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COMPLEX EMOTIONS, COMPLEX PROBLEMS: UNDERSTANDING THE EXPERIENCES OF PERINATAL DEPRESSION AMONG NEW MOTHERS IN URBAN INDONESIA

ABSTRACT. In this article, we explore how Javanese women identify and speak of symptoms of depression in late pregnancy and early postpartum and describe their subjective accounts of mood disorders. The study, conducted in the East Java region of Indonesia in 2000, involved in-depth interviews with a subgroup of women (N = 41) who scored above the cutoff score of 12/13 on the Edinburgh Postnatal Depression Scale (EPDS) during pregnancy, at six weeks postpartum, or on both occasions. This sample was taken from a larger cohort study (N cohort = 488) researching the sociocultural factors that contribute to women's emotional well-being in early motherhood. The women used a variety of Indonesian and Javanese terms to explain their emotional states during pregnancy and in early postpartum, some of which coincided with the feelings described on the EPDS and others of which did not. Women attributed their mood variations to multiple causes including: premarital pregnancy, chronic illness in the family, marital problems, lack of support from partners or family networks, their husband's unemployment, and insufficient family income due to giving up their own paid work. We argue for the importance of understanding the context of childbearing in order to interpret the meaning of depression within complex social, cultural, and economic contexts.

KEY WORDS: depression, late pregnancy, postpartum, socioeconomic and cultural context, Indonesia

Interviewer: *When you were pregnant you said that you often experienced fear, sometimes felt anxious, and blamed yourself when things had gone wrong. What would you call that condition?*
Tin: *Nelongso (Javanese: self-pity).*

INTRODUCTION

Postpartum depression (PPD) is the most common nonpsychotic mood disorder following childbirth investigated worldwide. It affects more than 10 percent–15 percent of women (Cox 1986; Cox et al. 1987; Cox et al. 1993; Grigoriadis 2006; Kok et al. 1994; Kumar and Robson 1984; J. Murray and Gallahue 1986; O'Hara et al. 1984; Pitt 1968; Small et al. 1994a), including in non-Western communities such as Bangladesh (Fuggle et al. 2002), India (Patel et al. 2002), Nepal (Regmi et al. 2002), Fiji (Becker 1998), Hong

Culture, Medicine and Psychiatry **31:** 101–122, 2007.

DOI: 10.1007/s11013-006-9040-0

Kong (Chan et al. 2002; Lee et al. 2004), Vietnam (Stuchbery et al. 1998), and Indonesia (Kusumadewi et al. 1998). Historically, the clinical course of PPD has been characterized with women most likely to develop symptoms (e.g., tearfulness, feelings of hopelessness, sleep disturbance, poor concentration, mood lability) within six weeks postpartum (Grigoriadis 2006); in the DSM-IV-TR it is now defined as a major depressive disorder with postpartum onset, beginning in the first four weeks after delivery. Depending on its severity, the duration of PPD can be from 3 to 6 months (Carothers and Murray 1990; Cooper and Murray 1998; Cox et al. 1996; Fowles 1998; Kumar and Robson 1984; Lee et al. 1997; Stamp and Crowther 1994) or, in a few cases, up to 12 months following childbirth (Cooper et al. 1988, 1996). The nosologic criteria do not distinguish the symptoms of PPD from those of major depression except with respect to their postpartum onset (Cooper et al. 1988; O'Hara et al. 1990). It has been reported that symptoms of PPD might also have their onset during pregnancy (Dennerstein et al. 1989; D. Murray and Cox 1990; O'Hara et al. 1984; Watson et al. 1984).

The social environment, including poverty, chronic and stressful life events, history of depression, anxiety, stress or depression during pregnancy, problematic marital relationships, and inadequate social support, are recognized as important predictors of PPD both in developed countries including the United States (C. Beck 1996, 2001; Lum 1990), Australia (Astbury and Cabral 2000), Japan (Kitamura et al. 1996), and Hong Kong (Lee et al. 2004), and in developing countries such as India (Patel et al. 1999; Patel et al. 2002; Rodrigues et al. 2003) and Fiji (Becker 1998). In addition, depression has been linked to specific social factors prevalent in early motherhood: social isolation, loss of previous identity, entrapment, and humiliation (Astbury 1994; Bernet et al. 1993; Broadhead and Abas 1998; G. Brown et al. 1995).

The most common instruments used to measure PPD worldwide have been developed from a concept of depression defined in the West, and include the Depression Inventory (A. Beck et al. 1961; C. Beck 1996) and the Edinburgh Postnatal Depression Scale (EPDS: Cox et al. 1987). The latter has also been validated for identifying depression for pregnant women and women not in the postpartum period, in which cases it is then referred to as the Edinburgh Depression Scale (EDS: Cox et al. 1996; D. Murray and Cox 1990). Despite rigorous efforts to translate Western constructs of depression and validate relevant instruments for non-Western study populations via the use of relevant local languages and cultural idioms, studies on PPD in non-Western societies typically overlook women's subjective experiences (Rodrigues et al. 2003; Small et al. 1994a, 1994b). Research by

Beck has begun to incorporate women's phenomenological experiences on rating scales to assess PPD (C. Beck 1992, 1993, 2002; C. Beck and Gable 2000, 2001), although further research is needed to examine the cross-cultural agreement between Western constructs of depression and the related idioms of distress used by women in non-Western countries.

The earliest published study on PPD in Indonesia, based on a relatively small hospital sample, was in 1998 (Ismail et al. 2000; Kusumadewi et al. 1998; Kusumaningsih et al. 1999; Yoga et al. 2000). While no local category corresponding to the Western notion of postpartum illness was observed in Indonesia, these studies assumed the existence of postpartum illness resembling the Western nosology of PPD. The researchers used standardized instruments that were developed in Western societies and which therefore lack references to Indonesian women's understandings and experiences of depression within their own sociocultural milieu. This study investigates women's own accounts of nonpsychotic depression pre- and postnatally, to explore whether culturally specific notions of PPD exist in Indonesia.

METHODS

Procedure

This descriptive study was nested in a cohort study of 488 Indonesian women recruited during late pregnancy to explore their emotional well-being in early motherhood (Andajani-Sutjahjo 2003). In the cohort study, 488 primiparas (16–44 years old) were interviewed in late pregnancy. Of these, 274 women were interviewed for the second time at six weeks postpartum; the sample attrition (42 percent) at the second interview was due to women moving, primarily returning to their hometowns or villages for delivery or postpartum care. Women who had stillborn babies or infants who died in the early postpartum were excluded from this study; their experiences are reported elsewhere (Andajani-Sutjahjo and Manderson 2004). Of all 274 women interviewed at six weeks postpartum in the cohort study, those who scored above the cutoff score of 12/13 on the EPDS (recommended cutoff score for detecting major depression) in late pregnancy or at six weeks postpartum were selected for the nested study; 46 women met this selection criterion.

This nested study was conducted at six months postpartum. Of the 46 who scored above 12/13 on the EPDS and were selected from the cohort study, at six months postpartum, 5 had moved to another house or returned to their hometowns for postpartum care, leaving 41 women available for

in-depth interviews. Women were interviewed at their homes, and each interview lasted between one and two hours. Interviews were conducted in Bahasa Indonesia and Javanese; women often used both languages to express the complexity of their emotion and experience. Prior to interviews with the women, ethics approval was granted by local collaborators in Indonesia, and permission to tape-record or note-record the interview was obtained from all women. Tape recordings were transcribed, preserving the lexical shifts, and notes were typed up and expanded. The resultant texts were entered into the ATLAS-ti program for qualitative data analysis. Thematic analysis was conducted using the two languages of interview (Indonesian, Javanese) and in English.

Instruments

The EPDS is a well-validated scale and has been used in many studies worldwide (Benvenuti et al. 1999; Boyce et al. 1993; Cox et al. 1987; Eberhard-Gran et al. 2001; Fuggle et al. 2002; Jadresic and Araya 1995; Patel et al. 2002; Regmi et al. 2002). In the early developmental study of the EPDS conducted with 84 mothers living in Edinburgh, Cox and colleagues (1987) recommended a cutoff score of 12/13 to best detect PPD, with a sensitivity of 86 percent, specificity of 78 percent, and positive predictive value of 73 percent. With this cutoff point, the misclassification rate reported was 14 percent and 16 percent, respectively, in pregnant and postpartum women (Cox et al. 1987; Cox et al. 1993). In other studies with diverse study populations, however, different cutoff scores were adapted to sensitively detect symptoms of PPD. Such differences in the use of cutoff scores have yielded varying sensitivities and specificities for detecting PPD in each observed population and with each cutoff score used (Georgiopoulos et al. 2005). For example, in a validation study with an Italian population, the cutoff point of 8/9 was recommended as optimal for screening use, with a sensitivity of 94.4 percent, specificity of 87.4 percent, and positive predictive value of 58.6 percent (Benvenuti et al. 1999). In Australia, the best cutoff score recommended was 12/13, with a sensitivity of 100 percent, specificity of 95.7 percent, and positive predictive value of 69.2 percent (Boyce et al. 1993).

In this study, the conservative EPDS cutoff score of 12/13 was used to identify all women who were likely to develop major depression or were on the borderline of depression (S. Brown et al. 1994; Harris et al. 1989). The aim of this study was not to examine the prevalence of PPD in Indonesia but, rather, to examine the existence of a culturally specific notion of PPD. Using this conservative 12/13 cutoff, it was in our best interest to avoid the

inclusion of women who were not depressed in the study sample. In this study, the EPDS was translated into Bahasa Indonesia and back-translated into English. The scale consists of ten items about women's feelings in the last seven days (e.g., being anxious, worried, panicky, scared). It takes 10–15 minutes to complete and can be self-administered. In this study, it was read aloud to the women. Each item on the EPDS can be scored from 0 to 3 and the total score ranges from 0 to 30. A high score on the EPDS is indicative of more negative or depressive feelings. Women scoring above a predetermined cutoff (12/13) are usually referred for further clinical investigation for PPD (Cox et al. 1987; Cox et al. 1996). In addition to the EPDS, an interview guideline was developed to explore women's personal, social, and cultural accounts of depressive symptoms experienced at different stages from late pregnancy to the early postpartum period.

RESULTS

Sociodemographic Characteristics

The sociodemographic characteristics of the 41 women in the nested study (Table 1) were comparable to those of the 488 women in the cohort study. Briefly, all women were literate, with a mean age of 24 years. While half of the women were housewives in late pregnancy, when the women were

TABLE 1
Sociodemographic Data

Age (years)	
Range	17–37
Mean	25.12
Education (percentage)	
At least 9 years of schooling	93
3–6 years of schooling	7
Marital status (percentage)	
Married	93
Separated/divorced	7
Pregnancy status (percentage)	
First time	93
Second time	7
Current employment	
Housewife	63
Factory worker/waitress	18
Clerical/administrative staff	10
Nurse or teacher	7
Self-employed (e.g., runs a food stall or a small shop)	3

interviewed at six months postpartum, more of them (63 percent) were housewives and had given up paid work to care for their babies at home. Commercial childcare centers are not common in Indonesia. Unlike most of the women in this study, only women of middle to upper socioeconomic classes can afford to pay a babysitter. Women from lower socioeconomic backgrounds more often need to give up their jobs and stay at home to take care of their infants. In this study, more than 80 percent of the women and their families lived in poor urban areas, sharing houses with parents,[1] in-laws, siblings, or other relatives. Alternatively, they lived in small rented rooms with communal kitchens, washing areas, and bathrooms. Living with extended families did not guarantee assistance with childcare for these women. In most circumstances, women's own parents or siblings were working in the formal sector to help support the family and therefore could not help the women with childcare. In urban areas, such arrangements provided them with a means to minimize their living costs and assist with saving money. Household expenses (e.g., electricity, water, rent) were shared among those who were employed, and those who were not in the labor force were expected to share daily household chores (e.g., cleaning and washing).

In the larger parental study, the mean EPDS score was 7.6 (SD, 4.4) in late pregnancy, 5.0 (SD, 4.5) at six weeks postpartum, and 5.8 (SD, 4.9) at six months postpartum, with median scores of 7.0, 4.0, and 5.0, respectively. Using the 12/13 cutoff score, the rate of women who scored above the cutoff scores in late pregnancy was 12.5 percent (61 cases/488 women interviewed). The rate was lower at six weeks postpartum, 6.6 percent (18/274), and at six months postpartum, 8.2 percent (8/97). The mean EPDS score for those who scored above the cutoff of 12/13 was 15.6 (SD, 2.7) in late pregnancy, 15.2 (SD, 2.4) at six weeks postpartum, and 18 (SD, 5.1) at six months postpartum. In this study, the mean EPDS scores of women who scored above the cutoff of 12/13 were similar to those found in the developmental study of the EPDS (range, 15.38–16.5). However, the mean EPDS scores for those who scored below the cutoff of 12/13 were lower than those reported in the early validation study of the EPDS (mean = 9.8) (Cox et al. 1987): 6.5 (SD, 3.2) in late pregnancy, 4.3 (SD, 3.6) at six weeks postpartum, and 4.9 (SD, 3.4) at six months postpartum.

Of the 41 women in this nested study, more than half (23/41) had EPDS scores above the cutoff of 12/13 only during pregnancy. Of the remaining 18, 10 began to show symptoms at six weeks postpartum and the symptoms had remitted at six months postpartum. The other eight experienced onset of their symptoms in the third trimester, and for some, the symptoms persisted until six weeks postpartum (five of the eight women) or longer (three of the eight).

During Late Pregnancy: Feeling Anxious and Worried

The 23 women with high depressive scores in late pregnancy were asked to give "names" or "terms" to the conditions that were measured in their EPDS tests administered during late pregnancy. Women were asked the following question: "By drawing together the story you have told me in late pregnancy [interviewer read through the woman's responses to the ten items on the EPDS administered to her previously, in late pregnancy], in one word, how would you describe the condition?" Women were also asked to elaborate on the reasons why they believed they were experiencing the different conditions measured in their EPDS tests.

The women described their condition using a variety of common terms including *cemas* (anxiety), *banyak mikir* (thinking too much or worrying too much), *kuatir* (worried) and *takut* (scared or afraid), *bingung* (scared and confused), *sedih* (sad), *serba kekurangan* (personal and economic inadequacy) and *nelongso* (Javanese: self-pity). The majority of women used only one of these terms, while some used a combination of the terms to describe their condition.

Of the 41 women interviewed, 3 reported a previous miscarriage, and 38 were primigravid. For most of the women, childbirth was a mystery. Women expressed this notion with the term *belum pengalaman* (not yet experienced) in giving birth. Some women were told by female neighbors, friends, or family members to expect pain or difficulty with *mengejan*[2] (pushing at the second stage of labor), possible cesarean delivery, having babies with deformities, or death. Sri, for example, was scared because of the horrendous stories about pain and childbirth that she had heard from her neighbors. While community women are a constant source of information, such shared knowledge is not necessarily accurate or designed to lessen women's anxieties and fears. While women during pregnancy were anxious or fearful about what to expect in childbirth, after experiencing childbirth, many said that it was not as terrifying as they had been told.

Besides the three women who reported miscarriages, one woman reported having a breech presentation in her current pregnancy. These four women, in contrast to the others, had foreseen complications and hence approached childbirth with greater anxiety. Iyah (age 25) explained how "thinking too much" about an earlier miscarriage had an impact on her well-being during her current pregnancy:

> While I was pregnant ... I don't know. I just got angry easily ... got irritated ... just listening to someone who talked harshly. I had a miscarriage before, maybe ... I was *kepikiran* [thinking too much].

Another woman, Aning (age 26), had a breech presentation in her current pregnancy. She was scared of losing either her own life or that of her baby in labor. Her fears were related to information received from neighbors and not from health professionals.

My baby was *sungsang* (breech). Which one of us would die? Many people in my *kampung* (urban village) said, "One will go," but I just *pasrah* (surrendered to God's will) and I felt better.

Aning's baby was delivered by cesarean section. Another woman, Ima (age 25), attempted unsuccessfully to terminate her current pregnancy and was scared that this might have caused deformity in her child:

When I was one month pregnant, I tried to terminate my pregnancy. I took *jamu* (traditional herb medicine). I was scared that my baby would be born with a defect. I regretted taking the medicine. Why did I give the jamu to my baby? I fell sick because of my worries and fears.

A number of women related their symptoms to marital problems. As explained earlier, women referred to their depressive symptoms as representations of feeling bingung (confused), sedih (sad), serba kekurangan (personal and financial inadequacy), and nelongso (Javanese: self-pity). The husbands of two of these women had left them in the second trimester of pregnancy. At six months postpartum, they reported feeling better and were looking forward to starting a new life. One woman, Kari, and her baby lived with her cousin, who opened a *warung* (food stall). Her cousin did not have a child of her own, and while Kari was helping her with the warung business, the cousin offered to take care of Kari's baby son and cover his expenses.

My husband was home with me at that time of pregnancy, but having an affair with another woman ... so I was sad. When I was pregnant, I often thought about what would happen to my life without my husband with me. Now I feel *tenang* (composed) because my cousin will take care of my child. I think my decision to live with and help my cousin with running the warung was the best one because I do not have a husband now. [Kari, age 26]

Dwi's husband also left her when she was six months pregnant. When interviewed at six months postpartum, she was filing for divorce. Her husband lived and worked on another island. He had returned home only

once to see the baby, soon after the birth, and left again without giving any financial support to his family except to pay the hospital bills. When asked to give a ''term'' to explain her depressive symptoms in late pregnancy, Dwi (age 25) said that she was confused about her marital situation because her husband was never there for her when she was pregnant.

I felt that he did not respect me at all, because he didn't care about me and the baby. Once I phoned him and said to him, ''Why did you just ignore me like this?'' He said, ''Yes, I deliberately do this to you.'' I felt very angry ... very disappointed. I felt *putus asa* (in despair or hopeless).

Children are highly valued in Javanese society: ''much wanted and enjoyed'' (Geertz 1961:83) and the ''bringers of warmth and happiness'' (Koentjaraningrat 1985:231). A common belief is that ''a child brings luck to the family,'' as in the old Javanese saying, ''Banyak anak banyak rejeki,'' or ''The more children, the greater the luck for the family.'' Wanti (age 22) termed her situation *serba kekurangan* (financial inadequacy), due to her husband's unemployment and her inability to find new paid work, but at the same time, she felt she was happier after the birth of her child:

Before I had the baby I felt sad and sometimes cried. After having him, I do not feel sad anymore. Now I just have arguments with my husband, not a big deal. Last time the fight was about money. There is a belief that children bring *rejeki* (luck), isn't there? Now I feel that our life is better.

Another woman, Tin (age 30), reported feeling nelongso (Javanese: self-pity) in late pregnancy, and this was partly associated with tiredness and exhaustion.

I was *hamil tua* (heavily pregnant). I got tired easily and felt worn out ... and I still had to help my mother with the housework. If not, I would feel sorry for my mum doing all the work by herself with nobody helping. One evening, my brother came and he put his things everywhere, making a mess. I got upset and was scornful ... but he just ignored me and left.... I felt upset that he looked down on me.

Six Weeks to Six Months Postpartum: Complex Emotions, Complex Problems

Eighteen women had high EPDS scores at six weeks postpartum, and eight of them had symptoms that had persisted since late pregnancy. Of these eight, three women had had the symptoms for more than nine months, from

late pregnancy to six months postpartum. Table 2 reports the ''terms'' given by women with regard to experiencing depressive symptoms at six weeks postpartum. These terms included complex emotional words that were related to and were expressive of complex life circumstances, including a state or condition such as *ekonomi tidak cukup* (inadequate economic life). Women were particularly likely to use Javanese to describe complex emotions and moods that could not be translated directly into Indonesian or English: *nelongso* (Javanese: self-pity), *kepikiran* (worrisome), *tertekan* (emotionally repressed), *bingung* (confused), *gelo* (Javanese: regretful), and *sumpek* (Javanese: overwhelmed, a feeling of being in trouble). The term *sumpek* refers to a mixed feeling of being overwhelmed, leading the woman to feel that her head is in a whirl because of problems, confusion of thoughts, and feelings of being in constant or chronic trouble. Many of these terms are not usually considered to be symptoms of depression, and some do not coincide with the feelings described in the EPDS.

Women tended to use more than one term to describe their depressive symptoms at six weeks postpartum. They related their conditions to complex

TABLE 2
Names for Depressive Symptoms Experienced at Six Weeks Postpartum

Naming	Explanations
nelongso (Javanese: self-pity), inadequate economic life	Inadequate economic resources; regretting her quitting previous employment; thinking of the possibility of having more adequate economic resources if she worked.
kepikiran (worrisome), *tertekan* (emotionally repressed), *pikiran bingung* (confused), *gelo* (Javanese: regretful)	Inadequate economic life; confused or uncertain about husband's work and income for the family; regretful of her marriage and having a child.
stress	The baby was born with harelip.
sumpek (Javanese: overwhelmed, feeling of being in trouble)	Unplanned motherhood due to premarital sexual relationship and unwanted pregnancy; feeling of being a loser, incompetent or inadequate
krisis mental (mental crisis)	Felt physically restrained; could not do what she likes to do and thought that her psychological complaints were due to this condition.

problems and stressful life events. Difficult life events commonly reported included financial problems, unemployment, marital problems, chronic illness in the family, concerns about the baby's health, and acknowledgment of painful feelings such as being an inadequate or incompetent mother. Two women tied their emotional distress to specific uncertainty about their husbands' unemployment and to quitting work during pregnancy, which caused economic difficulties. One of them was Sri (age 25):

> I was worrying over many things; confused because of the finances. I also felt regretful. I kept my feelings to myself.... I often cried until my eyes got puffy, and mum noticed and asked me ... only then did I tell her about what had been bothering me ... I used to have cash in hand when I worked but now it's *sepi* (not much work available for her husband). Yes, such things upset me ... I rarely blame myself now, but I used to tell myself: "Stupid, why did you get married, just to face difficulties?"

Sri, her husband, and their baby lived with Sri's parents and siblings in a temporary house in a poor urban area. The family rented a piece of land measuring 18 square meters, on which they erected a house at their own expense. The floor was cement, and the walls were half brick, half thin wood. During the monsoon season, flood water would inundate the house and leave the floors and walls damp. During the interview at six months postpartum, her husband was still unemployed and often the family had to ask Sri's mother for food. Life had become harder, as the baby needed baby food and milk formula.

Tuti was 19 years old. Although she planned to study at university, she became pregnant and was advised to get married. She termed her depressive symptoms experienced at six weeks postpartum "feeling sumpek" (Javanese: overwhelmed)) and described herself as an "error mother," referring here not to the unplanned nature of the pregnancy but rather to her incompetence in undertaking the tasks of and behaving like a "proper" mother:

> I felt that I could not take good care of my baby. My mother did everything for me. I did not have the patience. I often got angry with the baby ... so I was always stressed. I often felt sumpek and bored. If I were able to change faith ... I wish that I hadn't married yet ... because I wasn't ready at that time. After finishing high school, I wanted to study at university, but I had to get married because the baby was on the way.... I am not capable of being a mother. A mother is supposed to be able to do all women's work, but I can't do all those things. I can't cook ... I can't do anything.... So I feel like an error mother.

Not all women reported economic difficulties or felt they were failures as mothers; even so, many were unhappy because they were under stress,

overwhelmed, or in crisis for other reasons. Ani's baby was born with a harelip and she was worried about him. She felt much better at six months postpartum because she was certain that her son would get better in the future, after an international charity organization guaranteed him free treatment and surgery until he turns 17 years old.

Another woman, Mus (age 30), was an artist and a designer before having her baby. She defined her symptoms at six weeks postpartum as a mental crisis. She reported experiencing psychosomatic symptoms from the birth of the baby to three months postpartum. For example, at one time she could not bend her fingers and felt itchy all over her body, without any visible signs of inflammation or allergy.

It was *krisis mental* (mental crisis), *kelainan* (deviation, disorder) because of the physical restrictions; I couldn't do anything, just take care of the baby, and this physical restraint affected my psychological state.... I want to be like I used to be—free—but how can I? In my milieu, all my friends are productive artists.... Often when we hang out ... they tell me what they have made.... I can't be like them.... My feelings have really got to me.

As noted earlier, three women had depressive symptoms that started in late pregnancy and persisted to six months postpartum, and so had lived with such symptoms for some months when interviewed. The terms given by these three women related to numerous stressful life events. Such terms included *stress, pegel* (Javanese: feeling upset in the heart) and *pusing* (dizzy). Table 3 presents the terms used by the three women, related causes explained by them, and other related stressful life events.

Like those reporting PPD at six weeks postpartum, all three women cited economic difficulties and marital problems and, in addition, reported other stressful life events (e.g., chronic illness in the family, baby's serious illness, domestic violence). At six months postpartum one woman, Nike (age 24), was uncertain whether to divorce her husband or remain married for the child's sake. She and her husband came from different religious backgrounds, and she believed that such differences were the cause of their poor marital relationship.

I don't want to be a Moslem. But I have to keep going on now.... I don't want my child to have a psychological problem with his psyche when he grows bigger. I don't want him to be a child from a broken home. Even if I got divorced, I would want to keep the child through child custody using the court system, but I don't have money for that. It is hard for me to leave the child behind and also to leave my husband. I love both of them. I really don't know what I should do.

TABLE 3
Stressful Life Events of Women with Continuing Depressive Symptoms, Late Pregnancy to Six Months Postpartum

Pseudonym	Term	Explanation	Other stressful life event(s)
Nike	*stress*	Marital relationships, problems due to religious differences	Husband had a history of suicide attempts.
Maria	*stress*	Economy and marital relationship	Mother was paralyzed after an accident.
Trisna	*kesulitan ekonomi* (economic difficulties), *pegel* (Javanese: upset), *pusing* (dizzy)	Economy and marital relationship	Husband had chronic lung tuberculosis, and the baby (possibly) was hydrocephalic. Family members were abusive to her.

Another woman, Maria (age 22), had economic and marital problems—she felt her husband was childish, abusive, and inconsiderate—and also experienced other stressful life events. Maria and her family lived with her mother and two siblings. Both Maria and her husband were unemployed. Only Maria's brothers worked full-time and they shouldered responsibility for the family. Maria and her husband opened a *warung kaki lima* (a small food stall at the edge of a busy road) selling fried chicken. The business, however, was not doing well and the family was still in debt. When interviewed at six months postpartum, Maria explained that the telephone service had been disconnected and that creditors often came to their home and harassed them. Maria's mother was confined to bed because of an accident in the elevator where she used to work. Several discs in her back had fused and she was now paralyzed. As the eldest and the only daughter in the family, Maria was responsible for all the housework while taking care of her baby. She explained her stress:

> Stress ... for a while, I even wished to die ... it was just after giving birth. My mum has been very sick and I could not talk about anything to my husband. My husband is selfish, immature. When I felt stressed, I could go a whole day without food. Looking at my child cured me. At times ... I was like someone who had gone *edhan* (Javanese: insane). My relatives even offered to be my child's guardian ... helping me financially to raise the child if I wanted to leave my husband.

Another woman, Trisna (age 27), used various terms to explain her symptoms of depression, including *kesulitan ekonomi* (economic difficulties), *pegel* (Javanese: generally upset), and *pusing* (dizzy). Trisna experienced many life difficulties, including being labelled by her family as retarded or troublesome. She reported physical and emotional abuse from her siblings during pregnancy; her brother once kicked her in the stomach when she was pregnant, and her siblings and father treated her like a slave. While she was able to live with the family without paying rent, she was expected to do all the housework, including washing clothes and cooking meals for other family members. Her father arranged for her to marry a man who had active tuberculosis; his income was mainly used to meet daily food costs for the family, and they could not afford to see a doctor or pay their medical expenses. Coming from poor families, she and her husband were married in a church but could not afford a marriage certificate from the civil office. During the interview at six months postpartum, Trisna mentioned that her child's head was getting bigger and bigger and she thought it was because of "water in the brain." She took her baby to a general practitioner and was then told to take her to a pediatrician and, subsequently, to take her to a surgeon for screening. But Trisna did not have the money and had not done so. She spoke of her general feelings of failure and incompetence.

> It was economic difficulties, feeling pegel (Javanese: a feeling of being upset, that can be expressed as anger) and dizziness. I often felt sad, especially when my husband did not give me any money and when he was not here with me.... I was unhappy and often cried.... My husband has had TBC (tuberculosis) since he was *bujang* (single). He had been taking medicines but is still coughing ... and my child is still sick.... I blamed myself almost all the time ... because I don't think I am capable of doing anything.... I often get pegel with my child, sometimes I even hit her ... my baby has difficulty going to sleep. I felt pegel with my husband when he did not help me. Almost every single day I fight with him, I even hit him. When I asked him to help, he did not pay any attention, he just kept on day dreaming.

DISCUSSION

Depressive symptoms are not necessarily less common in late pregnancy and the early postpartum period in Indonesia than in Western societies, but how women experience, understand, and speak of their emotional and mental states is clearly different. In this paper, we have illustrated that Javanese women use familiar local terms to express their reactions to difficult life

circumstances in early motherhood, including unhappiness, worries, fears, disappointment, annoyance, regret, anger, guilt, confusion, and self-pity. In late pregnancy, the majority of women spoke of their emotional states in single words, including feeling takut (scared), cemas (anxious), or kuatir (worrying too much), or ''thinking too much,'' and related their feelings to the anticipation of the pain of childbirth and the birth itself. Such idioms—worrying too much and thinking too much—were also reported to be the common idioms used by Ghanaian women to explain their psychosocial related health problems (Avotri and Walters 1999). A few elaborated their emotional states as feeling sedih (sad), bingung (confused), or nelongso (Javanese: self-pity). Such findings confirm other studies suggesting two underlying dimensions measured in the EPDS: anxiety and depression (Green 1998; Pop et al. 1995). However, feeling nelongso and feeling bingung are not usually considered to be symptoms of depression. In addition to those idioms of emotion, a nonemotional word was introduced, *serba kekurangan*, referring to women's lack of readiness to become a mother or lack of financial resources (i.e., related to unemployment or poverty).

Most terms used for emotional states in late pregnancy were single phrases in Bahasa, which usually correlated with English terms. In early postpartum, however, the terms offered by women were often complex, and it was not always possible to translate them directly into English or to correlate them with Western symptoms of depression. Certain terms derive from English, for example, *krisis mental* (mental crisis) and *stress* (stress). The term *mental crisis*, as explained by the women, includes a sense of entrapment both by motherhood and by related problems from which women saw no escape. The term *stress* also relates to feelings of being trapped, and to experiencing stressful life events for an extended period of time.

When expressing complex emotion states in early postpartum, the women often used Javanese terms, most of which do not have equivalent translations in English or in Bahasa. The term *nelongso*, for instance, translates as feeling self-pity, but it also refers to a feeling of deep sadness. The term *sumpek* accommodates feelings of being in trouble, due both to personal incompetence and to poverty (*ekonomi tidak cukup*—inadequate finances). *Sumpek* also encompasses feelings of ''tiredness in the heart'' or of being overwhelmed by problems without any means to solve them in the near future—a sense of being frustrated or of having no solutions for multiple adversities in everyday life. Some terms have direct translations in Bahasa: *pegel* (*jengkel*: upset), *gelo* (*menyesal*: regretful), and *mumet* (*pusing:* headache or dizzy). The terms *pegel* and *pusing*, used together, connote mixed feelings of tiredness, being overwhelmed, and having constant problems, an

inability to think straight, and having lots of headaches. However, none of these feelings are context-specific to postpartum experiences. Rather, they are commonly used in daily conversation among Javanese and are locally understood as common expressions of having troubles or difficulties in life or as a means of expressing physical discomfort (i.e., having a headache). The generality of these terms makes it unrealistic to suggest that they form a local idiom of postpartum distress.

Our findings confirm mood variation around pregnancy and early motherhood, but draw attention to the significance of the social and economic context and individual setting in relation to the kinds of emotions experienced by women and their understandings of these. Women did not speak of their emotions as representing illness, low morale, or any moral deficiency within themselves. None of the women in this study medicalized their experiences and they did not perceive their situations as needing medical intervention. Rather, they explained their experiences in the context of life adversities. Many women spoke of emotions that are not usually strongly associated with the common symptoms of depression on the EPDS, such as feeling angry, upset, annoyed, regretful, or self-pity. Women were angered easily, upset or pegel, disappointed, and annoyed by poor marital relationships, emotional abuse, difficult economic circumstances, or lack of support from partners and social networks. Women did not describe themselves in local terms that equate with feelings of "hopelessness" or "desperation" or "being anxious or worried for no reason;" rather, they were disappointed and pegel (being upset expressed as anger) by their physical, personal, social, and cultural constraints.

Women's negative responses to difficult life circumstances in the postpartum period, however, were not generally related to their babies. Most women reported that their babies were a source of joy that motivated them to move on with life. For women particularly, their children were seen as an accomplishment, a mark of their social passage to adulthood. The evidence that women reported feeling upset and disappointed suggests the need to expand research on women's mental health beyond psychiatric diagnoses to encompass women's subjective experiences within specific social, cultural, and political milieus.

Further, as women in this study did not conceptualize their experiences in terms of illness or moral deficiency, it is important that other determinants of women's well-being that they identified (such as stressful life events, anxiety during pregnancy, humiliation, anger about entrapment in difficult situations, losses and disappointments, social injustice, and demoralization) be explored in greater depth (Andajani-Sutjahjo 2003; Astbury and Cabral 2000; Broadhead and Abas 1998). Results of this study may also stimulate

dialogue in the realm of women's health and human rights, social justice, and holistic approaches to women's health. This is because the findings demonstrate the importance and benefits of understanding women's health beyond purely biomedical discourses. Ensuring the right of women to the highest attainable physical, psychological, and social health clearly requires understanding how health is socially, culturally, and economically determined.

This study is not without limitations. The use of the 12/13 cutoff score may have been unnecessarily restrictive as a means of selecting women, and women who experienced mild depressive symptoms may have been omitted from the sample (Cox et al. 1996). However, as this study aimed to investigate how the concept of PPD, as defined in Western society, accords with Indonesian women's perceptions of the condition (Cox et al. 1996; D. Murray and Cox 1990), we perceived that it was important to avoid the inclusion of any nondepressed women.[3] This research indicates the need for a further study with a broader intake of women based on a less conservative cutoff score or other selection criteria that would allow comparative studies across diverse study populations.

Sample attrition encountered across different stages of the study, while providing important information on young women's mobility, also led to limited generalizability of the findings. Many women in this study felt most comfortable giving birth and spending the early postpartum period with their families (particularly their mothers). While the majority of the women had parents and relatives living in the same urban areas, some were migrant workers from nearby towns or villages, and they were more likely to return to their hometown for postpartum care. Follow-up of women who returned to "home" villages or natal towns was not undertaken. Further studies are needed to explore the impact of urban migration on women's experiences of first-time motherhood and postnatal depression.

Women in this study were those of low socioeconomic class among whom issues relating to unemployment, crowded housing, and inability to afford formal childcare were prevalent. Although the majority of women in Indonesia are those of such background, further studies are needed to examine the existence and the impact of socioeconomic factors on women's perception and understanding of postpartum mental illness in Indonesia. Finally, without reliance on and belief in the importance of women's accounts, this study would have missed the detailed and contextualized pictures of women's mental health during pregnancy and early postpartum, and would have overlooked the complex emotions, problems, and language that give rise to women's culturally specific understandings of depression.

NOTES

1. In Indonesia, it is common for young married couples, particularly from lower socioeconomic classes, to live with their parents for the first few years of marriage before moving to their own houses (Geertz 1961).

2. *Mengejan* or *ngedhen* (Javanese term) is a specific term describing the pushing act, sound, and facial expression of a woman in the second stage of labor. Unlike the English term, *pushing*, which can be used in a general situation, the term *mengejan* is context-specific and used to refer to humans and animals.

3. In a clinical setting, the lower cutoff score of 9/10 is recommended to avoid false-negatives (Cox et al. 1996).

REFERENCES

Andajani-Sutjahjo, Sari
2003 Motherhood and Women's Emotional Well-Being in Indonesia. Ph.D. thesis, University of Melbourne.

Andajani-Sutjahjo, Sari, and Lenore Manderson
2004 Stillbirth, Neonatal Death and Reproductive Rights in Indonesia. Reproductive Health Matters 12(24): 181–188.

Astbury, Jill
1994 Making Motherhood Visible: The Experience of Motherhood Questionnaire. Journal of Reproductive and Infant Psychology 12: 79–88.

Astbury, Jill, and Meena Cabral
2000 Women's Mental Health: An Evidence Based Review. Geneva: World Health Organization.

Avotri, Joyce Yaa, and Vivienne Walters
1999 "You Just Look at Our Work and See If You Have Any Freedom on Earth": Ghanaian Women's Accounts of Their Work and Their Health. Social Science & Medicine 48: 1213–1133.

Beck, A. T., C. H. Ward, M. Mendelson, J. Mock, and J. Erbaugh
1961 An Inventory for Measuring Depression. Archives of General Psychiatry 4: 561–567.

Beck, Cheryl Tatano
1992 The Lived Experience of Postpartum Depression: A Phenomenological Study. Nursing Research 40(3): 166–170.
1993 Teetering on the Edge: A Substantive Theory of Postpartum Depression. Nursing Research 42(1): 42–48.
1996 A Meta-analysis of Predictors of Postpartum Depression. Nursing Research 45(5): 297–303.
2001 Predictors of Postpartum Depression: An Update. Nursing Research 50(5): 275–285.
2002 Revision of the Postpartum Depression Predictors Inventory. Journal of Obstetric, Gynecologic, and Neonatal Nursing 31(4): 394–402.

Beck, Cheryl Tatano, and Robert K. Gable
2000 Postpartum Depression Screening Scale: Development and Psychometric Testing. Nursing Research 49(5): 272–282.
2001 Further Validation of the Postpartum Depression Screening Scale. Nursing Research 50(3): 155–164.

Becker, Anne E.
1998 Postpartum Illness in Fiji: A Sociosomatic Perspective. Psychosomatic Medicine 60(4): 431–438.
Benvenuti, P., M. Ferrara, C. Niccolai, V. Valoriani, and J. L. Cox
1999 The Edinburgh Postnatal Depression Scale: Validation for an Italian Sample. Journal of Affective Disorders 53(2): 137–141.
Bernet, Christine Z., Rick E. Ingram, and Brenda R. Johnson
1993 Self-Esteem. *In* Symptoms of Depression. C. G. Costello, ed., pp. 141–159. Toronto: John Wiley & Sons.
Boyce, Philip, Joanne Stubbs, and Angela Todd
1993 The Edinburgh Postnatal Depression Scale: Validation for an Australian Sample. Australian and New Zealand Journal of Psychiatry 27: 472–476.
Broadhead, Jeremy C., and Melanie A. Abas
1998 Life Events, Difficulties and Depression among Women in an Urban Setting in Zimbabwe. Psychological Medicine 28: 29–38.
Brown, G., T. Harris, and C. Hepworth
1995 Loss, Humiliation and Entrapment among Women Developing Depression: A Patient and Nonpatient Comparison. Psychological Medicine 25: 7–21.
Brown, Stephanie, Judith Lumley, Rhonda Small, and Jill Astbury
1994 Missing Voices: The Experience of Motherhood. Melbourne: Oxford University Press.
Carothers, Andrew D., and Lynne Murray
1990 Estimating Psychiatric Morbidity by Logistic Regression: Application to Post-Natal Depression in a Community Sample. Psychological Medicine 20: 695–702.
Chan, Sally Wai-Chi, Valerie Levy, Tony K. H. Chung, and Dominic Lee
2002 A Qualitative Study of the Experiences of a Group of Hong Kong Chinese Women Diagnosed with Postnatal Depression. Journal of Advanced Nursing September 39(6): 571–579.
Cooper, Peter J., and Lynne Murray
1998 Postnatal Depression. British Medical Journal 316(June): 1884–1886.
Cooper, Peter J., E. A. Campbell, A. Day, H. Kennerley, and A. Bond
1988 Nonpsychotic Psychiatric Disorder after Childbirth: A Prospective Study of Prevalence, Incidence, Course and Nature. British Journal of Psychiatry 152: 799–806.
1996 The Development and Validation of a Predictive Index for Postpartum Depression. Psychological Medicine 26: 627–634.
Cox, John L.
1986 Postnatal Depression. A Guide for Health Professionals. Singapore: Churchill Livingstone.
Cox, John L., G. Chapman, D. Murray, and P. Jones
1996 Validation of the Edinburgh Postnatal Depression Scale (EPDS) in Non-postnatal Women. Journal of Affective Disorders 39: 185–189.
Cox, John L., J. M. Holden, and R. Sagovsky
1987 Detection of Postnatal Depression: Development of the 10-Item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry 150: 782–786.
Cox, John L., Declan Murray, and Gail Chapman
1993 A Controlled Study of the Onset, Duration and Prevalence of Postnatal Depression. British Journal of Psychiatry 163: 27–31.
Dennerstein, L., P. Leher, and F. Riphagen
1989 Postpartum Depression—Risk Factors. Journal of Psychosomatic Obstetrics and Gynecology 10(Suppl): 53–65.

Eberhard-Gran, Malin, Anne Eskild, Kristian Tambs, and S. Opjordsmoen
2001 Review of Validation Studies of the Edinburg Postnatal Depression Scale. Acta Psychiatrica Scandinavica 104(4): 243–249.

Fowles, Eileen R.
1998 The Relationship between Maternal Role Attainment and Postpartum Depression. Health Care for Women International 19: 83–94.

Fuggle, P., L. Glover, F. Khan, and K. Haydon
2002 Screening for Postnatal Depression in Bengali Women: Preliminary Observations from Using a Translated Version of the Edinburgh Postnatal Depression Scale (EPDS). Journal of Reproductive and Infant Psychology 20(2): 71–82.

Geertz, Hildred
1961 The Javanese Family. A Study of Kinship and Socialization. New York: Free Press of Glencoe.

Georgiopoulos, Anna M., Amy B. Saltzman, and Anne E. Becker
2005 Postpartum Mood Disturbance in Cross-Cultural Perspective. *In* Perspectives in Cross-Cultural Psychiatry. A. Georgiopoulos and J. Rosenbaum, eds. pp. 105–134. Philadelphia: Lippincott.

Green, Josephine M.
1998 Postnatal Depression or Perinatal Dysphoria? Findings from a Longitudinal Community-Based Study Using the Edinburgh Postnatal Depression Scale. Journal of Reproductive and Infant Psychology 16: 142–155.

Grigoriadis, Sophie
2006 Postpartum and Its Mental Health Problems. *In* Women's Mental Health: A Life-Cycle Approach. S. E. Romans and M. V. Seeman, eds. Philadelphia: Lippincott Williams & Wilkins.

Harris, Brian, P. Huckle, R. Thomas, S. Johns, and H. Fung
1989 The Use of Rating Scales to Identify Post-natal Depression. British Journal of Psychiatry 154: 813–817.

Ismail, R. Irawati, S. D. Elvira, I. Kusumadewi, and S. Wibisono
2000 A Preliminary Report on Postpartum Depression: A Part of Multi-ethnic and Multi-centre Cohort Study. Jiwa, Indonesian Psychiatric Quarterly XXXIII: 169–193.

Jadresic, E., and R. Araya
1995 Prevalence of Postpartum Depression and Associated Factors in Santiago, Chile. Revista Medica de Chili 123(6): 694–699.

Kitamura, Toshinori, M. Sugawara, K. Sugawara, M. A. Toda, and S. Shima
1996 Psychosocial Study of Depression in Early Pregnancy. British Journal of Psychiatry 168(6): 732–738.

Koentjaraningrat
1985 Javanese Culture. Singapore: Oxford University Press.

Kok, L. P., P. S. L. Chan, and S. S. Ratnam
1994 Postnatal Depression in Singapore Women. Singapore Medical Journal 35: 33–35.

Kumar, R., and Kay Mordecai Robson
1984 A Prospective Study of Emotional Disorders in Childbearing Women. British Journal of Psychiatry 144: 35–47.

Kusumadewi, Irmia, I. Irawati, S. D. Elvira, and S. Wibisono
1998 Validation Study of the Edinburgh Postnatal Depression Scale. Jiwa, Indonesia Psychiatric Quarterly XXXI(2): 99–110.

Kusumaningsih, Prita, Frans Uktolseya, and Endang Warsiki
1999 Studi Banding Kejadian Depresi Pasca Persalinan Antara Persalinan Fisiologis dan Pathologis (A Comparison Study of Postnatal Depression between Physiological and Pathological Labour). Surabaya, Indonesia: FK Unair/RSUD. Dr. Soetomo.

Lee, Dominic T. S., C. K. Wong, G. S. Ungvari, L. P. Cheung, C. J. Haines, and T. K. H. Chung
1997 Screening Psychiatric Morbidity After Miscarriage: Application of the 30 Item General Health Questionnaire and the Edinburgh Postnatal Depression Scale. Psychosomatic Medicine 59: 207–210.
Lee, Dominic T. S., Alexander Yip, Tony Leung, and Tony Hung
2004 Ethnoepidemiology of Postnatal Depression: Prospective Multivariate Study of Sociocultural Risk Factors in a Chinese Population in Hong Kong. British Journal of Psychiaty 184(January): 34–40.
Lum, Cheryl U.
1990 The Relationship of Demographic Variables, Antepartum Depression, and Stress to Postpartum Depression. Journal of Clinical Psychology 46(5): 588–592.
Murray, Declan, and John L. Cox
1990 Screening for Depression during Pregnancy with the Edinburgh Depression Scale (EDS). Journal of Reproductive and Infant Psychology 8: 99–107.
Murray, John B., and Sister Louise Gallahue
1986 Postpartum Depression. Genetic, Social, and General Psychology Monographs 113(2): 193–212.
O'Hara, Michael W., D. J. Neunaber, and E. M. Zekoski
1984 Prospective Study of Postpartum Depression: Prevalence, Course, Predictive Factors. Journal of Abnormal Psychology 93: 158–171.
O'Hara, Michael W., E. M. Zekoski, L. H. Phillips, and E. J. Wright
1990 Controlled Prospective Study of Postpartum Mood Disorders: Comparison of Childbearing and Nonchildbearing Women. Journal of Abnormal Psychology 99(1): 3–15.
Patel, Vikram, R. Araya, M. de Lima, A. Ludermir, and C. Todd
1999 Women, Poverty and Common Mental Disorders in Four Restructuring Societies. Social Science and Medicine 49: 1461–1471.
Patel, Vikram, Merlyn Rodrigues, and Nandita DeSouza
2002 Gender, Poverty, and Postnatal Depression: A Study of Mothers in Goa, India. American Journal of Psychiatry 159(1): 43–47.
Pitt, Brice
1968 "Atypical" Depression Following Childbirth. British Journal of Psychiatry 114: 1325–1335.
Pop, V. J., H. A. Wijnen, M. Van Montfort, G. G. Essed, C. A. DeGeus, M. M. Van Son, and I. H. Komproe
1995 Blues and Depression during Early Puerperium: Home versus Hospital Deliveries. British Journal of Obstetrics and Gynaecology 102: 701–706.
Regmi, Shishir, Wendy Sligl, Diana Carter, William Grut, and Michael Seear
2002 A Controlled Study of Postpartum Depression among Nepalese Women: Validation of the Edinburgh Postpartum Depression Scale in Kathmandu. Tropical Medicine and International Health 7(4): 378–382.
Rodrigues, Merlyn, Vikram Patel, Jaswal Surinder, and Nandita De Souza
2003 Listening to Mothers: Qualitative Studies on Motherhood and Depression from Goa, India. Social Science and Medicine 57(10): 1797–1806.
Small, Rhonda, Jill Astbury, Stephanie Brown, and Judith Lumley
1994a Depression After Childbirth: Does Social Context Matter? Medical Journal of Australia 161: 473–477.
Small, Rhonda, Stephanie Brown, Judith Lumley, and Jill Astbury
1994b Missing Voices: What Women Say and Do about Depression After Childbirth. Journal of Reproductive and Infant Psychology 12(2): 89–103.

Stamp, Georgina E., and Caroline A. Crowther
1994 Postnatal Depression: A South Australian Prospective Study. Australian and New Zealand Journal of Obstetrics and Gynaecology 34(2): 164–167.
Stuchbery, M., S. Matthey, and B. Barnett
1998 Postnatal Depression and Social Supports in Vietnamese, Arabic, and Anglo-Celtic Mothers. Social Psychiatry and Psychiatric Epidemiology 33: 483–490.
Watson, J. P., S. A. Elliott, A. J. Rugg, and D. I. Brough
1984 Psychiatric Disorder in Pregnancy and the First Postnatal Year. British Journal of Psychiatry 144: 453–462.
Yoga, Bambang Hastha, Soewadi, and Firngadi Moetrarsi
2000 Prevalensi Depresi Pada Wanita Postpartum di Bangsal Kebidanan RSUP Dr Sardjito Yogyakarta [The Prevalence of Depression among Women in the Postpartum Ward at the RSUP Sardjito, Yogyakarta]. Jiwa, Indonesian Psychiatric Quarterly XXXIII(2): 163–167.

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