# *Dissecting an Indian Immigrant's Holistic Experience of Postpartum Depression: A Medical Anthropology Perspective*[1]

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Immigrating to another country is an arduous journey rife with many stressors. The obstacles only seem to grow larger once the individual reaches their new home. Feelings of despair and regret from leaving their treasured homeland, family, and culture may overwhelm the individual, in addition to having to adjust to a distinct environment. All of these hurdles can induce physical, mental, emotional, and social burdens, which can increase the likelihood of mental illnesses. Postpartum depression, along with other mental disorders, is shaped by numerous biological, and arguably more impactful, social factors such as race, income, and culture. Through a meticulous holistic analysis of an Indian immigrant's illness narrative, we find that immigration is an experience that can strain an individual in multiple ways. With a medical anthropology focus, this ethnographic research raises concerns, and encourages improvement, regarding the current state of mental health identification and treatment.
**Keywords:** Illness narrative, local biology, postpartum depression, biological reductionism.

## Theoretical Background

> 'In my hometown of Bombay, I was very happy. I had a supportive family and friend group. After I got married, my husband moved to the United States for his job. I was encouraged to settle in the West because of its advancement, so I joined him […] The reality was distinct from the idealized picture foreigners have. Adjusting to the American life was a struggle.' ― Interviewee

Local biology, or how the environment can shape an illness, is of enormous relevance to immigrants. The entire process of leaving one's way of life in one's native country to settle in an environment riddled with unknowns can induce a plethora of stressors and corresponding illnesses. Not only is one leaving one's family and friends behind, but one faces the challenge of acculturating to new traditions which are distinct from one's homeland's beliefs.

The concept of local biology is relevant to postpartum depression (PPD), which is influenced by an array of local biological, economic, and social factors. This paper will focus on the illness narrative of an Indian mother currently in her 40s, who immigrated to San Francisco from Bombay in the early 2000s and experienced PPD similarly after each of her two childbirths. It is essential to clarify that, given the deeply personalized nature of illnesses, her experience cannot be generalized to all immigrants. Nevertheless, her illness narrative shares insights into the multifaceted nature of individual health. Moving to a new country can contribute to an immigrant's experience of PPD because acculturation is a journey fraught with

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social stressors; strained familial relationships induce psychological burdens; and the treatment of mental disorders is rife with structural deficiencies.

**Social Stressors from Acculturation**

> 'Bombay is a crowded city with a constant hustle and bustle. You are surrounded by friends and family, and people are always moving in and out of your home. Living in San Francisco was a lot different as people were more private […] Even after we moved to the suburbs, it was challenging to connect with neighbors as the homes were large and spaced out. In Bombay, you could talk to your friends who were steps away through the windows.' — Interviewee

Acculturation, or the process of adjusting to a new environment and culture, can induce stressors that can contribute to mental illness. In the abovementioned extract from an ethnographic interview I had with her, the mother alludes to some of the social obstacles she faced when adjusting to life in the United States. She identifies the stark contrast between life in India and in America. While she considers the former as an atmosphere conducive to social interactions, the latter is considerably quieter and more reclusive. She believes that this is because Indian culture places a much greater emphasis on the community (collectivism) while America is largely focused on the person (individualism). Humans are social animals who crave interactions with other beings and may fall ill with lack of interactions, especially when they are accustomed to a previously social lifestyle.

This sentiment has been echoed by anthropologist Niccolo Caldararo. His research into the effects of social distancing during the COVID-19 pandemic determined that psychological conditions often arose from the isolation spurred by a lack of vibrant communities. Moreover, Caldararo found that quarantining seemed to 'deprive human society of the "hum of the hive"' (Caldararo 2020: 19).[2] Consequently, it is reasonable to find that my interviewee experienced social stressors from being unable to mimic the social vibrance of a place like Bombay while residing in the Bay Area. The lack of a sense of community caused by the larger barrier in meeting neighbors caused her to feel isolated and long for the energy of her hometown.

Mina Qobadi, an epidemiologist investigating PPD, concluded, 'Similar to other studies, we found a dose–response relationship between stressful life events and the prevalence of PPD. Other studies have also found that the more stressful life events that occur in the perinatal period, the more likely mothers will experience PPD' (Qobadi et al. 2016: 168).[3] According to Qobadi's research, my interviewee might have had a greater likelihood of developing PPD because she was burdened with the social stress of struggling to find a social group she felt connected to. Bonding with friends is essential to one's well-being and allows for relaxation or leisure time outside of work and family. Being part of a close community

[2] Caldararo, a professor at San Francisco State University, focuses on medical anthropological research.
[3] Qobadi and her team from the Mississippi State Department of Health conducted an experiment on the potential causes of PPD.

enables us to share our struggles, learn from each other's experiences and support one another during challenging times. Hence, my interviewee's difficulty in acclimating to the individualistic American culture may have added additional social stress.

Local biology likely had a considerable effect on my interviewee's experience of PPD. The unique environment and cultural views in America did not seem to foster the tight-knit community that she experienced in India. It is important to note that throughout her time in America, she did sometimes feel alone, but never experienced depression. However, after she delivered her first baby (and two years later, the second baby), the social stress and isolation contributed to her PPD. Markedly, her struggle to acculturate to the individualistic American lifestyle made it difficult for her to raise children without the support of local friends and family.

**Familial Relationships**

> 'In my homeland, there would have been many friends and family members constantly visiting to check up on me and provide support […] I could only call my family on a monthly basis for minutes at a time, as international calls were expensive.' — Interviewee

A few weeks after she had her first child, the postpartum depression began. Her feelings of isolation intensified and she suffered periods of anxiety and depression. In the interviews, she discusses how she felt more distant from her family members whom she was very close to before settling in the West. It was extremely challenging to raise a baby for the first time without a strong and accessible support system. She had lived with her parents and brother for two decades, and had been surrounded by other cousins, aunts and uncles, all of whom helped raise her since birth. Moving across the world inevitably strained these relationships because of the difficult communication. The weakened familial ties imposed psychological stressors on my interviewee which contributed to her PPD.

> 'Because we were foreigners from humble beginnings, my husband had to work grueling hours to make a living to support our growing family in a country with a higher standard of living compared to India. He worked full-time and traveled across the country during the weekdays, so he was only home for the weekend.' — Interviewee

Throughout her time in America, my interviewee was not completely alone, as she had her husband with her. However, due to the demanding nature of his job, and his will to pave a better future for his family, he was absent most of the time. Hence, she was often alone at home, raising two babies single-handedly. She explains that this would not have been the case had she been in Bombay. In India, it is customary for the extended family and community to help a new mother with household tasks, so that she can rest and support the newborn. This again pertains to the first contention, as she did not have access to an intimate local community that could help her. She felt that she was not only growing apart from her parents but also her husband, due to the nature of his work.

Virginia Schmied and her team from the Western Sydney University's School of Nursing found that postpartum depression is most common amongst migrants, 'particularly for women lacking family support, who have no employment, a precarious migration status and/or relationship conflict' (Schmied et al. 2017: 2).[4] Similarly, my interviewee faced all three of these circumstances: her only accessible family member was her husband who was justifiably devoting more time to his job to support the family, and she did not have time to work, as she needed to look after their two children. Connecting this to the first contention, having familial or community support in looking after the children might have enabled her to pursue a part-time job and thrive in a social and work environment. Consequently, the psychological stressors accumulated from strained spousal and other familial relationships could have increased her likelihood of developing PPD.

## Structural Deficiencies in Mental Health Treatment

### *Social Stigma of Mental Illnesses*

> 'In the weeks following my delivery, I experienced stronger bouts of depression which the doctors reassured were normal 'baby blues.' Even though the depression persisted for months after, I was in denial because of the social stigma of mental illness […] Mothers are always expected to be happy but this is just unrealistic given the hormonal changes and exhaustion that comes with raising a child.' ― Interviewee

While attitudes toward mental health have improved significantly in modern times, mental illness is not a topic freely discussed in the 2000s. There was little awareness about depression, so the uncertainties about the optimal treatment and what it was that she was feeling contributed to her delaying seeking help. Additionally, my interviewee shared how pursuing treatment was an extremely difficult first step to take as she was too worried about how others might negatively see her. Eventually, the depression worsened to a point where it was unbearable, so she began seeing a psychiatrist and taking medication after her two childbirths, which included similar experiences. All these points pertain to the social construction of reality which describes how society has standardized unrealistic expectations of mothers to always be content, which results in mothers feeling 'subpar' as they compare themselves to perfect beings with the consequence of harmful internalization.

Margaret Lock (2008) contends that disease is a subjective experience, with different cultures having varying attitudes toward a disease. Lock explains how Japanese women experienced *konenki*, the renewal of life corresponding with menopause, differently than Americans, although both conditions were similar. She shares a quote from a Japanese doctor which could explain the discrepancy: 'Why do Western women make such a fuss about hot

[4] Schmied's research group scrutinized trends in PPD among different demographic groups.

flashes?'" (Lock, 2008: 13).[5] This cultural attitude points to a typical misconception, whereby Western women are more sensitive to suffering than Asian women. According to my interviewee, Indian culture, similar to Japanese culture, discourages medications and complaining about symptoms. She says that Asian cultures tend to have an attitude of 'Yes, you faced an obstacle. Now get over it. Move on'. While this belief can cultivate positive determination in some cases, it can also cause harm in some subjects such as mental illness. As indicated by the anecdote given by my interviewee, mental disorders are obstacles deeply rooted in the mind that cannot be dealt with solely through mental fortitude (which Indian culture advocates for). Indian culture's emphasis on dealing with problems naturally by 'toughening up' delayed my interviewee's seeking medication and the help of a psychiatrist, both of which were deemed 'unnatural' and harmful to the infant and mother.

The findings of Deepika Goyal, a nursing scientist from UCSF, and her colleagues strengthen this argument. They found that 'Indian women living in the United States are as likely to experience postpartum depressive symptomatology as white women […] up to 50% of women remain undiagnosed' (Goyal et al. 2006: 98).[6] Explaining how Indian women experience PPD similarly to white women, they debunk the myth that, due to their 'tougher' mentality, Asian countries do not suffer mental illnesses. My interviewee shares the Indian culture that adheres to traditional gender roles, according to which the woman's duty is to bear children and care for them successfully. Hence, she had reservations about pursuing treatment for depression because of cultural standards of maternal toughness and success that she thought she had to live up to. This is yet another example of a social construction of reality that pressures Indian women into bottling up their depression so that they can conform to misinformed societal expectations of being 'strong'. Due to cultural stigma, patients are often reluctant to seek professional help, explaining why half of women are undiagnosed with PPD.

Arthur Kleinman (1988) supports this notion in *The Illness Narratives: Suffering, Healing, and the Human Condition*, arguing that most patients feel shame not because of their disease, but because of the negative societal perception which publicly discredits the individual.[7] My interviewee explained how she delayed seeking treatment for postpartum depression because of the social stigma of mental illness, which was prevalent in the 2000s. This is extremely harmful to the patient, as prolonging suffering can worsen their mental disorder and make depression unbearable. As with many instances, here, the phrase 'the sooner the better' is especially relevant to those wanting remedies to their suffering.

[5] Lock is a renowned academic in the medicine and anthropology departments at McGill University who focuses on the different cultural perceptions of health.

[6] Goyal received a Ph.D. in nursing education from UCSF and studies perinatal mental health.

[7] Kleinman is a Harvard psychiatrist and medical anthropologist who focuses on mental illness in Chinese culture.

*Oversimplification of Patients*

> 'After I started taking medications and seeking professional counseling, I felt a lot better. But the improvement wasn't instantaneous. It took six weeks to test each medication that was recommended by different psychiatrists. This trial-and-error process was really tedious and had many side effects… It also took time for me to visit various doctors and see who I connected the best with.' — Interviewee

Thus, my interviewee explains how she sought treatment for a while but did not get better until months later. The entire journey associated with taking various medications took time and was not successful until much later. She says that it was extremely difficult to raise children while coping with PPD and the added side effects of each medication. She sheds light on another flaw in the treatment of mental illnesses — not all medical professionals are equally effective, and a patient can experience various degrees of success depending on their physician. At times, she felt like she was generalized and treated as 'just another person with depression'. As she poured out to a complete stranger her recollection of her intimate experiences during the darkest times of her life, she described as especially frustrating that some of the professionals dismissed the complexity of her story, forcing her to keep visiting new psychiatrists. Although the final combination of medications and psychiatric help eventually worked for her, it is important for those with mental disorders to seek treatment as soon as possible, considering that the treatment process is not a straight and fast path to betterment. My interviewee's experience strengthens the view that illnesses are best treated when the physician understands the deeply personalized story of each patient. As suggested by my interviewee's experience, psychiatrists strive to identify the core problems of mental illnesses in the various stages of patient's life since birth. So, the oversimplification of patient narratives is especially problematic in the case of mental illness, where much depends on the open dialogue between patient and physician, as opposed to physical impairments, which are not as dependent on the patient's life story.

Anita Jain and David Levy from the University of Sydney's Medical School found that Western countries fail to treat migrant women with PPD effectively because they do not 'develop culturally sensitive approaches to postnatal care'. They determined that healthcare providers often had biases and misinterpretations about immigrant mothers, and suggested that, in order to avoid treating immigrant mothers as a homogeneous group, doctors should become aware of 'details of specific cultural practices regarding the delivery environment, diet, and personal care' (Jain and Levy 2013: 966).[8] The insights of Jain and Levy are strengthened by the aforementioned research by Deepika Goyal et al., which found that 'only 50% of women who suffer from PPD are correctly assessed, diagnosed, and treated for this potentially devastating disease' (Goyal et al. 2006: 98). Consolidating both of these findings, it is clear that some American psychiatrists' lack of knowledge about foreign cultures could have bled into incorrect diagnoses and treatments for PPD. My interviewee described how some of the psychiatrists she saw were not effective because they failed to understand her circumstances,

[8] Jain is a homeopathic practitioner and Levy investigates ethics and law in medicine.

which were incompatible with the treatment plans. Consequently, she had to spend unnecessary time in the trial-and-error phase of testing various medications and psychiatrists because they did not grasp the importance of Indian culture to her story.

This pertains to the principle of biological reductionism, which refers to the oversimplification of an illness to only its biological abnormalities. This kind of myopic perspective is not conducive to optimal patient outcomes, as the treatment neglects the larger social and cultural factors that are at play (Jain and Levy 2013). For instance, the psychiatrists that did not take into consideration my interviewee's need for a vibrant social atmosphere would not foresee how medications might treat only the superficial problem. This explains why my interviewee had greater success with psychiatrists who were more understanding of her full story and, therefore, could recommend non-biological remedies like certain social support groups for mothers. Physicians employing a holistic view of medicine can expedite the recovery process for the patient by benefiting from a better understanding of the patient's non-biological circumstances, thus reducing their suffering during the trial-and-error process. Structural barriers to mental health treatment — including social stigma and oversimplification of patients — may have played a significant role in my interviewee's largely inefficient recovery.

**Conclusion and Discussion**

Moving to the West can shape an immigrant's experience of postpartum depression because acculturation involves social stressors, tense familial relationships induce psychological burdens and the treatment of mental disorders is fraught with numerous deficiencies. Evidently, individual health is determined by a multitude of factors, aside from biology. In my interviewee's story of immigrating to the United States, her PPD was shaped by various environmental, social and cultural factors.

Sara Harkness, a social anthropologist, argues this multifaceted relationship. Her research into PPD concluded that there are three primary models that explain postpartum depression: the biological, which includes hormonal and physiological changes; the psychological, which considers relationships with other family members; and the interactive, which includes general stresses in the mother's life (Harkness 1987).[9] My interviewee's narrative of PPD was a combination of all of these factors, as her experience pointed to several examples within each category. This consistency in academic research and patients' real-world experiences strengthens the argument that several illnesses are largely explained by factors aside from biology.

In order to tackle diseases (especially mental illnesses) successfully, society must acknowledge that non-biological factors can have a greater influence over one's health than biology itself. My own research sheds significant light on the intertwined relationship between the environment and individual health. It is important to restate that my interviewee's story was unique to her, and that other immigrants may have vastly different experiences of settling in America. Nevertheless, I suggest that this ethnographic material encourages future research into

[9] Harkness received her M.P.H and Ph.D. from Harvard, and focuses on maternal and child health.

immigrant health and into the multitude of obstacles that they may encounter, which can worsen their physical, emotional and mental well-being. Thus far, society has placed a huge emphasis on physical health and only recently has started to prioritize (and de-stigmatize) mental health. Looking forward, the United States need to allocate more funding to developing a preventative biosocial approach to mental illnesses. Additionally, healthcare providers need to be aware of cultural differences when providing treatment to foreigners. Only by providing care specific to the individual — instead of assuming that what works for the majority native population will also work for foreigners — can immigrant health be optimized.

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