk for depression. Despite advancement, women as a group continue to occupy an inferior and disadvantaged place in societies across the world (UN Women 2013). Gender-acquired risks for mental health issues resulting from lower social positions are multiple and interconnected, affecting women's vulnerability to mental illness. Although their work focuses primarily on gene-environment interaction, Vigod and Stewart (2006) have noted:

> Women may be particularly vulnerable to the genetic predisposition to depressive symptomatology because many significant life stressors differentially disadvantage girls and women. Discrimination, violence, physical, sexual, emotional, financial abuse and poor working conditions remain problems that differentially affect women worldwide. (397-398)

Significant risks for mental illness arise from women's greater exposure to poverty, discrimination, malnutrition, hunger, overwork, and domestic and sexual violence (WHO 2010; WHO 2001). Furthermore, the social gradient of health is heavily gendered, as women continue to earn less than men and constitute roughly 70% of the world's poor (WHO 2010). These issues may be especially salient in the postpartum period due to further strain on a woman's

marginal social and economic position. In an illustrative case, Patel et al. (2002) found gender-based determinants such as poverty and violence against women to be significant risk factors for PPD in women in India. Findings such as these indicate the considerable impact that women's status and resultant economic, social and cultural disadvantages may have on postpartum mental health.

In addition to their disadvantaged status, women's multiple roles contribute to a greater risk of experiencing depression (WHO 2010; 2001). Gender differences in rates of depression are strongly age related, and women are most likely to experience depression during the ages of 18-44 (Stewart et al. 2006). Women of reproductive age may be particularly at risk due to changing and conflicting roles, including productive, reproductive and caring work (WHO 2010). Across countries, women bear the burden of responsibility associated with being wives, mothers, caretakers of others and increasingly, primary sources of income for their families (WHO 2001). As Vigod and Stewart (2009) note, "role strain (too many roles), the sandwich generation (caring for children and elderly parents) and double shifts (at work and at home) have received attention as stressors leading to depression" (398). Following birth, women's mental health may be particularly vulnerable, as the arrival of a new baby can result in additional strain on women's already exhausted responsibilities and roles.

In addition to their status and roles, women's gendered expectations can also affect their mental health. The mental wellbeing of a new mother may be compromised when societal, cultural and personal expectations concerning the postpartum period are not attained. In their work, McMullen and Stoppard (2006) have found that diverse groups of women commonly reference "gender-based expectations of what constitutes a 'good woman', a 'good wife' and a 'good mother' in their understandings of depression" (277). In a comparative study between Chinese and Australian women, Chan and colleagues (2009) found that while Hong Kong Chinese women attributed their PPD to external sources, Australian women felt guilt due to their perceived failure to be ideal mothers (116). Such research indicates that women internalize their gender-driven sociocultural expectations and can become depressed when they feel inadequate as mothers. This is, however, entirely dependent on personal and sociocultural context and, as such, varies considerably across cultures.

Cross-cultural studies have alternatively shown that gendered expectations can mitigate the emergence of PPD or cause underreporting rather than act as conducive to mental health issues. Many cultures and societies are considerably different from the West in terms of how they view mothering and the expectations that they place on women in the postpartum period. These cultural variations have implications for how women respond to postpartum changes. For instance, in Japan, considerable emphasis is placed on the continuation of the family line and as such, delivering a healthy baby can bring

increased status to a Japanese woman (Halbreich and Karkun 2006). As a result, Japanese women are typically more willing to endure physical and psychological discomfort and less likely to report depressive symptoms (Halbreich and Karkun 2006). Similarly, Chan et al. (2008) have proposed that Hong Kong women are less likely to admit to postpartum depressive feelings due to the dishonor and shame that would be associated with not being able to fulfill their social duty of mothering (116). Finally, in a particularly illustrative case for my own work, Ghosh (2005) determined that South Asian migrant women's socialization and gendered-expectations highly influenced their postpartum mental health. Although the women in her study conducted in Perth, Australia acknowledged that they had painful postnatal feelings, they accepted them as being a part of life rather than an illness. She explained this as being due to women's internalization of the cultural schema of womanhood which is affected by South Asian values on female virtue as well as experiences with suffering.

Overall, the literature on the relationship between gender and depression indicates that women's status, roles and expectations can highly influence their postpartum mental health. As shown in UN reports, women worldwide continue to occupy a disadvantaged position in society which can negatively influence their health (UN Women 2013). Exposure to gender-based violence and inequalities in education and employment, for example, can compromise women's mental health (WHO 2009; 2001). This can be especially pronounced following the birth of a child when pre-existing economic and social

conditions are further strained. The numerous responsibilities and roles that women perform have also been linked to negative mental health outcomes (WHO 2001). Finally, women's gendered-expectations direct the way that they approach motherhood and understand any negative feelings that occur postpartum. These interrelated findings form the foundation for my own work with Bhutanese women, discussed in the proceeding sections.

***Bhutanese Women and Mothering***

The environment in which women are socialized can have a significant impact on the way that they perceive and experience changes in the postpartum period. Bhutanese women's responses to the postpartum period can thus be understood by reflecting upon their socialization and conceptualizations of motherhood. In order to illustrate this process, I first discuss the socialization that women undergo and the associated roles and responsibilities that they are expected to perform. I then examine how women's internalized schemas of womanhood direct Bhutanese women's postpartum expectations. It will be shown that schemas of womanhood are intermingled with motherhood, meaning that childbearing is viewed as an essential component to being a Bhutanese woman. This may make women more willing to accept difficulties in the postpartum period and explain the lack of perceived postpartum mental depression in Bhutanese women.

Women's schemas of womanhood are, in part, developed and internalized through a process of socialization. Socialization is the process by which people learn to behave in a certain way, as informed by societal and cultural beliefs, values, attitudes and examples (UNICEF 2007). This process arguably begins the moment a woman finds out that she is pregnant and others in her social world begin to make judgments and expectations regarding the value of males and females (UNICEF 2007). Following birth, young girls in Bhutan begin to acquire the meanings and behaviours associated with their gender. Girls as young as four will assist and perform the duties of their mothers and other women in the community, often without being asked to do so. My community partners, including the men, remarked that this process results in young girls taking on a level of maturity beyond their years. Furthermore, women learn to accept their place in the world as being caretakers of the home and family. This process of socialization marks the beginning of the internalization of cultural meanings attached to gender and the construction of schemas of womanhood.

Through socialization, women not only learn the behaviours appropriate to their gender, but also acquire the meanings and values attached to womanhood. As shown in Chapter Four, Bhutanese women define "the self" in relation to their social environment. Gender, as part of the self, is also constructed through one's social roles, responsibilities and relationships. For the Bhutanese, womanhood is largely dependent on the roles of mother and wife. When I asked Sabika what made her a woman she responded: "Before marriage I

am not a woman. I'm a girl. After marriage, I am a woman. And then when I'm woman I have the responsibilities of the house. Taking care of children, taking care of husband, and how to deal with in-laws, everything." This response shows the role of marriage in attaining womanhood and the association between being a woman and performing certain, particularly caretaking, responsibilities. The importance of motherhood was articulated by Janu, who told me: "Our community people, when they have a baby, they talk like good about that lady. If I have baby they talk like “oh she has baby, so nice.” And then if I don’t have baby after 7 or 8 years of marriage they start talking bad thing about that lady." Women are thus entirely responsible for fertility, and inability for a woman to produce a child reflects poorly upon her alone. In Bhutanese culture, motherhood is an essential component to being a woman, and the birth of a child fulfills women's gendered expectations.

Bhutanese schemas of womanhood also reflect cultural responsibilities related to their social position. Within traditional Bhutanese patriarchal society, the responsibilities of men and women are clearly divided[15]. When asked what the expectations and responsibilities of women are, all twelve of my respondents had similar answers that only varied slightly with respect to migration (discussed further in a later section). As a result of their prior gender socialization,

[15] Interestingly, this is not the case among all cultures in Bhutan. Outside of the Southern regions, gender roles may be more overlapping. See Crins 2008.

Bhutanese women recognize that as wives and mothers, they need to take care of the home (cooking, cleaning, washing clothes), take care of family members (children, husband, parents, in-laws and extended relatives), and contribute to family and community economic welfare (farming and raising livestock). The only exception to this pattern is during menses, when women are considered unclean and are not allowed to touch, prepare or serve food to others. Traditional women's gender roles in Bhutan are shown in the following quotes:

> "In our place, in back home, men used to go out for five months or six months to earn money and the lady, the wife, used to be at home to take care of family - in laws, brother-in-laws, and sister-in-laws - to make them happy and do the household work in absence of husband. She has to hold the family." - Janu

> "What [the family and community] expect is like kitchen work, cleaning, laundry, everything they expect to be done by woman. Wife or sisters or daughter-in-laws they're expected to do that. And in our culture everything is done by woman. Everything, cooking, cleaning, taking care of children, everything, and taking care of the husband too, is done by wife... in our culture, in back home, men used to work in field but woman also used to work in field. They work in field together but still at home everything is for woman." - Bhima

> "The women, they need to do things inside the house. They do the inside things, everything, cooking, take care of the baby, you know? Ya...cows, the food for the cows. I would take care of everything." – Durga

> "In my time, like when I got married, I had to stay at home, do the work at home like everything, cleaning and everything." – Devika

In Bhutan, women are expected to take care of all responsibilities associated with the home and caretaking of children and family members. Women also play a significant role in farming and rearing animals, thus contributing to their families' primary means of income. Many women understood their role as being

all-encompassing, as noted by three of the participants quoted above, who recognized women as being responsible for "everything." Due to socialization and the performance of gendered tasks related to being a wife and mother, Bhutanese women associate and internalize their responsibilities as being prerequisites of womanhood.

In comparison to women, men's traditional gendered roles are centered on what women repeatedly referred to as "outside work." Whereas women are responsible for "inside work," men are traditionally expected to tend to the farm (the most common form of income in Bhutan) and provide for the family financially. As Durga stated:

> "The role of the men is that they need to go outside and get the money and they have to work in the garden, like the big field. The men, they do that thing. And they bring the money, you know? If they need to, they collect the money from their relatives or in the community. They do the outside thing only."

Although women overlap with men's gender roles by assisting them with farming and providing for the family, the opposite is very rare in traditional Bhutanese culture. In our discussion, Janu joked about men being unable to find ingredients on the rare occasion that they work in kitchen: "If men have to work in the kitchen, they are asking “Where is this? Where is that? Where is turmeric? Where is salt? Where is sugar?” They are asking everything because they are not used to kitchen [laughter]." Using humor to illustrate her point, Janu brings to light the substantial differences between men and women's responsibilities.

Although the traditional roles and responsibilities of Bhutanese men and women may seem to result in gender inequality, this is not necessarily the case for all families. Even among my small sample, family dynamics and women's perceptions of gender relations varied considerably. It is of great importance to remind readers that the differences between the roles and responsibilities of men and women are not simply due to cultural norms and beliefs; they are also shaped by additional social, economic, and political factors. While most of the older women in my study remarked that their husbands did not help them with housework and childcare, this may be explained in part by reflecting upon their contextual settings.

In Bhutan, many couples had arranged marriages from ages as young as 15. Given this, it is perhaps unsurprising that a young couple would be uninterested in helping one another or discussing their needs. Variances in gender roles and relations can also be recognized based on the education levels of a couple. In general, more equality exists when both have had some form of education rather than only one. In addition, this community comes from a remote and poor area of Bhutan, necessitating men to spend the majority of their time working (sometimes great distances away) to provide for the family. This overburdened them as well, and may have made it impossible for men to assist their wives even if they wanted to. Finally, in Bhutan men were issued unpaid, mandatory work from the government (usually for infrastructure) that they had to comply with. This resulted in men being removed from their homes

for months at a time against their will. Although the patriarchal nature of traditional Bhutanese culture may have resulted in gender imbalances for some families, it is important to be mindful of additional contextual variables that constitute men and women's gendered lives.

Whether or not women receive assistance from their husbands, it is clear that are responsible for many overlapping roles and responsibilities. Although the literature on gender and postpartum depression would lead one to expect the multiple roles attributed to Bhutanese women to be harmful to women's mental health, this is not necessarily the case. In my research, I found that women accepted their roles within their families without complaint and viewed their positions as wives and mothers with pride. For example, in our discussion of women's roles Devika told me:

> "Woman is powerful. She's the most powerful person in the family and she takes care of husband. Woman take care of children. Do all the household work, even if she works outside. She has the more role in the family. Woman has the most role in the family. She is the powerful person in the family."

Rather than viewing her multiple gender roles as burdensome, Devika understood herself as powerful and capable. Gita shared this view in saying "Women can do lots of things. They play a vital role in our community. They can do everything." As did Ranju, who told me "I feel like I am worshipped in my family. I feel important." Instead of viewing their multiple roles and responsibilities are problematic, Bhutanese women perceive themselves as

powerful, capable and essential to the wellbeing of their families. Furthermore, Bhutanese women do not necessarily view divisions in labour as problematic. For instance, Krishna told me that she *prefers* to work in the kitchen alone:

> Krishna: "The odd thing is I don't like the way he works in the kitchen [laughs]. The other thing is I don't like my kitchen being messy. If he goes in the kitchen he will just leave things scattered around and I hate that." [laughter]
>
> Christina: "So you'd just rather do it yourself." [laughter]
>
> K: "Ya." [laughter]

The women in my second focus group shared Krishna's view, telling me that although they are responsible for everything in the household, they take a sense of pride in their responsibilities of caring for their families and do not find it burdensome. They also told me that women who do not adhere to traditional gender norms are viewed as lazy and may be gossiped about by other community members. This emphasizes the role of community in regulating and replicating women's gendered duties. Overall, I found that women's gendered roles and expectations associated with motherhood lead them to view themselves as powerful and capable, rather than dependent and weak.

So far, I have outlined the ways in which Bhutanese women's socialization, performance of gendered roles and responsibilities results in an internalized schema of womanhood. This schema is characterized by the view that women must become mothers and perform gendered duties associated with this role without complaint. Women's postpartum mental health can be

understood with respect to this schema, as women's preconceived expectations can influence their postpartum perceptions. I propose that because Bhutanese girls are socialized to expect motherhood as an essential component to womanhood, they subsequently internalize any difficulties associated with being a mother as essential and necessary components to being a woman. The following discussion with Janu demonstrates this connection:

> Janu: "In our culture, in our tradition, woman is like earth. They bear everything. They bear the pain of husband, they bear the pain of children. We step on earth and earth can't complain about "oh, you step on me!" Woman is like earth, she bears everything and she never complains of children or husband."
>
> Christina: "So women aren't supposed to complain?"
>
> J: "No no, like we have the power of that. We are not supposed to complain but we have the power that we can tolerate. Like earth can't complain right it's like we can pee, we can poo, we can do everything...like woman. And as mother I'm like earth."

Through the use of a wonderful metaphor, Janu articulated to me the way that her schema of motherhood affects her responses to the challenges associated with being a wife and mother. Janu's passages also reinforce women's recognition of themselves as powerful rather than helpless beings. In acknowledging the responsibilities associated with their roles, Bhutanese women accept distress or challenges associated with motherhood as part of their gendered duties. Bhutanese women are able to tolerate and endure difficulties associated with their roles as mothers and may not perceive or choose to

express distress due to their gendered expectations (in addition to cultural taboos discussed in the previous chapter).

Before closing this section, it is worth noting the role of gender preference in women's schema of motherhood. In traditional Bhutanese culture, womanhood is dependent not only on giving birth to a child, but preferably a son. The inability for a woman to produce a son may result in negative mental outcomes. Indeed, stress or anxiety resulting from the pressure or desire to give birth to a boy has been found to be a determinant of PPD, especially among Asian cultures (Morrow et al. 2009; Savarimuthu 2009; Klainin and Arthur 2006; Patel et al. 2002). In our discussion, Gita told me that depression can arise if a woman has a girl instead of a boy and her husband and family are unhappy. She explained: "They want at least they want one boy. They think like their generation will end if they don't have a boy. "Oh our generation will be end, we don't have boy" it's like that. Before if they have girls, they don't like the moms. You know if I have girls, girls, girls, they don't like me. The mother-in-law, the father-in-law, they hate me." Gender preference was mentioned by two other women, whose experiences are reflective of traditional beliefs. During our conversation about her children, Ranju noted that following the birth of both her second and third girls, her husband had told her that he wanted a boy. After giving birth to a girl, Sumitra revealed that she was happier with her second child because it was a boy: "My second child is boy, the first one is girl, and like in our

culture boy is like important. People used to celebrate when they had boy. I was more happy when I got boy."

While son preference can certainly factor into PPD, it is nonetheless very complex and surrounded by considerable variation. In my study, none of the women admitted gender preference resulted in tension, perhaps reflecting changing attitudes and contextual variables. For instance, although Gita recognized son preference persists in her culture, she also stated that families wanted at least one girl as well, and the pressure to have a boy is lessening in Canada. She also stated that in her case, the gender of her baby was a non-issue and her family was elated because her daughter was the first in her husband's family: "In my family, it doesn't matter. My daughter is first daughter in their family so they are so happy. Otherwise they don't have girl in their family." Gita's response was echoed by my community partners, who informed me that girls are cherished members of the family and that many families try to have a girl and are very disappointed when they cannot. The diverse experiences and beliefs of the Bhutanese women in my study show that although gender preference can factor into women's postpartum experiences, it is a complex factor dependent on specific social contexts.

Overall, I found that schemas of motherhood direct Bhutanese women's postpartum expectations and perceptions. Women associate the birth of a child with the fulfillment of their gendered expectations, which gives them increased

status and importance in their families and communities as well as a sense of personal accomplishment. In addition, their schema of motherhood results in the recognition that, as mothers, they must take care of their children and persevere through any distress or hardship without complaint. This may in part explain my finding concerning the lack of perceived or reported postpartum depression among Bhutanese women in the postpartum period. These findings also offer insight into the resilient nature exhibited by Bhutanese women, which will be discussed in the next section.

***Bhutanese Women and Suffering***

As I have shown, one way that Bhutanese women's schema of womanhood can be understood is by considering their socially-constructed roles and responsibilities. Bhutanese women's schemas of womanhood can be further understood with respect to their experiences with discrimination and hardship throughout their lifetimes. In this section, I discuss the cultural and political (i.e. state government) discrimination and suffering that Bhutanese women have endured in Bhutan and Nepal. I argue that women's lived, gendered experiences result in an internalized schema of suffering. By enduring gender-based discrimination, Bhutanese women internalize hardship as part of life and accept suffering as a component of their gendered experiences. I propose that in the postpartum period, this schema leads to a resilient response to any perceived challenges that arise following birth.

In 2003, Human Rights Watch issued a comprehensive report on the status of Bhutanese refugee women based on interviews with women in Nepal's refugee camps, UN agencies, NGOs, and Nepalese officials and police. The report revealed considerable gender-based violence and discrimination at both a cultural and state level. Within patriarchal Bhutanese culture, women have experienced inferior social, economic, political and legal status. Due to strict gender roles, women are prevented from cultivating their own economic independence and social autonomy. Girls are less likely to be sent to school and receive any education, resulting in high rates of illiteracy. Women did not have equal representation in political affairs in Bhutan, and there was little awareness about women's rights. Furthermore, polygamy was common among communities and women were often not consulted when additional wives were taken, potentially resulting in economic abandonment and loss of status. In cases of divorce, laws prevented women from retaining custody of their children if they remarried. (HRW 2003)

At the political and state level, women faced gender-based discrimination in both Bhutan and Nepal. In Bhutan, land and property was registered under the male household head despite the fact that women often equally contributed to the family’s agricultural efforts. Bhutan's state-instituted marriage and family planning laws targeted women and the "one nation, one people" policy prevented them from wearing their traditional sari or their hair long. During the exportation and flight of the Bhutanese people in the 1990s, women suffered

sexual violence, arbitrary arrest and detention, and other human rights violations at the hands of state officials. (HRW 2003)

In Nepal, gender discrimination has been recognized in camp registration policies and Nepalese laws. Categorization processes carried out by the Joint Verification Team (JVT) designed to verify and categorize refugees excluded women from full participation, affecting the future of not only the women but also their children. Registration and ration distribution systems are organized around male heads, and women are unable to access rations for themselves or children without male consent[16]. This practice was especially detrimental to women attempting to leave polygamous or abusive relationships. Sexual assault and domestic violence was recognized as a pervasive issue in the camps, and sexual exploitation by aid workers and government officials has also been also documented. (HRW 2003)

Although gender-based discrimination was not a topic intended to be discussed in my interviews, it nonetheless arose during several discussions on womanhood. Several women disclosed to me traditional cultural practices concerning education and patriarchal practices. Two women shared with me the traditional cultural convention of not sending girls to school:

[16] According to my community partners, this male-headed ration distribution system was altered in 2004, giving women independent access to aid.

> "In our culture, like in the past, the female, they are not educated. Their parents did not send them to school." - Preeti

> "In my age, like when [myself and other women] were kids, we don't have school and we didn't get chance to go to school. If we had that opportunity to go to school we could work in like office, we could hold a good position, we could work. But we didn't get opportunity to go to school and we have to do the household work." – Bhima

Out of twelve of the women that I interviewed, nine did not have institutionalized education and eight were illiterate in their own language. Although this can be viewed as cultural discrimination, it may also be reflective of families' social and economic realities in Bhutan. As I discussed in the previous chapter, young girls often assist their mothers and other female relatives with tasks without being asked. In poor families that need extra help around the home, it is often girls that are needed to stay at home to help their mothers while boys receive an education. Whether viewed as cultural discrimination or economic need, women have faced a disadvantage in not receiving an education.

In addition to being less likely to be sent to school, some Bhutanese women have also suffered cultural discrimination due to patriarchal beliefs and practices. In traditional Bhutanese culture, women are viewed as inferior to men and subsequently lack certain freedoms. As Gita explicated:

> "In our culture some of the women only work in the kitchen and they cannot go outside. Most of the women is scared, like with their husband. I think with like freedom kind of things. And in our culture like women do not get freedom like if they go outside and then stay two, three days it's not ok for our culture."

Within traditional Bhutanese culture, women do not have the freedom to come and go as they please, and are afraid to disobey their husbands by doing so. Cultural discrimination was also brought up by Bhima, who said:

> "In the past women are seen under the supervision of men. They have no power to speak in front of men, they don't have any power, they have no any rights to speak in front of men in the past. And now also it's in my mind like "I'm not supposed to speak."

In her response, Bhima shares her experiences with women's lack of freedom and rights, as well as their inferior position to men. As the second oldest participant in my study, Bhima's response is especially insightful in providing information regarding traditional cultural practices. Again, it is important to remind mindful of additional contextual factors in understanding these women's experiences. My community partners reminded me that in some cases, men will forbid their female relatives from leaving the home in an effort to protect them. For example, as a young woman, Gita's narrative may reflect her experiences in Nepal where women were in danger of sexual trafficking. It is possible that what women perceive to be lack of freedom are attempts by male relatives to protect them.

As the report compiled by Human Rights Watch and the responses collected from my own interviews show, generations of Bhutanese women have endured considerable gender-based discrimination across time and space. At every stage of the migration process, Bhutanese women have encountered

cultural and institutionalized discrimination that has resulted in hardship. Especially in the context of forced migration, women have experienced violence and uncertainty. These gendered experiences have resulted in schemas which view suffering as a normal component of life. In making this claim, I do not mean to present women as helplessly accepting their fate or naturalize women's subordination. Rather, I believe that Bhutanese women frame their current and future experiences through their past experiences with suffering, which leads to an incredibly strong and resilient active response to adversity.

In the postpartum period, this schema of suffering interconnects with that of womanhood, resulting in women perceiving any distress or difficulty as normal, rather than abnormal. Just as schemas attached to motherhood result in certain gendered expectations, women's understandings of suffering direct their future understandings and perceptions of distress. As I discussed in Chapter Four, with the exception of two women, none of the women in my study perceived or admitted to postpartum mental changes or depression. While many admitted to perceiving increased tension, these feelings were not explained as depression. Schemas of womanhood which view suffering as a part of life may explain this, as Bhutanese women internalize challenges as part of life and exhibit resilient responses in turn. For example, when probed on how she dealt with distress resulting from worry about her children, Devika responded: "I can't think of the past, I have to go ahead." Similarly, when I asked Durga on how she coped with negative mental changes following birth she replied:

> "If I have something, I have to solve myself. Whatever problem - if I'm pregnant, if I have a headache, if I'm sick - I have to complete everything you know. I solve every problem whatever there is. I solve everything. Whatever problems I have I don't care. If I'm sick, if I can't do something, I HAVE to do it."

Durga's response is especially representative of the resilient nature that I witnessed in the Bhutanese women in my study. Despite having challenges in the postpartum period and recognizing negative mental changes within herself, Durga did not interpret these feelings as depression. In part due to a schema which views suffering as part of life, Durga and the other women in my study viewed postpartum distress as normal, rather than indicative of depression. They subsequently dealt with increased tension in a resilient manner, accepting it as a part of life and enduring for the sake of their families.

### *Gender in the Context of Migration*

Following their migration to Canada, I found that women's views concerning their gender roles, gender relations and rights and freedoms have begun to change considerably. Although all of the women in my study were raised in Bhutan and able to speak to traditional gender norms, they also recognized intergenerational changes that were occurring within their community and/or own families following their migration to Nepal and Canada. Although women's experiences varied family to family, the majority of women recognized changing gender roles, increased equality between men and women, and increased freedom and rights for women. As schemas are fluid and

susceptible to change based on personal experiences and environment, these sociocultural changes may influence future generations' schemas of motherhood and responses to postpartum distress.

As I have already shown, Bhutanese women traditionally have strict gender roles and there is a clear division of labour between men and women. Eight women in my study mentioned increasing gender equality as well as changing gender roles. These changes appear to have begun in Nepal, intensifying following resettlement to Canada. This initial shift was described by Bhima:

> "When we were in Nepal the men got education and they knew that they need to help their wife. So if somebody saw, like if suppose my husband started washing my clothes - we don't have washing machine there we need to use our hands and soap, water - and if another man saw that he started criticizing "oh look at him, he is washing wife's clothing, now he's out!" [laughs] They would talk about that. In Nepal, they knew that they should help their wife but because of the friends and those things, they have to be careful about the friends."

Due to educational programs within the refugee camps, men began to alter their roles and help their wives with what would have previously been only "women's work." These gender role changes were initially accompanied by some social resistance as other men would make fun of those helping their wives. However, Bhima later elaborated further and said that eventually, her husband and other men in the camps continued to change and would help despite criticism from others.

Men's changing gender roles have continued to progress in Canada across generations. Bhutanese women have recognized increasing male involvement and assistance:

> "Comparing to the past now [men] are helping and they are part of the team, right. They are part and they help. Nowadays, both they are working in the kitchen. They help." - Preeti
>
> "Nowadays, like in the past like I already told you, men never think of woman, "what if something happens to her what happens" they never think of that but nowadays there is little changes. The men started thinking about woman too. Most of the time women are taking care of men but nowadays in return to that men are also helping and men are also thinking about like "I have to help her." Now the men are helping to take care of children and to do the house hold kitchen work, they are helping." - Bhima
>
> "They all help me. My boys and husband, they help." - Sabika
>
> "When [my husband] came here, he changed. He work at home. He help me with cooking, cleaning, everything and to take care of the baby. He do. Ya he changed." - Durga

These women all acknowledged that the men in their families were showing more concern about them and assisting them in the home and with child care. During community events, I couldn't help but notice these changes for myself, as men of all ages were involved in serving food, the cleanup process, and taking care of young children.

I found gender role changes to be especially pronounced among the youngest generation in my study. The four youngest women all had considerable help from their husbands with respect to housework and childcare. When I asked Dhana, if there was anything that men do that women do not, she replied that

her husband does the same things as her and helps with their daughter. This was consistent among the other three women:

> "In past in Bhutan my mom she need to do everything like cooking and prepare some food for all kids and they need to go like – she have to do everything at home, cleaning and everything. And she need to go outside to do the field work also. But here I feel like it's lots of change because my husband is helping lot. It's lots of change from past days, like my moms...I think its equal now." - Nadya
>
> "For me ya my husband can do everything. Now he's going to clean, vacuum cleaning [laughs] even change diaper. Ya he can do. He's doing everything." - Gita
>
> "If I'm too tired I ask [my husband] to cook. [my son] loves being with [my husband] otherwise he normally jumps in to help me out with the cooking. But [son] likes to be with his Daddy most of the time. So that leaves [my husband] to be with [my son] all the time when he's at home and me in the kitchen so that's how we manage. And balance, ya." - Krishna

The experiences of these younger generation Bhutanese women are particularly indicative of a shift in gendered roles and responsibilities. However, while the majority of the women in my study mentioned these changes (9 of 12), they are not representative of all Bhutanese families. As my community partners reminded me, there is considerable variation family to family. For instance, although Sabika recognized gender role changes occurring in Canada, she also said that they were not representative of all women's situations, including her own: "Men, some men like help household things too. But some doesn't. Like my husband." This was also clear to me during my fieldwork, as younger men were much more likely to be helping their wives or other women during community events or in the household during the interviews. In general, older generations

continue to be responsible for the majority of housework and childcare while younger generations exhibit a higher degree of role equality.

While most of the traditional gendered responsibilities of Bhutanese women have endured, some have taken on additional responsibilities within the context of migration. Although women did contribute to farming efforts in Bhutan and Nepal, few had paid, outside employment due to their lack of education. Following migration to Canada, women are increasingly expected to get an education, gain English proficiency and outside employment. When I asked Krishna why this change has occurred, she explained that as new immigrants to Canada, it is not financially viable for one person to stay at home while the other works:

> "In Bhutan you own your own house and most people live in joint families. So you have lots of people living in the house who take care, you know help you on day-to-day basis and you know day-to-day chores of the house and the men they just go out and do the work. So the pressure doesn't come to single one family, you know to maintain and to earn. And in most cases the women are not very highly educated and men are. So they tend to be at home right and then men have the ability to go out and work. So that's where the difference is. And out here it's entirely different. You know you can't just stay at home and expect one person to go out and work and have nothing and then be covered in debt and go bankrupt. [laughs] Right?"

Due to changing economic and social settings, Bhutanese families are more likely to require women to get an education and a job; roles that were previously assigned to men. Although this change is positive in some ways, giving women increased agency as well as the ability to cultivate their economic independence,

it also may pose a threat to their well-being. The "double burden" experienced by women in Bhutan has continued and intensified in Canada, with women continuing to do the majority of the cooking, cleaning and childcare, while also needing to hold an outside job. As Preeti said: "Women are getting education and they have their jobs in one hand and on the other hand they take care of house cleaning, everything." Dhana recognized her multiple roles as a new mother, wife, daughter and daughter-in-law, as she was required to take care of all of her family members as well as learn English and get a job.

In addition to changing gender roles and gender relations, Bhutanese women (and men) are experiencing increased freedom and rights in Canada following a long history of human rights violations in Bhutan. As well as having improved access to educational opportunities, Bhutanese women have already recognized an increase in personal freedoms and rights. In our discussion concerning women, Bhima related to me some of the changes that she witnessed following migration to Canada:

> "When we first arrived here, I went to [an agency serving newcomers] and I found out that a child's last name comes after mom's name but in our culture it's not like that. Child's name comes after father's name. There is no divorce and all those things back home, it was rare in back home. I found out here it's ok, it's our right. When I arrived I knew that it's the place of woman's right too. There is right for woman too. And back home if, for example, if I have a husband who is strong and he beats me all the time and I want to divorce him and I got divorce, the men keep the children not the woman. So here I learned that mom has that right to keep the children. And this is the place where woman has some right."

Upon arrival to Canada, Bhima learned that within Canadian culture, women have increased rights and freedoms as compared to Bhutan and Nepal. Her example of divorce is particularly telling, as she realized that in Canada women have greater agency in leaving abusive relationships and considerably more rights following divorce. Gita also recognized changes in Canada, telling me that she had increased freedom within her family: "In my case my father, he change a lot. He's allowed me to go outside of the home now, he said "ok you can go."

Changing gender roles, gender relations and increasing freedom and human rights may positively or negatively affect the postpartum mental health of younger and future generations of Bhutanese women. Due to changing experiences and cultural conventions within a Canadian context, Bhutanese women's schemas of motherhood and suffering will likely differ from those among current generations. Motherhood may increasingly be viewed as a shared responsibility among women and their partners, releasing women from some of their multiple roles and duties and giving them increased support. However, increased expectations of women to enter the workforce may result in increased stress when coupled with the need to fulfill gendered responsibilities concerning the house, children and family. Increased freedom and access to human rights will conceivably have a positive effect on women, as they may have an increased ability to express any perceived distress arising in the postpartum period. However, without having the shared experiences with discrimination and

hardship of current generations, second-generation Bhutanese women may cope with postpartum and other life difficulties in a less resilient way.

### *Conclusions*

In this chapter, I have shown that women's socialization and understandings of motherhood, along with their previous experiences with suffering, result in schemas that direct their postpartum expectations and responses. These two schemas view childbearing and struggle as necessary components of life, and result in resilient responses to postpartum distress or struggle. Schemas of motherhood are internalized following a process of socialization through which they learn the culturally-determined roles and responsibilities associated with womanhood. Having been raised in Bhutan, all of the women in my study shared this schema of womanhood and recognized that, as women, they are expected to get married and give birth to children. Associated with these roles, they acknowledged the expectations that they take care of the home and their families, and contribute to the families farming efforts. Despite having multiple roles and duties, I found that Bhutanese women understood them as essential to womanhood and performed them without complaint. Having internalized the Bhutanese schema of womanhood, the women accepted challenges associated with motherhood as being part of their gendered self. This may in part explain women's lack of perceived or expressed

distress, as women recognize that, as mothers, they have a responsibility to care for children and persevere through any associated challenges without complaint.

In addition to having a shared schema of motherhood, I argue that Bhutanese women also internalize a shared schema of suffering. In both Bhutan and Nepal, women experienced significant hardships associated with cultural and state-level discrimination. Due to these experiences, Bhutanese women internalize suffering as a normal part of life and exhibit a resilient response to adverse situations. The women in my study demonstrated this in their responses to perceived difficulties and tension. Rather than getting depressed, women endured postpartum challenges and exhibited a strong nature. Schemas of womanhood which view suffering as a part of life may explain this, as Bhutanese women internalize challenges as part of life and exhibit resilient responses in turn.

In the context of migration, gender roles and responsibilities, as well as gender relations and women's rights and freedoms are beginning to change. Men are increasingly taking on traditional women's roles (i.e. housework, childcare) while women are taking a more active role in outside employment. Men are also beginning to show more care and attentiveness to their wives' needs. Furthermore, women recognize that they have increased agency, freedom and rights in Canada and are able to attend school and make independent decisions. Although these changes are not consistent across

different families, the fact that all of the youngest women in my study exhibited these changes indicates a trend. Within the context of migration and these social and cultural changes, women's schemas of womanhood are likely to change in ways that can positively and negatively affect their postpartum outcomes. Women may view motherhood as a shared responsibility among men and women, giving them increased support. However, the effects of women's "double burden" in Canada remain to be seen. Furthermore, without having the experiences of past generations, younger Bhutanese women may have altered schemas of suffering and exhibit less resiliency when faced with adversity.

Overall, in this chapter I have demonstrated the relationship Bhutanese women's schemas of motherhood and suffering, and the way that these schemas direct their gendered expectations of the postpartum period. Women's lack of perceived and/or expressed distressed following the birth of a child is interrelated with internalized gendered experiences and expectations. As such, gender is a vital component to consider when interpreting women's postpartum mental health.

# Chapter 6: Postpartum Sociocultural Support

The transition from to childlessness to motherhood is accompanied by significant changes to a woman's cultural status, social roles and responsibilities. As a woman adapts to these changes, cultural traditions and social support may be of increased importance and value. In most non-Western cultures, the postpartum period is accompanied by a number of rituals, prohibitions and proscriptions as well as increased social support and guidance (Oates et al. 2004). The postpartum period, widely defined as forty days, is marked by special postnatal customs including a distinctive diet, isolation, rest, and increased assistance for a new mother (Eberhard-Gran et al. 2010). It has been proposed that this cultural patterning of the postpartum period may result in low mental distress in women as it provides emotional and practical support for new mothers (Oates et al. 2004, Robertson et al. 2003). In this chapter, I examine this proposal regarding the association between social support and PPD, and discuss the role that cultural traditions and social support networks have on the postpartum mental health of Bhutanese women.

In this chapter, I utilize Stern and Kruckman's (1983) hypothesis concerning the role of social support and cultural traditions in warding off negative postpartum feelings. In their classic paper, Stern and Kruckman present an anthropological critique on the literature on PPD, and propose that an important relationship exists between social structuring of the postpartum

period and women's mental health outcomes. Their review of ethnographic accounts of childbirth found remarkably little incidence of postpartum depression among women in non-Western settings. Conscious that this difference could be due to the previous lack of anthropological interest in PPD or issues with assessment and diagnosis, they attribute this gap as being due to differential cultural patterning of the postpartum period. As they explicate:

> A hypothesis is proposed that a relationship exists between post-partum social organization/mobilization and post-partum depression. The experience of "depression" in the U.S. may represent a culture bound syndrome resulting from the lack of social structuring of the post-partum events, social recognition of the role transition for the new mother and instrumental support and aid for the new mother. (Stern and Kruckman 1983, 1027)

Although contemporary research has shown that PPD can be experienced by all women regardless of sociocultural background and should not be viewed as a "culture bound" syndrome as Stern and Kruckman originally proposed (Zubaran 2010; Kumar 1994), their hypothesis is useful in its pioneering recognition of the importance of postpartum sociocultural support.

Stern and Kruckman further develop their hypothesis by presenting six cultural components that provide the necessary social support to "cushion or prevent the experience of post-partum depression regardless of whether its etiology is biological, psychological or social" (1983, 1039). These components include: (1) structuring of a distinct post-partum time period; (2) protective measures and rituals reflecting the presumed vulnerability of the new mother;

(3) social seclusion; (4) mandated rest; (5) assistance in tasks from relatives and or midwife and (6) social recognition (through rituals, gifts, etc.) of the new social status of the mother (Stern and Kruckman 1983, 1039). Each of these components has a proposed role in PPD, acting as mediators in the emergence of negative postpartum feelings. In my research, I found Stern and Kruckman's recognition of sociocultural components and overall hypothesis to be reflective of Bhutanese women's postpartum experiences.

This chapter begins with a review of the literature on the relationship between sociocultural support and postpartum depression. This review emphasizes both positive and negative mental health outcomes that have been associated with postpartum rituals and support. Next, I discuss the importance of family and community for Bhutanese women. In the proceeding section, I present Bhutanese women's postpartum experiences in relation to their cultural traditions and associated perceived social support. Lastly, I discuss generational differences and the effects that migration may have on traditional cultural patterning of the postpartum period. I propose that Bhutanese women's postpartum mental health is positively influenced by traditional beliefs and practices as well as high levels of social support. I further posit that the protective qualities of these cultural patterns may be compromised following migration due to changing social networks and decreased ability to adhere to traditional traditions and rituals.

***Sociocultural Factors and Postpartum Depression in the Literature***

Since Stern and Kruckman's seminal paper was published, an extensive body of literature has emerged dedicated to understanding the link between cultural rituals, social support and postpartum depression. Despite the concentration of work within this domain, the links between social support and cultural traditions remain inconclusive. Many researchers have supported Stern and Kruckman's original hypothesis, determining sociocultural components to act in positive and protective ways. Still others have maintained that sociocultural factors result in increased risk of PPD in certain settings. In this review, I discuss both sides of the argument in order to show that social support and cultural factors have a significant influence on postpartum mental health outcomes[17]. Despite the inconclusive nature of the current literature, sociocultural factors have been firmly established as one of the most important considerations in postpartum mental health.

A number of studies and ethnographies have successfully demonstrated the ways in which sociocultural factors mitigate or eliminate the emergence of postpartum depression. Postpartum cultural traditions and beliefs can assign women increased status, value and respect, increasing their self-esteem and leading to positive mental outcomes (O'Mahony et al. 2013). Postpartum

[17] For a wider discussion on the relationship between cultural variables and postpartum depression see Bina 2008.

customs and rituals can also bolster women's social networks and levels of support (O'Mahony et al. 2013) giving them functional assistance and emotional guidance. In China, women often enter a thirty-day period of confinement known as "doing the month," which may result in a lack of PPD due to increased attention and support from their families and extended social networks (Pillsbury 1978; Hung and Chung 2001). In their study of rural women in Pakistan, Rahman and colleagues (2003) found that social support by the extended family was negatively correlated with incidence of PPD (1164). This was related to the practice of *chilla,* a 40 day period of mandated rest when all responsibilities are taken over by female family members (1164-1165). In many patriarchal cultures, women are prescribed rest and assistance related to the view that women are polluted in the postpartum period (Eberhard-Gran et al. 2010). Beliefs concerning female pollution result in the need for others to take over a new mothers duties, leading to increased rest for women, the promotion of breastfeeding and care of the newborn and increased access to material and emotional resources (Eberhard-Gran et al. 2010).

In their recent review of the literature on PPD, Collins et al. (2011) determined that a lack of social support was strongly and consistently associated with PPD in both the general population and immigrant women (5). Robertson and colleagues (2003) also determined low levels of social support to be one of the strongest predictors of PPD. Their review found a consistent negative correlation between PPD and perceived emotional and instrumental support

during and after pregnancy (Robertson et al. 2003). Similarly, in their transcultural study which spanned fifteen centers in eleven locations, Oates and colleagues (2004) found loneliness, lack of emotional and practical social support and poor relationships to be among the strongest causes of postpartum unhappiness (s13). Conversely, they found good social support to be a cause of happiness (s13). Due to having relief from their roles, time to rest and increased practical and emotional support, cultural traditions may protect women from developing PPD. When cultural expectations and beliefs are not met or social support is perceived to be low, however, women can be more susceptible to depression (O'Mahony et al. 2013).

While the majority of research on social support and cultural traditions indicates that they provide buffer against negative postpartum feelings, some researchers have argued that they can actually make women more vulnerable to PPD. Cultural beliefs and traditions may be conducive to PPD when practices are viewed as oppressive and/or support by certain family members is not desired. According to Eberhard-Gran and colleagues (2010), cultural beliefs regarding female pollution may legitimize the oppression of women (460). Although others have shown this belief to result in bolstered psychological status, when viewed as oppressive by women this tradition may result in undesired isolation, restricted agency and subsequent development of depressive symptoms. Several researchers have also shown that prescribed seclusion and support may be harmful rather than helpful depending on certain contextual factors. Heh and

colleagues (2004) found that higher social support was protective against PPD in Taiwanese women, but that this outcome was dependent on the sources of support and the place that they "do the month." They found that instrumental support coming from women's own parents was protective, whereas too much emotional support from in-laws resulted in postpartum dissatisfaction (577). Similarly, Chan and colleagues (2002) found that Hong Kong Chinese women attributed their postpartum depression to their relationship with controlling and powerful in-laws (576). These studies indicate that in some cultures, the presence and support of in-laws can negatively affect women's mental health.

In their own review of the literature on PPD in Asian cultures, Klainin and Arthur (2009) found that women may perceive postpartum rituals as a "double-edged sword which offers physical comfort on the one hand but serves as major sources of interpersonal conflicts and emotional frustration on the other" (1370). To explain this finding, they offer four explanations:

> First, the women may not have practiced the rituals by choice but have had to comply with their caregivers' (e.g., mother-in-laws) suggestions in order to avoid unnecessary interpersonal conflicts. Second, the pre-existing relationships between the new mothers and their caregivers may not be satisfactory, leading to difficulties in forming the caring relationship during the confinement period. Third, some aspects of postpartum rituals, especially restricted activities, may generate stress, tension, and frustration. Finally, other challenges surrounding the postpartum situation may interact with the traditional practice and affect women's mental health. (1370)

The mediating role of social support and cultural factors on women's postpartum mental health may be dependent on their individual situations regarding

satisfaction with interpersonal relationships, pre-existing challenges with caregivers and views concerning traditional practices. These factors indicate the ways in which traditional cultural practices can negatively, rather than positively, affect postpartum situations in Asian women.

Although the current literature is mixed concerning the relationship between postpartum traditions, social support and postpartum mental health, it nonetheless demonstrates that both have a significant influence in the aetiology of PPD. Postpartum rituals may eliminate or mitigate the emergence of PPD due to enhanced status and self-esteem as well as increased emotional and practical support and ability to rest. Conversely, postpartum traditions may compromise mental health outcomes when expectations are not met, they are viewed as oppressive, support is undesired from certain relatives, and/or when conditions are confounded by individual issues. In order to resolve this discrepancy, the effects of cultural traditions and support networks need to be considered from the perspective of women themselves (Heh et al. 2004). For the rest of this chapter I present my findings concerning women's views on the protective nature of Bhutanese traditions and social networks.

***The Importance of Family and Community***

> "It’s very important, family and community are very important in my life. If I have only one finger then there is no point of being this hand. If I have all these fingers, I can do everything. And if I have a big family, it’s really good. And if I have a big community, that helps a lot. Community and family are really important." – Janu

Bhutanese culture is profoundly social in nature and family and community have considerable importance in the lives of Bhutanese people. As I have already shown, the collectivist nature of Bhutanese culture affects all aspects of individuals' lives, including their concepts of self, views of wellness and illness, construction of their gendered identities, and life experiences and expectations. The Bhutanese cultural focus on social environments and relationships also extends to the value and emphasis that Bhutanese women place on family and friends. When I asked the women in my study what the importance of family and community was in their lives, all participants indicated that both were of the utmost value to them. The following quotes capture the general consensus found among Bhutanese women:

> "My children, they love me. They help me. The family's really important for me. I need family. It's really, really important." - Sumitra

> "If I love [the community] I get the same thing. Like feedback. They love me, and we have cooperation, we work together right. That's the one thing. Another thing is like - It's really important. Community is really important for me. If something happens like, we need our community. So community is also very important." - Sumitra

> "Family is very, very important for me and I want to be with everyone. Family like, son, daughter, everyone, living together is important for me. Living together means, within the reach. Not like I have two daughters in Bhutan, three children in the Netherlands, not like that. In the reach. And family is very important for me." - Preeti

> "It's very important. Community is important. If I have something, some problem, they will help. And then I won't be alone if there is community." - Sabika

As these quotes and Janu's metaphor at the outset of this section demonstrate, Bhutanese women view the support derived from their family and community as essential in their lives. Within both the family and community there is a strong feeling of mutual love, connectedness and a commitment and obligation to helping others. The tight-knit composition of the Bhutanese community was apparent to me early on in my research. Even in Canada, many families continue to live in extended families and when they do not, family members are often only a door, a floor, or a few minutes' drive away. Many homes that I visited had pieces of paper tacked onto their walls with the phone numbers of family and friends. The community places a heavy emphasis on maintaining ties and puts a great deal of effort into getting together to celebrate special events and talk about their concerns. At community events, people are constantly walking around to visit with different groups, passing around children, and embracing one another. The women in Edmonton who are unemployed spend a great majority of their time visiting and gossiping with friends, an activity that was also very common for them in Bhutan and Nepal.

Bhutanese families have an "open door" policy by which friends, family and community members can freely come and go as they please. I experienced this first hand, as I was always welcomed with open arms into the homes of Bhutanese people and offered tea, refreshments, and complete meals. After visiting with one family, I was asked why I had not come by more regularly. I explained that I did not think it would be okay to stop by unannounced because

in my culture, it is not acceptable to visit someone's home without an invitation. My friends laughed and were absolutely shocked by this information. They told me that I was not only a friend, but a sister, and that I should feel comfortable to walk into their home any time I wanted and share food and tea. The focus that the Bhutanese people have on friends and family was something that I, as a Westerner, found to be quite wonderful and remarkable. This feeling is shared by others working with re-settled Bhutanese communities (Chase 2011).

The fundamentally social nature of Bhutanese culture has a considerable impact on women's understandings and perceptions of wellness. As I have discussed in the preceding chapters, women's perceptions of their own wellness are largely based on relationships and circumstances within their social environment. In addition, their conceptualizations of what constitutes "normal" and "abnormal" are based in their cultural socialization and experiences as women. In addition to these prior findings, I propose that the value placed on social support and love has a considerable impact on women not only in the context of everyday life, but also in special circumstances including the postpartum period. Just as family and community have an impact on women's perceptions of health and cognitive responses to distress, perceived social support is an integral part to women's responses in the postpartum period.

***Bhutanese Rituals, Support Networks, and Postpartum Mental Health***

In Bhutanese culture, the postpartum period is structured through cultural traditions and beliefs that result in a mandated period of seclusion and rest, as well as high levels of social support. This traditional postpartum structuring impacts the women's postpartum experiences and their perceptions of their own postpartum mental wellness. In order to present the typical postpartum patterning in Bhutanese culture, I discuss traditional traditions, beliefs and related social support in light of Stern and Kruckman's (1983) organization of postpartum components. I show that the structuring of the postpartum period in Bhutanese culture results in increased rest, social support and social recognition for a new mother. I propose that the traditional cultural traditions and rituals and levels of family and community support in the Bhutanese culture result in increased emotional and practical support that helps to mitigate the emergence of PPD. I also recognize that women's mental health can be negatively affected when women are not able to adhere to traditional rituals or lack a strong social support network.

Bhutanese women traditionally work throughout their entire pregnancy and do not take a period of rest before delivering their child. Several women in my study even gave birth on the fields, as they had gone into labour while working. Following birth, however, women are proscribed a mandatory period of rest which is typically viewed as continuing for one month. As Preeti revealed:

"When they give birth they become weak. The female becomes weak. So [the family] give one whole month to gain their energy." During this postpartum period, women's lives are impacted by beliefs concerning their postpartum state as well as the traditions and support networks that arise from these beliefs. After birth (and during menses), Bhutanese women are viewed as "unclean" and "polluted," a belief that Stern and Kruckman found to be common in non-Western cultures (1983, 1036). The postpartum ritual related to this belief was explained by several women:

> "Until the naming ceremony on the 12th or 11th day after the baby born, 12th or 11th, difference between baby girl or baby boy. On the 11th or 12th day they have the naming ceremony of the baby and till that day she - the mom - is not allowed to touch anything. Not allowed to touch anything. They serve in the bed. And after the naming ceremony she can move around the house. And then still she can't touch, like she can't cook. On the 22nd day she can have water by herself, she can do that. And after one month she can work. Till one month they will serve." - Janu
>
> "No work in the kitchen. We cannot touch anything. Somebody needs to help me for 22 days. In Bhutan after 22 days I had to go to work in field." - Durga
>
> "We don't normally move out after we have baby, right. We don't exercise, we stay in the bed for you know, for 12 days we don't even come out of the house. You know until the baby has a ceremony, their naming ceremony. After that we just rest, you know stay at home, stay on bed and rest and do nothing. Don't go to kitchen, no cooking, no cleaning, nothing. All we have to do is sit. Like lie on the bed and rest. After 12 days you can move around the house but you know you don't take the baby outside. Ya you don't touch things." - Krishna

Until the child's naming ceremony - which takes place after 11 days for a girl, or 12 days for a boy - women must be secluded and are forbidden from touching

anything, including food. Although other sources have reported that women return to work and their normal duties following the naming ceremony (Maxym 2010), this is not what the majority of women in my study reported. According to my respondents and community partners, following the naming ceremony women are allowed to move around, but because they are still considered unclean they must continue to refrain from touching anything, cooking for others or taking the baby outside. After 22 days, women can resume their duties and go back to work, although some are able to continue to rest until the end of the 30-day postpartum period. This is, of course, highly dependent on women's individual situations, as some women returned to their normal duties earlier than others due to necessity (i.e. needing to help farm crops in Bhutan).

As Stern and Kruckman noted, the belief that women are vulnerable and polluted following birth is associated with a pattern of seclusion, wherein the duties of a new mother are taken over by female relatives, ensuring that the new mother rests (1983, 1037). I found this pattern to be representative of the experiences of Bhutanese women, who mentioned receiving a great deal of support related to their period of rest and seclusion. All but one of the women (whose circumstance will be discussed individually below) in my study reported receiving support in the postpartum period in Bhutan, Nepal and Canada. The women told me that their roles and responsibilities were temporarily relieved and that family members and friends would take over their duties and serve them while they rested. Women mentioned having primarily instrumental

support in the form of others cleaning and cooking for them and the rest of the family. Krishna's response indicates the experience of most postpartum Bhutanese women who experience traditional rituals and support: "I obviously had nothing to do [laughs]. Just stay at home, stay on the bed, lay on the bed, the food would come to my bed and I just eat and then they take the plates away [laughs]. All I had to do was pee and poo [laughter]." This social support temporarily absolves women of their multiple roles and responsibilities, allowing them to relax and rest following birth. It also allows women to focus on connecting with their newborn child and get accustomed to breastfeeding (which was practiced unanimously among the women).

For some women, instrumental support was also provided with respect to economic assistance and care of the newborn or older children. For Janu and Preeti, who both gave birth only in Bhutan, support also came in the form of extra assistance with farm work. As Preeti explained:

> "[Social support] is really important. Like neighbor, friend and community were really important for me because we had lots of land and need to cultivate patty. One of my children was born during the time of patty planting, on that season he was born. Every community people they helped saying “she had baby so she can’t come to the field so we need to help. We need to finish hers first and then we have to do ours.” It’s really important."

For women in Bhutan, assistance with work was important as farming formed the basis of most families’ subsistence and financial income. The loss of a woman's assistance in the field was supplemented by the assistance of

neighbours and community members, ensuring that a woman could continue to rest rather than be forced to return to work after the naming ceremony. This type of assistance was also noted by Nadya, who said that in the postpartum period in Nepal, others would fetch water instead of her: "We need to carry the water far away from my house and [family members] brought the water." Social support was also provided with respect to taking care of children. Devika, Nadya and Krishna, who gave birth in Bhutan, Nepal and Canada respectively, all mentioned getting social assistance from others who cared for their newborn, helped with a sick child, and took older children to school. This support alleviates any stress that could arise from women's need to care for her new baby in addition to older children, who may become sick or need assistance in their own way.

The social support that Bhutanese women receive in the postpartum period was derived mostly from female relatives, although support was also mentioned as coming from husbands, male relatives and friends in the community. Female relatives including women's mothers, mothers-in-law, sisters and sister-in-laws all provided the majority of instrumental, informative and emotional support. Elders, such as women's own mothers and their mothers-in-law, were the primary sources of postpartum support for women, providing them with practical assistance, advice regarding their postpartum diet and childcare and offering care and love. This finding is consistent with the literature on postpartum social support, as cross-cultural research indicates female

relatives to be the primary caregivers in the postpartum period (Stern and Kruckman 1983).

Interestingly, I found that many of the women also referenced their husband when discussing their postpartum support networks. Eight women indicated that their husbands had provided some level of instrumental support by taking over their duties and assisting them in other various ways. The influence of the husband's support in the postpartum period is shown in the following quotes:

> "The food, everything, is prepared by husband or next person for the whole one month. My husband helped with the cooking and fed me for whole one month." - Preeti, gave birth in Bhutan
>
> "My husband helps me a lot and that makes me feel better." - Gita, gave birth in Canada
>
> "My husband cooked. My husband took turns [taking care of] other people's small kids and outside camp. After that my mom's and my father's brothers they cook for me." - Dhana, gave birth in Nepal
>
> [My husband] was very cooperative. Giving me food, food for me. And helping me take showers because I couldn't stand properly, all that stuff, and taking care of [my son]. And he was at home for roughly 20 days after. With me for 20 days after baby was born to help me out. So he basically did the household - like cleaning the house and you know and doing groceries and you know taking care of [son] at times you know giving him a bath and stuff like that. - Krishna, gave birth in Canada

Women that gave birth in Bhutan, Nepal and Canada revealed that their husbands had assisted them in some way during the postpartum period. However, only two out of four women who gave birth exclusively in Bhutan said that they received some support from their husbands (the other two said that

their husbands were too busy working) and spousal support was much more common amongst generations under 40 who gave birth in Nepal and Canada. Older generations were more likely to have little, or no, assistance from their husbands, as explained by Bhima: "I gave birth to my children and I looked after them. I took care of them and now they are grown up. I did everything for them. My husband didn't help. And not only my husband, like in the past all the husbands are like that." This is consistent with my previous findings (see Chapter Five) regarding intergenerational gender roles, as men's changing gender roles beginning in Nepal have led to increased care for their wives and taking additional responsibilities within the household.

Lastly, support in the postpartum period came from male relatives and community members. Four women specifically mentioned their uncles, brothers-in-law and/or fathers-in-law helping with home maintenance and childcare. Interestingly, none of the women specifically mentioned their own brothers in providing support. Seven women also made mention of friends and community members in their postpartum narratives, noting their role in farming, childcare, household assistance, and providing them with feelings of love and encouragement. In Durga's case, the majority of the support she received in Bhutan and Nepal came from friends, as her husband and other family members were often away working or tending to other responsibilities.

The final component to women's postpartum experiences is increased social recognition and value. In addition to the social support resulting from functional assistance, there is also typically an increase in personal attention to a new mother (Stern and Kruckman 1983). As I explained in the last chapter, Bhutanese women are expected to have children and their value is defined by their ability to do so. When Bhutanese women have a child, family and community members recognize her new social position by talking about them in a positive way to others and showering the mother and new baby with attention, nurturance and love. During the naming ceremony, family and community members also offer gifts and money to the new mother and her baby. Following the naming ceremony, family and community members continue to visit the new mother, often bringing her offerings such as food. This can result in women having increased self-esteem and feelings of self-worth. Again, this outcome is dependent on contextual factors, as women's situations are highly variable depending on their family structures and beliefs. For example, in older generations, the birth of a girl may have resulted in less social status and recognition in the postpartum period than if the baby had been a boy (see Chapter Five).

The patterning of the postpartum period in Bhutanese culture may result in positive postpartum mental outcomes when traditional practices are adhered to and women receive increased social support and social recognition. This connection was made by Gita, who explained her lack of postpartum stress and

negative mental changes as being due to support from her husband, her family and her in-laws:

> "I don't think I have any stress because everybody's helping me. My family and my husband's family are also here they also help me, so everything going well. They support me a lot. Like household things. They cook for me, they do laundry for me, everything. First weeks was hard time for me to take care of [my daughter] because of third degree tear and then ya I had constipation for 3, 4 days. So I had hard time and they help me a lot. Ya everything, they did everything for me. I really appreciated that."

Although Gita is a young mother in a new country and suffered a painful third-degree tear during the birthing process, she did not perceive any stress in her life or negative emotional or mental feelings in the postpartum period. She explained this as being due to having a great deal of support in her life from her husband, parents and in-laws, who would cook and clean for her, do laundry, and take care of her newborn while she rested. Gita's experience is representative of the other ten Bhutanese women in my study who were able to follow traditional postpartum rituals and receive social support and recognition.

Sabika was the only woman in my study who indicated that she did not receive any postpartum support. Although she did not indicate feeling depressed at any time, she did experience increased stress due to her postpartum situation. Living with her husband and in-laws in Bhutan, she was mandated the 11 or 12 day period of time to rest and received minimal assistance during this time due to her perceived pollution. After the child's naming ceremony, however, she was

expected to return to the field and leave her newborn child at home. She found this to be difficult, especially when one of her children became sick:

> "When I was in Bhutan I had a stressed situation. Even when my daughter was so sick and she was at the end like my husband or in-laws they used to send me to the field - "go work" - and that makes more stress, right? The baby's fighting with life and death and I had to leave the baby and go work in the field."

Due to being separated from her newborn early, Sabika experienced postpartum stress and difficulty. Sabika also completely lacked social support from her husband, revealing to me that he did not care for her or their children and that all caretaking responsibilities laid entirely on her. During our conversation Sabika did not mention her parents at all, and when I probed about the role of her in-laws she said that they watched the baby while she went to work, but she received no support outside of that. She also mentioned a lack of food and starving at times, but did not wish to expand further on those memories. Sabika noted that her situation improved in Nepal, as she received better food and was visited by agencies working in the camps after both of her babies: "In refugee camp they used to visit the mother like new born child's mother. And they used to inspect the food, what kind of food she's getting. Ya. That kind. So because of that it was better in Nepal." Overall, Sabika's inability to rest outside of 12 days and lack of social support and attention resulted in increased stress and postpartum difficulty. Her challenging experience associated with lack of support

provides further evidence for the importance of cultural rituals and support networks in providing a buffer against PPD.

### *Sociocultural Support in the Context of Migration*

Migration and generational changes can have an influence on women's traditional postpartum rituals and levels of postpartum social support and may subsequently impact their postpartum mental health. Following migration, changing cultural environments and social structures can result in a lack of ability to adhere to traditional practices and decreased social support networks. Without the protective qualities of these factors, women may be threatened by an increased exposure to isolation and stress, and may suffer negative mental outcomes. This correlation has been presented through a significant body of research on the absence of social support and risk of PPD among immigrant women in particular (Morrow et al. 2009; Collins et al. 2011; Ahmed et al. 2008). For instance, in their study of first-generation immigrant women with PPD, Morrow and colleagues (2009) found that women experienced postpartum stress related to the disruption of cultural rituals, the absence of their own family members to take care of them and a lack of social support or perceived social support (606). They concluded that "disrupted family relations and the inability to follow certain rituals, especially as they relate to women having their own mothers' support after the birth of their child were important for women" (613).

In my research, I did not detect significant generational differences regarding women's post-migration postpartum experiences. Regardless of age or location that they gave birth, all of the women received at least 11-12 days rest related to the ritual surrounding postpartum pollution, and only one woman indicated that she did not receive any postpartum social support. Interestingly, it appears that women's levels of postpartum support may have actually slightly improved through migration. In Bhutan, levels of social support and periods of rest were highly dependent on contextual factors. For instance, if a child was born during a season when crops needed to be harvested, a woman could have a reduced rest period or may lack social support as her relatives were out of the home. In addition, women were less likely to have support from their husbands. In Nepal, some women (such as Sabika) indicated that they received increased support and better food due to the aid agencies working in the camps. Finally, in Canada, women's postpartum situations appear to be very positive, reflecting their ability to continue traditional practices, the closeness of the resettled community, and a potential increase in perceived support.

Each of the three women (Gita, Krishna and Durga) who had given birth in Edmonton received a great deal of social support. Gita and Durga both had positive postpartum feelings, and although Krishna revealed having perceived some negative feelings, these were not connected to social issues (see Chapter Four). Durga's case is especially revealing, as she had children in Bhutan, Nepal and Canada. As I discussed in the Chapter Four, Durga perceived some negative

feelings during the postpartum periods in Bhutan and Nepal. In Canada, however, she did not experience any tension. When I asked if she received more support here as compared to the other two locations, she replied with a definitive "Yes. A lot more!" This was due to not only improved environmental conditions, but also increased social support. Whereas she received support only from friends in Bhutan and Nepal, in Canada she perceived a great deal of support coming from the community as well as her husband. Like previous generations, all of the postpartum women in Edmonton were able to rest and were temporarily resolved of their duties as they had a great deal of support from their husbands, relatives and friends. They also received emotional support, giving them feelings of importance and status. A significant amount of attention was placed on not only them, but also their babies, due to the fact that children are viewed as holding the future of the Bhutanese community in Canada.

My findings concerning younger generations' increased levels of support may be explained in part due to changing gender roles discussed in the last chapter, as well as other contextual factors in Canada. Due to increased gender equality and improved gender relations, husbands are recognizing the need for them to assist their wives after the birth of a baby. Although many of the women are currently unemployed, those that are employed may have access to maternity and parental leave programs in Alberta that may allow for longer periods of rest than they would have in Bhutan and Nepal. Whereas many

women were required to return to the fields after the postpartum period in Bhutan, in Edmonton eligible women who are financially able can take up to a year's leave from their jobs. For instance, Krishna was able to take one year off of work as her husband also held a well-paying job. Finally, unemployment among older generations may increase social support as women's parents and in-laws often live with them or within a short distance and are readily accessible.

Although I found that the women who gave birth in Edmonton had positive postpartum experiences, continued cultural traditions, and had access to support networks, it is important to remain mindful of potential risks to future generations. In the year after I had completed my interviews, major changes had already begun to take shape within the Bhutanese community. Families were moving away from one another, dispersing across the city in search of more affordable housing and job opportunities. Younger generations of women were also establishing nuclear households. As one woman confided to me, this was an intentional decision made to escape her husband's parents whom they previously lived with. Due to increased movement and acculturation, it is quite possible that future first and second-generation Bhutanese women in Canada will experience different postpartum structures than their mothers or earlier migrants. Women who do not practice traditional rituals or have less support from relatives and community members may lose their associated protective qualities and thus have an increased risk of PPD.

***Conclusions***

In this chapter, I interpreted Bhutanese women's overall lack of perceived or expressed postpartum mental distress as being due, in part, to their traditional cultural postpartum traditions and social support networks. In addition to their constructions of wellness and gendered schemas, sociocultural components in the postpartum period impact women's postpartum responses and wellness. Using Stern and Kruckman's (1983) hypothesis and proposal of six factors that structure the postpartum period in non-Western cultures, I have discussed the traditional postpartum pattern in Bhutanese culture. I argue that Bhutanese postpartum rituals and beliefs surrounding female pollution and associated mandated periods of rest and increased social support function to protect against or mitigate the emergence of PPD.

The postpartum period, defined as thirty days, is characterized by cultural traditions, rituals and beliefs that result in seclusion, mandated rest and increased social support and recognition. Until the naming ceremony, which takes place 11 or 12 days postpartum, women are isolated and observe a period of mandatory rest. During this time, women must avoid touching anything, including food. Following the naming ceremony, women are no longer required to remain isolated but continue to be considered polluted until 22 days postpartum. Women may return to work following the naming ceremony or 22 day period, although many are able to continue resting until the end of the 30-day postpartum period. The structuring of the postpartum period around

women's perceived pollution results in a temporarily relief of their duties and the reliance on others to cook them food, take care of the home, and care for their newborn, other children, and relatives. Having the opportunity to rest, heal and form a bond with their baby, along with increased social assistance, protects women from developing depressive feelings. On the other hand, as Sabika's case revealed, lack of rest and social support can result in increased stress and risk of negative postpartum feelings.

In addition to increased rest and social support, Bhutanese women receive increased social recognition and status in the postpartum period. At the naming ceremony, family and community members bring gifts and money for the mother and newborn. Due to the importance placed on having children, new mothers are held in high regard in the Bhutanese culture and are often the subject of positive gossip. Furthermore, family and community members alike provide nurturance, guidance and general feelings of love and care. Social recognition of a mother's new status can make women feel important and loved, resulting in increased self-esteem and feelings of worth.

In my work, I found that cultural traditions surrounding female pollution were adhered to by all women regardless of age, and that all but one woman received support in some way. Although I did not find significant changes based on age or location that women gave birth, there were slight variations in women's experiences. Postpartum social and cultural factors appear to have

slightly improved throughout generations and migration experience. As Durga's case illustrated, changes over time and space have resulted in increased support from husbands and more perceived social support. Despite this finding, it is important to remain mindful that future generations may no longer adhere to traditional postpartum patterns, lose important social networks, and be more susceptible to PPD.

Although the literature on the relationship between sociocultural factors and PPD remains inconclusive, the Bhutanese women in my study recognized them as important factors in their postpartum wellbeing. As a collectivist culture, the Bhutanese place a significant emphasis on both family and community. Given this quality, it is unsurprising that Bhutanese women value cultural traditions and related social support in one of the most significant periods of their lives. Understanding the impact of sociocultural factors is thus integral to interpreting Bhutanese women's postpartum response

## Chapter Seven: Conclusion

Throughout this thesis, I have focused on determining the diverse and interconnecting ways that culture influences Bhutanese women's perceptions and responses in the postpartum period. Despite having suffered considerable hardship throughout their migration experiences as well as being recognized as a group vulnerable to mental illness, I found that the majority of women did not perceive or express distress in the postpartum period. By completing an ethnographic research project with the support of community partners, I was able to investigate a range of sociocultural variables shaping postpartum responses. My work has contributed to knowledge and awareness concerning cross-cultural variations in postpartum mental health and the sociocultural factors that contribute to this variation. By incorporating several anthropological approaches I have offered a unique perspective on the study of PPD in refugee women that incorporates three intersecting cultural factors: cultural constructions of health, gendered schemas, and sociocultural support networks.

The first factor that I implicate in understanding Bhutanese women's responses to the postpartum period is cultural constructions of self, wellness, illness and depression. In Bhutanese culture, each of these constructions is embedded in one's social environments and deeply affects how women understand and perceive their own health. Due to sociocentric conceptualizations of self, one's own physical and mental wellness is perceived

through the quality of their social relationships and the wellbeing of others around them. As such, in the absence of social issues or concerns about the wellbeing of a child, no negative postpartum feelings are perceived. In addition, cultural taboos regarding the expression of mind-body issues may factor into women's lack of expressed postpartum distress. Within the context of migration, Bhutanese views concerning the self and personal wellness may change, influencing the postpartum mental health outcomes of future generations. Increased individualism coupled with a higher degree of introspection within a Canadian context may result in an increased recognition and expression of negative postpartum feelings.

The second cultural factor that I have discussed is women's gendered experiences and related cognitive schemas. Through the process of socialization, women have learned and internalized a schema of womanhood which characterizes childbirth as a necessary component to being a woman. This relates to the social construction of self and wellness, as women understand the self through their place in their family and community, and view associated social roles and responsibilities as necessary to their gendered self. In addition, women's experiences with cultural and state-level discrimination have resulted in a schema of womanhood which views suffering as a normal part of life. These internalized cultural schemas direct women's postpartum expectations and result in resilient, strong responses to any perceived challenges and a lack of expressed distress. Again, this schema interconnects with the cultural taboo on

discussing strong, negative emotions, as women are socialized and learn through experience that they need to endure struggle without complaint. Within the context of migration, women's schemas of womanhood are likely to change in ways that can affect their postpartum outcomes. Improved gender relations and equality may result in increased support for women and improved postpartum conditions. On the other hand, the effects of women's "double burden" in Canada and younger women's responses to adversity remain to be seen.

The final way that I examined Bhutanese women's postpartum mental health is through postpartum sociocultural support. The traditional structuring of the postpartum period in Bhutanese culture results in a mandated period of rest and seclusion due to women's perceived vulnerability and pollution, as well as increased social support and social recognition. These traditional postpartum beliefs and rituals, coupled with increased emotional and instrumental support, result in positive postpartum experiences. Alternatively, when women do not receive social support and/or do not have the opportunity to rest for an extended period of time, negative feelings may result. This finding emphasizes the social basis of health, for women understand wellness through their local social environments and view illness and depression as resulting from a lack of social support and poor social relationships. It is also related to schemas of womanhood, as childbirth is viewed as fulfilling women's gendered duties. As such, it understandably follows that the birth of a child would lead to increased status and recognition and result in positive mental health outcomes. Within the

context of Canada, future generations of Bhutanese women may be more susceptible to negative postpartum feelings if social support systems deteriorate and there is less focus on, or ability to adhere to postpartum traditions.

Overall, my thesis has explored and presented the complex intersections between cultural factors and Bhutanese women's postpartum mental health outcomes. By considering women's own responses concerning their postpartum feelings and experiences in Bhutan, Nepal and Canada, I have shown that Bhutanese women largely do not perceive or express in the postpartum period. By investigating these findings through an anthropological framework I have demonstrated the importance of cultural factors in understanding women's perceived postpartum mental wellness. This research has helped to fill the current gap concerning the impact of cultural factors on the development of PPD, as well as looking at and honoring women's own understandings of their postpartum mental health (O'Mahony and Donnelly 2010). In addition to expanding the knowledge concerning cultural factors in postpartum mental health, my work contributes to the literature on mental health of Bhutanese refugees. To my knowledge, mine is the first study to discuss Bhutanese women's mental health in the postpartum period. It is also the only study to have focused specifically on the mental health of women following their re-settlement to a third country. Lastly, it is my hope that my work will contribute to the field of public health. My work will help mental health care workers contextualize Bhutanese women's needs, allowing them to better assist women

who are recognized as having any form of mental illness. It also emphasizes the pressing need for mental health care workers to consider cultural variables including culturally-determined understandings of health, taboos concerning mental illness, gendered determinants of wellness, and social support needs when dealing with newly re-settled, diverse immigrant and refugee groups such as the Bhutanese.

### *Directions for Future Research*

This thesis raises numerous opportunities for future research on the postpartum mental health of Bhutanese women re-settled across the world, as well as groups of refugee women in general. Although some generational differences and migration effects were noted in my study, the community was still very young and I spoke with only three women that had given birth in Canada. As such, I relied heavily on creating a discourse regarding future implications based on the literature concerning other refugee women. In the coming years there will be a need for research to focus on the impact of migration and changing sociocultural environments on Bhutanese women and the community as a whole. Future researchers working with first- and second-generation Bhutanese women will have a greater opportunity to determine the effects that post-migration stressors (such as unemployment, isolation and language barriers) in conjunction with changing social and cultural landscapes have on the mental health of Bhutanese women within and outside the

postpartum period. These studies may benefit from focusing on the considerations made in each of my three discussion chapters.

Future research concerning the mental health of diverse groups of refugee and immigrant women should focus on understanding women's own cultural backgrounds and individual experiences as well as continue to establish the role of cultural variables in postpartum mental health issues. Researchers looking at women's postpartum mental wellness will need to consider women's own perceptions of their mental health as well as factors that they consider important to optimum wellness. Although other variables (such as biological factors, individual life histories, and psychological factors) need not be abandoned, it is also of great importance that research continues to consider cultural determinants of health. Anthropological evidence of cultural variations in understandings and expressions of depressive illness are well established. However, the cultural variations in perceptions and expression of postpartum distress are less concrete. To overcome this shortfall, future studies will need to continue to review the role of culture in women's postpartum mental health outcomes.

Studies reviewing cultural factors will benefit from incorporating several variables reviewed in my thesis. Firstly, they should assess women's cultural models of mental illness and mental health. Rather than using Western-based diagnostic tools, women's mental health should be investigated in a culturally-

relative framework based on their own understandings. Secondly, research should consider women's unique engendered experiences. The relationship between gender and depression has been established, yet the connections between gendered variables and PPD are often overlooked. Research will benefit from looking at the effects that gender has on women's perceptions and expectations in the postpartum period. Lastly, studies should consider the roles of traditional postpartum practices and women's desired levels of social supports. This will help determine how traditional rituals and cultural beliefs interplay with women's expectations of the postpartum period and what constitutes adequate support.

Future research is also needed to fill the large gap concerning men's postpartum experiences and mental health outcomes following forced migration. To my knowledge, there are no current studies that have investigated Bhutanese men's postpartum mental wellness or that consider refugee men's perceptions of their own mental health following re-settlement. There is a large gap in current research regarding men's postpartum experiences in general, and it is important to remember that men are also vulnerable to postpartum mental health changes. As my study focused on entirely on women, men's perspectives on issues brought up in this thesis should also be taken into account. Future research on men's mental health following resettlement will also be incredibly important and understanding their own unique gendered experiences is vital to this endeavor. For instance, men's experiences with mandatory work,

discrimination and violence in Bhutan have likely had a considerable impact on their mental wellness. Finally, it is important to consider men's perceptions of and responses to changing gender roles and relations following migration. Previous research has shown that changing gender roles can result in negative situations not only for women but also for men. For instance, re-settled men may be subject to domestic violence or violence from other men, and this can conceivably have an impact on their mental health outcomes.

As I noted at the outset of this thesis, the case for carrying out cross-cultural research into PPD is of compelling and increasing importance due, in part, to increasing migration. Moving forward, it is crucial for future research to expand its scope and incorporate anthropological methodologies and perspectives into understanding postpartum depression. By performing compassionate research that considers women's own words and remains cognisant of cultural variables and contexts, it will be possible to mitigate or prevent the emergence of postpartum depression in refugee women worldwide.

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## Appendix 1: Interview Guide

1. What is a typical day for you?
2. What is the role of women in your community? (Probes: expectations in family, in community, how women are defined as a group, role of men in comparison)
3. What is the role of family and community in your life? (Probes: migration history)
4. How would you explain "the self"? (Probes: situation, components)
5. What is wellness? (Probes: body vs ?, individual vs social, illness)
6. What is depression? (Probes: symptoms, causes, treatment)
7. Please describe for me your experiences with pregnancy (Probes: Location, environment, circumstances, delivery method)
8. Please describe for me how you felt after having your baby (or babies)? (Probes: physically, emotionally, difference based on point in migration/before pregnant)
9. Why do you think these changes happened? (Probes: Religious beliefs, generational, external stressors)
10. How did you deal with the changes that occurred after your child was born? (Probes: Seeking social support, role of partner, ways of healing, food as healing)

## Appendix 2: Information Letter

**Information Letter**

**Study title: Postpartum Depression in Edmonton's Nepali Bhutanese Community**

**Research Investigator: Christina Davey, University of Alberta**
**Research Supervisor: Helen Vallianatos, University of Alberta**

**Contact Information:**
**Christina Davey, (780) 884-3864, cdavey@ualberta.ca**
**Helen Vallianatos, (780) 492-0132**

**Background and Purpose:**
Edmonton is a city that is growing fast, with increasing numbers of people born in places other than Canada. New communities, like yours, have had difficulties in their journey to Canada. They also have unique cultural norms that are different from other people. These differences are special, but may not be understood by health care professionals from another culture.

Pregnancy is an important event to many women, their families and their communities. Following the birth of a child (postpartum), some women experience changes in their bodies and the way that they feel. Women will understand any changes based on their own unique culture and background. Health care workers in Edmonton who are from a different culture may view these changes differently than you do.

This study is the basis of my Graduate Thesis. I hope to find out how women in your community feel about pregnancy and what your experiences of having children have been like. I want to use these stories to inform Edmonton's health care workers to better help you and other pregnant women who are new to Canada be understood in the health care system.

**Study Procedures:**
Your participation in this study will include interviews and observation.

The interview will take approximately 1 hour of your time. We will talk about your thoughts on health and pregnancy, as well as your own experiences with being pregnant and/or having children. Our talk will be tape-recorded so that I can listen to them later, rather than writing while I am talking to you. If I have more questions after our first meeting I may ask if I can talk to you a second time.

In addition to the interview, I will be attending community events and/or meetings. This will help me to get a first-hand understanding of your culture.

**Potential Benefits:**
By taking part in this study, you may increase how you understand any changes in yourself following pregnancy. You will also help women in your community be understood in Alberta's health care system because your information will be used to inform nurses and doctor's about your cultures unique cultural beliefs and practices during pregnancy.

**Potential Risks:**
Taking part in this study may cause you some inconvenience as it will take some time out of your day. I will make every attempt to meet you when and where it is most convenient.

In addition, our interviews may bring up some emotional memories for you and cause some discomfort. If any emotional or other problems arise for you, I will be sure to help you by providing information about support services.

**Compensation:**
In order to show you my appreciation for you spending the time to meet with me and take part in the study, I will provide you with a $20 gift card as a thank you gesture at our first meeting.

**Confidentiality:**
All information that you provide to me will be kept confidential. All information that can identify you will be removed from the records. Any names that you use during our interviews will be removed afterwards. Any tapes, notes and meeting records will be marked with a code number and locked in a filing cabinet. Your name will be recorded only on the consent to contact form and consent form that I will ask you to sign, and will also be in a locked filing cabinet. Computer and audio files relating to this study will be stored on a computer with a secret password.

All information will be accessible only to me, or by the ethics board should they make a request. Study data, including personal information about you, is securely stored for five years after the study is over, at which time it will be destroyed.

The findings of this study will be used for my Graduate Thesis and may be published in an academic journal or used in research articles or conference presentations. Data may also be used in future research. When I report the

results of the study, I will not report any names. Any details about you or your family that would allow others to name you will not be reported.

You will be provided with a report of the research findings as well as invited to an information session for the community.

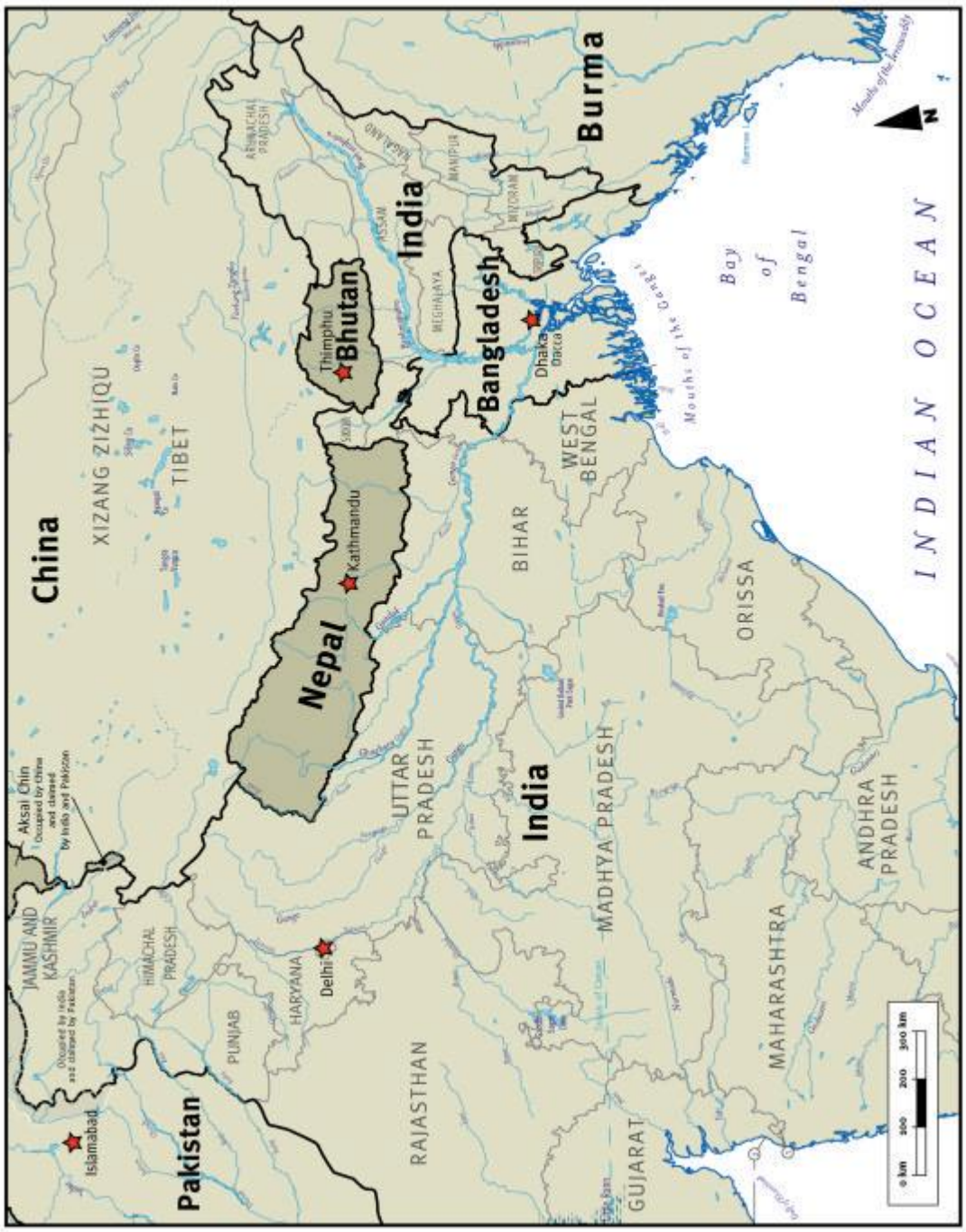
**Voluntary Participation:**
You are under no obligation to participate in this study. Your participation is a free choice. You may refuse to answer any question. You may say no to participate or leave from the study at any time without any result. If you choose to leave, I will not report any information that had been collected from you. The only exception to this will be if I have already written up my study results, which will start October 2012. If you had received the $20 this will not need to be returned.

**Contact for information about this study:**
Feel free to ask any questions, at any time, about this study. You may ask questions to me at (780) 884-3864 or the Research Ethics Office, at (780) 492-2615. This office has no direct involvement with this project.

## Appendix 3: Verbal Consent Script

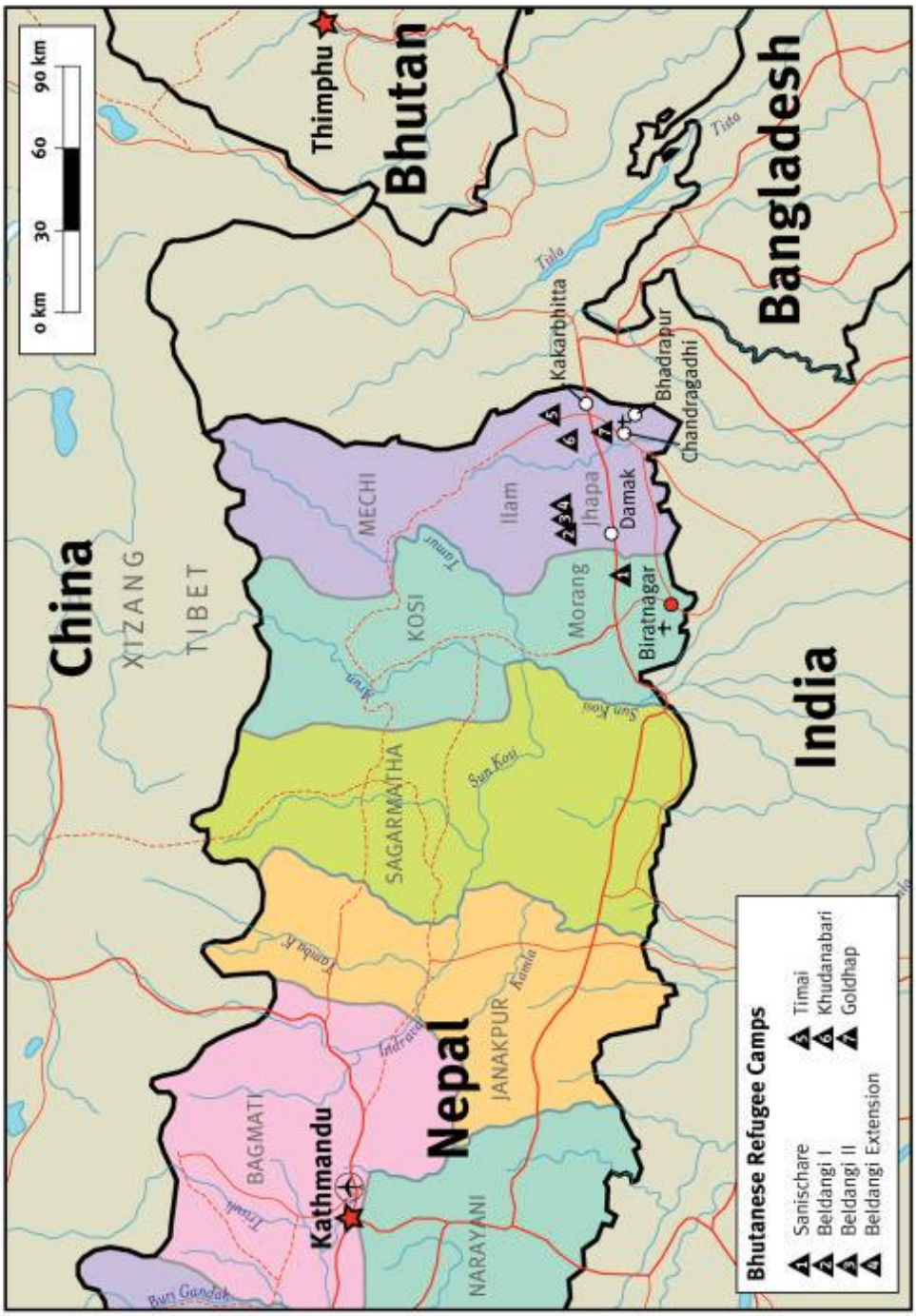
1. Do you understand that you have been asked to be in a research study?
2. Has the information letter been read to you in full?
3. Have you had an opportunity to ask questions and discuss the purpose of the study?
4. Do you understand the benefits and risks involved in taking part in this research study?
5. Do you understand that you can withdraw from taking part in this study at any time and that there will be no penalty for withdrawing early?
6. Has the issue of confidentiality/anonymity been explained to you? Do you understand who will have access to the recorded interviews and other records?
7. Do you agree to the use of the information for the purpose described?
8. Do you agree that this information may be used in future research?
9. Do you agree to participate in this research?

## Figure 1: Map of Nepal and Bhutan




From HRW (Human Rights Watch). 2003. "Trapped by Inequality: Bhutanese Refugee Women in Nepal." Human Rights Watch 15 (8C): 3.

## Figure 2: Location of Bhutanese Refugee Camps in Nepal




From HRW (Human Rights Watch). 2003. "Trapped by Inequality: Bhutanese Refugee Women in Nepal." Human Rights Watch 15 (8C): 4.