College of Humanities

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Probing experiences of motherhood and postnatal depression amongst Black African women: The case study of Durban, KwaZulu-Natal

by

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DECLARATION

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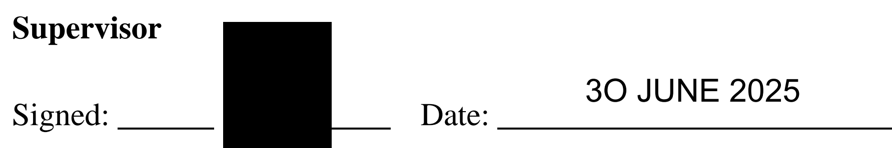

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DEDICATION

This thesis is dedicated to my late father, S.J. Mabaso and his late brother, B*abomcane* Bonginkosi Mabaso. Thank you for believing in me and seeing what I could not see in myself. Thank you for believing in an institution that you did not have the opportunity to experience. Tyma, this was our last conversation on your deathbed. *Babomcane* Bonginkosi, *ngiyabonga,* for being a kind extension of your brother in my life. I hope you are proud, gentle giants. I am thrilled to learn that God honours the wishes of those who have gone before us. Sobonana kwelizayo, Mntungwa, Mbulase, Gqomokhulu, Ndawonde…

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ABSTRACT

Postnatal depression is a mental disorder that affects women who have recently given birth and negatively impacts on their ability to carry out daily routines and take care of the baby. Postnatal depression is not routinely screened for in primary healthcare facilities in South Africa, despite its reported compromise on mother and child health. This contributes to the prevalence of new mothers experiencing postnatal depression. Factors associated with postnatal depression include the mother's medical condition, body mass index, psychological factors obstetric factors, sociodemographic factors, and cultural factors. This study explored the experiences of ten Black African mothers who have been diagnosed with postnatal depression and are living in Durban in KwaZulu-Natal. The study investigated Black African mothers' understanding of motherhood and postnatal depression and probed the effectiveness of social networks in assisting mothers to cope with the condition while attending to their newborn children. It further investigated the influence of 'cultural beliefs' in understanding postnatal depression and the role of 'culture' in women's understanding of their health. This study adopted an interpretivist paradigm and was complemented by a phenomenological research design and a qualitative approach to capture the phenomenon of the lived experiences of Black African women diagnosed with postnatal depression. A semi-structured interview schedule was used as a data collection tool to gather emic perspectives from ten Black African mothers aged between 18 and 40 who were purposively sampled. Framed within the identity theory and the theory of social constructivism, this study revealed that the understanding of postnatal depression is not homogenous, rather, it is understood and interpreted through heterogeneous experiences. It further revealed that within the Black African context, postnatal depression is experienced from both a biomedical and a cultural perspective. Additionally, the study revealed the pivotal role of support groups, peer support and social capital in transitioning to motherhood and with coping with postnatal depression.

Keywords**:** postnatal depression, motherhood, Black African women, mental health, culture and support networks.

GLOSSARY OF ABBREVIATIONS AND ACRONYMS

BAW	Black African women
DHHS	U.S. Department of Health and Human Services
EPDS	Edinburgh postnatal depression Scale
KZNMSN	KwaZulu-Natal's Mums Support Network
PND	Postnatal depression
STI	Social identity theory
SADAG	South Africa Depression and Anxiety Group
WHO	World Health Organization

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Abstract

Postnatal depression is a mental disorder that affects some women who have recently given birth and negatively impacts their ability to carry out daily routines and take care of the baby. Postnatal depression is not routinely screened for in primary healthcare facilities in South Africa, despite its reported compromise on mother and child health. This contributes to the prevalence of new mothers experiencing postnatal depression. Factors associated with postnatal depression include the mother's medical condition, body mass index, psychological factors, obstetric factors, sociodemographic factors, and cultural factors. This research study explored the experiences of ten black African mothers who have been diagnosed with postnatal depression and are living in Durban in KwaZulu-Natal. The study sought to understand motherhood and postnatal depression, the influence of cultural beliefs, and the effectiveness of social networks in helping mothers while attending to their newborn children. This study used the qualitative research method. It adopted an interpretivist paradigm to capture the phenomenon of the lived experiences of Black African women diagnosed with postnatal depression. A semi-structured interview schedule was used as a data collection tool to gather emic perspectives from ten Black African mothers aged between 18 and 40. Framed within the identity theory and the theory of social constructivism. It further revealed that within the Black African context, postnatal depression is experienced from both a biomedical and a cultural perspective. Additionally, the study revealed the pivotal role of support groups, peer support and social capital in transitioning to motherhood and in coping with postnatal depression. Based on these findings it is recommended that the Department of Health intentionally educates the community about postnatal depression. A collaboration between traditional practitioners' and health practitioners is recommended in order to share ideas about treating postnatal depression.

Keywords**:** postnatal depression, motherhood, Black African women, mental health, culture and support networks.

CHAPTER 1: INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 Preamble

Global mental health is about addressing inequities, namely the "treatment gap" for people with mental health conditions (Ndyanabangi et al., 2004; Roberts et al., 2018). The concept of mental illness has a variety of meanings in different discourses (Espinoza, 2024). In the medical model, mental illness is a disease, or a disease-like entity, with a psychological, genetic or chemical base that can be treated through medical means (McCann, 2016). The concept of mental illness is a multi-faceted one and every discipline has their own viewpoints to understand this concept (Demir, 2023). The medical model of mental illness always focuses on the internal process of an individual, but the social model focuses on a socially unacceptable behavior which is labeled as deviant by others (Manago and Mize, 2022). Vaka (2016), argues that the western approach to mental health challenges may not consider cultural subtleties, which could lead to misdiagnosis and inappropriate treatment. Also, belief in ancestors is a widespread practice in Africa. Ancestors are often believed to be able to influence the lives of their living descendants, and they may be consulted for advice or guidance. In some cultures, ancestors are seen as intermediaries between the living and the spirit world, while in others, they are seen as more powerful beings who can directly influence the course of events (Morgan & Okyere-Manu, 2020). The perception, understanding and view that each group of people have about mental health is important because it has the potential to influence and to inform them how they respond to the symptoms of mental health and which treatment avenue to consider be it from health practitioners or other treatment avenues outside of the health system, like the traditional remedies.

Mohan et al, (2021) a study on two sets of depressed outpatients was conducted, one of Malaysian Chinese and the other of Australian Caucasians, matched by age and sex. They identified the prime symptom nominated by them when they first sought assistance and required them to complete an inventory of both somatic and cognitive symptoms and rank the three items they judged as most capturing their distress. Results: The Chinese were distinctly more likely to nominate a somatic symptom as their presenting complaint (60 % vs 13 %), while the Australian subjects were more likely to nominate depressed mood, cognitive and anxiety items.

Cultural psychiatry is concerned with the impact of variations in ways of life on psychiatric disorders and their treatment (Kleinman 1988). The above study is an example of that reality between the Malaysian Chinese and the other of Australian Caucasians. This speaks to the reality that each racial group has a manifestation of symptoms that they are familiar with, that fit into their category of cultural health belief systems that are acceptable and considered as ‘’normal’’ in their society. In this particular study the aim of the research is to understand how Black African women process the manifestation of their symptoms, if they understand and interpret them from a cultural perspective or from a biomedical perspective as well as how their belief informs their diagnosis process be it in a public or private facility or if they consult with a traditional healer. In addition, if they will seek psychological or psychiatric help or if they will use traditional medicine. Depression is a disease that straddles all genders, ethnicities, races, and walks of life (Bailey et al, 2019).

Postnatal depression (PND) is an internationally recognized public health concern, defined as a serious maternal mental health problem occurring within four to six weeks after childbirth (Modjadji and Mokwena, 2020). Approximately 85% of mothers after giving birth will experience signs of postpartum blues; feelings of being overwhelmed, sadness, cry easily, mood swings, anxiety, tiredness, feeling of failure, headache, feeling unhappy and fatigue. It is a mild, temporary stage of emotional changes and it may last up to two weeks (Rashad, 2019). Postnatal depression (PND) is one of the most common causes of maternal distress representing a considerable public health problem affecting the mother, her baby, and her family. Within the postnatal period, there is an increase in the physical and emotional demands on the woman and the debility associated with PND may impinge on her capacity as a mother for example, to care for and bond with her new-born. Without diagnosis and treatment, maternal PND may affect her ability to participate in normal activities and interfere with her family and other social relationships (Arifin et.al 2018). PND has profound effects on the quality of life, social functioning, and economic productivity of women and families (WHO, 2023). The health consequences could also lead to adverse effects on the long-term emotional and physical development of the infant (Pessoa and Almeida, 2024). While Western women express their depressive symptoms overtly, new mothers in Asian cultures tend to manifest their emotional problems through somatic complaints (Kim et al, 2024). Chinese women express exhaustion of their hearts and feelings of being squeezed and weighed down (Chu et al ,2025). Some cultures dictate traditional rituals and supportive mechanisms that are believed

to protect women from the crippling symptoms of depression (LeMasters,2020). Previously, it was postulated that African women were not affected by PND, due to traditional rituals and other cultural factors. However, the assumption has been refuted because of the existence of empirical evidence of PND in Africa and beyond, particularly among women living in socio-economic disadvantaged regions. (Modjaji,2020) Hence, this research aims to probe the experiences and the interpretation of PND amongst Black African women in KwaZulu-Natal. Furthermore, this research aims to investigate the role support networks and groups like the Mums Support Network play a role in assisting mothers to cope with their role as 'mother's and with PND. To explore the role of culture when it comes to Black African women understand of their health and PND.

1.2 Background and significance of the study

Mental health is "a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in (WHO, 2022: 1). Mental health is a human right. The perceptions, understanding and views that each group of people have about mental health are important because it has the potential to influence and inform how they respond to symptoms of mental health and which treatment avenues to consider, be it from health practitioners or from other treatment avenues outside of the traditional Western health system (Mboweni et al, 2024). Recently, there have been debates about the cross-cultural relevance of depression central to cross-cultural psychiatry and global mental health (Dumke et al, 2024**).** Although there is now a wealth of evidence about symptoms across different cultural settings, the role of the health system in addressing these problems remains contentious (Choudhry et al, 2016)

These debates are inspired by the seminal work of Marcel Mauss (1935/1985). Marcel Mauss' classic essay on the person (Mauss, 1938) remains a central point of reference for all social scientists to this day, be they social psychologists, social historians, sociologists, or anthropologists. While the notions of person and relation he proposed are undoubtedly among our central analysis tools, his interpretation of their role as categories has changed significantly (Pina-Cabral, 2021). A major theme in psychological anthropology has been the concept of the 'person,' understood as a social and cultural construct that underlies self-understanding and

self-representation (Eller, 2018). Implicit cultural concepts underpin how the person shapes the current psychological theories of development and social behaviour, psychological assessment, psychopathology, and forms of psychotherapy (Hahn, 2023). Hence, the importance of continuously educating the community about depression and the different types of depression that can affect a person.

Global mental health is a field of research and practice that addresses the expansion of universal and equitable mental health care worldwide. Global mental health advocates and critics assume an ontological separation between 'nature' and 'culture' to typify mental illness, linking it predominantly to one or the other of these two categories (Wenceslau & Ortega, 2022). Psychological and medical anthropology have a long history of investigating cultural conceptions of mental health and illness and their relationship to health-seeking behaviours (Kozelka et al, 2021). Cultural conceptions of illness are the "common sense" knowledge used to interpret experience (Kozelka et al, 2021). This framework has shown that biomedical and psychiatric understandings of illness and treatment exist alongside social, spiritual, and supernatural explanations of distress and diverse modalities to alleviate suffering (Ross et al., 2012). Cultural conceptions of mental health and illness must be understood because they play a significant role in shaping health-seeking behaviours, treatment options, therapeutic experiences, and recovery (Carpenter-Song et al, 2020).

Since the 1980s, several population surveys have explored the prevalence of mental disorders. Some of the first large-scale studies were the Epidemiologic Catchment Area (1980-1985) (Bourdon et al., 1992) and the National Comorbidity Survey (1990-1992) (Kessler *et al.,* 1994), both conducted in the United States. It took several years before such studies were conducted in developing countries. Although a few surveys have been carried out in recent years, their methodological differences make it difficult to obtain comparable results, even within the same country. The World Health Organization has addressed this issue through the World Mental Health Project, a series of population surveys of identical methodology conducted as a coordinated effort in several countries (Kessler & Üstün, 2008). Nevertheless, some authors question whether it is valid to apply the same methodology to Western and non-Western settings (Weich & Araya, 2004). Methods of understanding, interpreting, and diagnosing illness are critical, and they cannot be limited to one lens; hence, it is important to understand the experiences of people and the role that factors like culture play in informing how they understand the illness. The study, which sampled 4,351 individuals, revealed that

15.8% of the population would experience an anxiety disorder, while 9.8% would encounter mood disorders over their lifetime. Similarly, the Global Burden of Disease report in 2016 highlighted that 15.9% of South Africans experienced a mental health issue, indicating a substantial burden. More recent studies, such as the one conducted by Wits University in 2022, have further underscored the prevalence of depression symptoms, revealing that approximately 25.7% of the population experiences symptoms associated with depression (Louw et al, 2023).

Acknowledging the limitations of the concept of trauma in Western society (Lewis-Fernández,), anthropologists are in a unique position to address the COVID-19 global mental health pandemic through culturally and politically contextual epistemologies of mental health (Fletcher *et al*., 2022) within the global sociocultural contexts where anthropologists are located (Briggs, 2020; Closser & Finley, 2016; Ennis-McMillan & Hedges, 2020; Kim, 2020; Palinkas et al., 2021). Anthropologists have been called on to align their professional capabilities and sensitivities to support the alleviation of mental health conditions incurred during the pandemic and to take direct action related to the development and implementation of solutions. This is because anthropologists pride themselves in their holistic approach to understanding phenomena from an emic perspective, which allows them to understand phenomena from the perspective of the people being researched.

For example, in rural Wisconsin, VA psychiatrists (psychiatrists that focus on prevention, evaluation, diagnosis, and treatment of mental health disorders in their patients) leverage anthropological techniques vis-à-vis narrative medicine (Charon, 2008; Sweet, 2021) to treat veterans with traumatic stress. Narrative medicine, which incorporates patient experiences during treatment, can improve clinical engagement and empathy, a nuanced understanding of how others are feeling, in settings where participants have experienced traumatic stress compounded by isolation (Remein *et al.,* 2020). Another application of narrative medicine is in the form of "writing therapy" or expressive writing, where instead of talking, trauma-affected individuals are instructed how to write about their thoughts and feelings about a given traumatic experience. Working in conjunction with clinicians, anthropologists have contributed to developing this type of intervention (Groleau, Young & Kirmayer, 2006; Sweet, 2021) that could be done individually, in a group setting, or via telehealth, enabling a greater treatment reach. This example speaks to the importance of understanding the experiences of people from their perspective so that a people-centred resolution that is culturally sensitive to the people being researched is implemented.

1.2.1 pregnancy and motherhood in the African context

Pregnancy and birth are celebrated in every part of the world (Wojtkowiak, 2020). In African cultures, because of the numerous superstitious beliefs, many families will perform different rituals to safeguard the pregnancy. It is believed that witches and evil spirits can steal the pregnancy or interfere with it. For that reason, the pregnant woman is not permitted to associate with the known witches in the neighbourhood or allow strangers to rub her stomach. Furthermore, a woman is not permitted to attend some social functions or perform some social tasks. For instance, a woman may not be permitted to go to some funerals or be involved with any morbid social issues (Nunez Carrasco et al, 2025). The superstitious beliefs and rituals in the African culture point to the fact that the mother abides by and agrees with rituals to ensure that the baby is safe both in the womb and after she gives birth, and it also points to a supernatural element that plays a role in ensuring the safety of the baby, whilst in the womb and for a safe delivery. These beliefs and superstitions have the potential to cause a considerable amount of anxiety during the pregnancy journey, as well as during the delivery and after giving birth. The birthing experience differs from women that are married and those that are not married.

For the unmarried woman, pregnancy can be dreadful and unbearable. A revolting stigma results from unwed pregnancies. Since pregnancy before marriage is considered forbidden, strangers and family members will ridicule, ostracise, or even subject the unmarried woman to violence (Echezona-Johnson, 2010). The mother-to-be will be considered a "whore" and a "prostitute." Furthermore, the pregnancy will be seen as a shameful event for the mother-to-be and her family. These out-of-wedlock pregnancies are considered shameful, and such pregnancies and births are not celebrated. Sometimes, to avoid the stigma associated with these pregnancies, the families may disown the pregnant woman and children born from out-of-wedlock pregnancies are considered "bastards" or "ifezandlebe. Children being conceived outside of marriage can also be as a result of fertility issues within the marriage.

Childless couples are seen as selfish. In some cases, they are ridiculed and insulted by their peers and families. In various African countries, the status of the mother-to-be and her family usually determines the outcome and the pregnancy experience Khosa-Nkatini, 2020). Being *inyumba* (barren) in the African culture is the most embarrassing reality for a woman, especially a married woman. This is viewed as not being blessed, and it can cause considerable turmoil

for a woman, put a great deal of strain on a marriage, and cause tension between "umakoti" and the bride *nabasemzini* (in-laws).

Motherhood as a social construct

Feminists in medical anthropology, such as Neyer and Bernardi (Thapa, 2023), assert that for many women, becoming a mother means changes to their lives that are often unimaginable until they have experienced motherhood for themselves. Motherhood encompasses the daily management of children's lives, and the daily care provided for them (Izhak and Aharoni, 2023). Mothering as a natural activity has been deconstructed to reveal existing cultural ideologies (Williamson et al, 2023). Women describe intense feelings associated with motherhood, ranging from overwhelming love to resentment towards their babies. They further argue that the depth of these emotions sometimes surprises and dismays the women themselves. According to Card (1996), "mother" is a term used to refer to women who give birth to a child and care for and raise a child. Childbirth marks a significant event in any woman's life as it is recognised as a rite of passage (Reed et al., 2016). Accordingly, childbirth has both a biological and a cultural definition.

The perceptions and experiences of motherhood are different in every culture. According to (Marken, 2025), "the diversity of the prevalence of postpartum depression across the cultures may assist researchers in understanding whether psychological or biological factors primarily bring on this disorder." Chodorow (1999) further argues that motherhood is presented socially as a biologically determined phenomenon. The good mother ideology refers to beliefs that women are only 'good' mothers if they adhere to the tenets of dominant parenting discourse, such as the intensive mothering ideology, which prioritises children's needs and child-raising above all else. Undergirded by this ideology, some mothers' attempts to navigate the transition to motherhood are fraught with pressure, and the transition is associated with adverse health outcomes for mothers and children (Williamson, 2023).

1.2.2 Postnatal depression

Maternal and child health are priority areas for public health interventions globally, including in South Africa (Gülmezoglu,et al., 2016). However, the targets to reduce maternal and child morbidity and mortality have been missed consistently in South Africa, with the mortality rates of children having increased during the Millennium Development Goals (MDGs) period in

1990 (Abajobir, 2025). Mental disorders are the most significant contributors to the disease burden among women of childbearing age, and poor maternal mental health often impacts the overall health of their children. Although the focus of postnatal depression (PND) is on the mother, it also has a wide range of neurodevelopment consequences for children (Abdollahi et al., 2017), including language development (van Heyningen, 2016). If left undiagnosed and therefore untreated, PND has long-term adverse outcomes on the well-being of both the mother and her child.

Postnatal depression affects women in the immediate postpartum stage, thereby impacting the ability of the mother to care for herself, her baby, and her family (Netsi et al., 2018). It has also been linked directly to a lower infant height and weight, higher rates of malnutrition and stunting, higher rates of diarrheal diseases, infectious illnesses, frequent hospital admissions, the reduced completion of the recommended schedules of immunisations in children, as well as the poor cognitive, social, behavioural and emotional development of the child, disturbances in the mother-infant relationship, the mother's insensitive engagement with the infant, and increased mortality in children up to five years (Chen et al., 2012).

Antenatal exposure to extreme societal stressors, which includes witnessing a violent crime and being in danger of being killed, difficulties with partners, and the father's negative attitude towards the infant, has been found to be associated with PND in South Africa (Redinger et al., 2018).

Although the negative impact of PND on both mother and child is well documented (Bernard-Bonnin, 2004), this area of maternal mental health has not enjoyed adequate attention in many countries, including South Africa (Mokwena & Masike, 2020). The symptoms of PND can be easily identified using the EPDS, a well-validated screening tool used in many countries (Novotney & Maurer, 2017). Although this tool is economical and easy to use, PND is not routinely screened for use in primary healthcare settings in South Africa. This is because the emphasis of maternal and child health priority in South Africa is on decreasing physical morbidity and mortality (Maternal, Newborn, Child and Women's Health, 2012). The implications are not only the lack of the estimation of PND but also that the majority of child-bearing Black South African women who receive their postpartum care at primary healthcare are neither screened nor treated for PND.

Postnatal depression is one of the most common causes of maternal distress, representing a considerable public health problem affecting the mother, her baby, and her family. Within the postnatal period, there is an increase in the physical and emotional demands on the woman, and the debility associated with postnatal depression may impinge on her capacity as a mother, for example, to care for and bond with her new-born (Van der Waerden *et al.,* 2015). Without diagnosis and treatment, maternal postnatal depression may affect her ability to participate in normal activities and interfere with her family and other social relationships (Arifin *et al.,* 2018).

Currently, two paradigms exist in explaining and understanding the etiology of postnatal depression. The first is the medical model, which explains that internal factors such as personality and biophysical factors cause postnatal depression in women (McIntosh, 1993). Within this model, biophysical factors such as hormonal changes following childbirth have been implicated in the development of postnatal depression (Martinez et al., 2000; McIntosh, 1993; Nicolson, 1998). From this perspective, postnatal depression is conceptualised as an illness or disease. The second paradigm that explains the aetiology of postnatal depression is the social model. Within this model, social factors within the individual's circumstances are implicated in the development of postnatal depression (McIntosh, 1993). This study aims to explore the understanding of Black African women residing in Durban, KwaZulu-Natal understanding and the interpretation of postnatal depression. In this study, postnatal depression will be looked at from the medical model and from the concept of 'the person.' These concepts will be discussed in the literature review.

<u>Prevalence rate of postnatal depression</u>

Postnatal natal is an internationally recognised public health concern, defined as a severe maternal mental health problem occurring within four to six weeks after childbirth. Postnatal depression affects 15% of postnatal women; the disease is well-documented in low and middle-income countries (Arifin et al., 2018). The overall combined prevalence of postnatal depression has been estimated to be 16.84% in Africa. At the same time, a range between 6% and 50% has been reported in Sub-Saharan Africa (SSA) and 16.4% to 50.3% in South Africa. Several studies in South Africa have reported variations of postnatal depression prevalence among adolescents (26%), women living with HIV (25% to 45.1%), in rural settings (47% to 50.3%), peri-urban settlements (30% to 34.7%), urban areas (16.4%) and different provinces (34.7% to

49.3% (Modjadji & Mokwena, 2020). Depression is evident in different geographical spaces, although it is more prevalent in certain regions than others. PND remains underdiagnosed and undertreated in different socio-economic backgrounds in South Africa. KwaZulu-Natal has the highest antenatal HIV seroprevalence at 44.4%, with a reported 2% increase each year (Mbatha et al., 2020).

It is also a political and social phenomenon (Esposito, 1999; Schneider, 2002) argues that social and cultural power creates the potential for diversity in birth, beliefs, practices, and experiences. Liamputtong states that "the social meaning of birth is shaped by the society in which the birthing women live" (Liamputtong, 2005: 2). Martin *et al*. (2003) asserts that our cultural attitudes towards birth differ according to the individuals' social culture, social class, and social resources. For example, middle-class women seek more medical technology to control their births (Liamputtong, 2005). According to Davis-Floyd, human actions, such as the cultural creation of traditions, customs, and rules, directly construct childbirth practices. These actions take place through social interactions, communication, and exchanges inside social institutions (Klein *et al.,* 2006).

A recent white paper by the Witwatersrand Medical Research Council (2024), Developmental Pathways for Health Research Unit (DPHRU), reveals that 25.7% of South Africans are most likely depressed, with more than a quarter of respondents reporting moderate to severe symptoms of depression. Researchers have consistently found that depression is more likely to be chronic, severe, and immobilising for Black African women compared with their White counterparts. Furthermore, Some Black women are less likely to seek or receive adequate mental health treatment. Moreover, when Some Black women do seek treatment, they are less likely to receive an adequate amount of treatment, in part because providers detect their depression less often and often delay seeking treatment until symptoms are severe and misdiagnose their depression as psychotic disorders, such as schizophrenia.

Depression amongst Black women is associated with a sense of weakness; hence, it continues to be understudied. Cultural perceptions included the "strong woman syndrome," which contains messages that (a) women could manage mental illness personally, (b) mental illness is unacceptable among Black women, and (c) silence, rather than the self-disclosure of emotions and feelings, is preferred (Nelson et al., 2020). Ngcobo-Sithole's study (2008) confirms this fact as it revealed that in South Africa, inadequate mental health services, in

general, and specifically for African people in our society, have led to the underreporting and underdiagnosing of the disorder.

The prevalence of postnatal depression in South Africa has been reported to be higher than in other African countries, which may be partially explained by a range of reported risk factors experienced by South African women. The prevalence of postnatal depression in South Africa varies across communities and socio-economic status. While the prevalence of postnatal depression may be as high as 34.7% in a peri-urban area (Tomlinson et al., 2006), a recent study reported a higher prevalence of 50.3% in a rural setting (Abrahams & Stellenberg, 2015). In a recent survey conducted among adolescents in Kwa Zulu Natal, postnatal depression was reported to be as low as 9.0% (Govender *et al.,* 2020), which contrasts with a high of 49.3% reported in Tshwane among an older sample (Mokwena & Shiba, 2014) Because of the wide variations in prevalence estimates in different communities and because South Africa does not have frequently and routinely collected data on postnatal depression, which would provide country estimates, it is necessary to conduct studies in different areas of the country.

Mokwena and Masike (2020) argue that this area of maternal mental health has not enjoyed adequate attention in many countries, including South Africa. An example of the above-mentioned is as follows: previously, it was postulated that African women were not affected by postnatal depression due to traditional rituals and other cultural factors. The traditional rituals acted as protection and preventative methods to safeguard African women. However, this assumption has been refuted because of the existence of empirical evidence of postnatal depression in Africa and beyond (Modjaji, 2020). The researcher viewed this reality as a knowledge gap and an opportunity to contribute to the body of knowledge on how Black African women residing in Durban, Kwazulu-Natal, understand and interpret their experiences of postnatal depression. Thus, this study used a qualitative approach and an emic perspective to learn more about this phenomenon in the Black African community.

The field of anthropology prides itself on using a holistic approach when conducting research by including biological (biocultural) perspectives in the study of humankind (Boskovic, 2010). This study is located within the contours of medical anthropology. Conceptually and methodologically, medical anthropology is well-positioned to support a “big tent” research agenda on health and society. It fosters approaches to social and structural health and well-being models in critically reflective, cross-cultural, people-centred, and transdisciplinary ways.

Medical anthropology is a subfield of anthropology that draws on social, cultural, biological, and linguistic anthropology to understand those factors better which influence health and well-being (broadly defined), the experience and distribution of illness, the prevention and treatment of sickness, the healing processes, social relations regarding therapy management, and the cultural importance and utilisation of pluralistic medical systems (Omobowale, 2022). The discipline of medical anthropology draws upon many different theoretical approaches (Jaiswal, 2018). Medical anthropology examines how health and well-being are constituted socially and culturally in comparative and transnational contexts and how culture influences the experience of illness, the practice of medicine and the process of healing for the individual and community (Panter-Brick & Eggerman, 2018).

This study examined the relationship between culture and PND, their role in influencing how mothers interpret PND, health in general, and the diagnostic and treatment avenues. Medical anthropology involves an up-close, person-centred, and ethically engaged examination of the complex cultural dynamics that underpin and give rise not only to health and wellbeing, illness, and death but also the medical systems on which we rely for treatment and cures (Raikhel, 2012). It explored how the experiences and perceptions of the body, self, or notion of the individual or person influence the illness experience. It is also concerned with how cultural values and practices shape and are themselves shaped dynamically by biomedical research and practice and non-Western medicines and healing traditions (Jaiswal, 2018). Accordingly, this research is interested in the experiences of mothers living with PND, the role of how their beliefs, be they Western or African, shape their experiences, inform how they understand PND and their coping mechanisms as well as their preferred treatment avenues.

1.2.3 Culture and mental health

'Culture' is a core concept in cultural anthropology, so it may seem that cultural anthropologists will likely agree with what it is. In the 1950s, an effort to collect definitions of culture resulted in the formulation of 164 different cultures (Kroeber & Kluckhohn, 1952). Since then, no one has tried to count the number of definitions of culture used by anthropologists. The British anthropologist Sir Edward Tylor proposed the first definition in 1871. He states, "Culture, or civilisation is that complex whole which includes knowledge, belief, art, law, morals, custom, and any other capabilities and habits acquired by man as a member of society" (Kroeber & Kluckhohn 1952: 81). Culture plays a prominent role in the perception, experience, response,

treatment, and outcome of mental illness (Siewert et al., 1999). Significantly, culture not only influences mental health and disease, but is also an essential part of it (Sam & Moreira, 2012). Mental illness is the product of a complex interaction among biological, psychological, social, and cultural factors. Depending on the disorder, the role of any of these major factors can be stronger or weaker (DHHS, 1999). Cultures also vary regarding the meaning they impart to illness and how they make sense of the subjective experience of illness and distress (Daniels & Isaacs, 2023). The symptoms of mental disorders are found worldwide. Mental disorders are defined in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association [APA], 2016). Schizophrenia, bipolar disorder, panic disorder, obsessive-compulsive disorder, depression, and other disorders have similar and recognisable symptoms throughout the world (Weissman et al., 1994, 1996, 1997, 1998). Culture-bound syndromes, which appear to be distinctive in certain ethnic groups, are the exception to this general statement. The research has not yet determined whether culture-bound syndromes are distinct from established mental disorders, are variants of them, or whether both mental disorders and culture-bound syndromes reflect different ways in which the cultural and social environment interacts with genes to shape illness (DHHS, 1999).

Mental illness and culture cannot be isolated, as culture plays a crucial role in the perception of mental illness. Cultural relativists emphasise that concepts are socially constructed and vary across cultures. As mental illness is a social construct, different cultures have their own beliefs about finding the aetiology of mental illness, as well as its treatment and intervention processes (Scott & Marshall, 2004; Jimenez, Bartels & Cardenas, 2012). It is not only culture but also time and situation/place that have influenced the determinants of mental health. Due to those changing determinants, it is exceedingly difficult to define mental illness. According to the biomedical model, mental illnesses are “fundamentally biological in origin, and, given the common physiology of homo sapiens worldwide, psychopathology will be essentially homogeneous, with only superficial disparities in presentation across peoples” (Thakker & Ward, 1998: 502). The biomedical model of mental illness focuses on the cause of mental illness, namely by regarding it as a neurotic problem, and it is considered to be a disease like other physical diseases (Foucault, 1957).

The biomedical model of mental illness is linked to an individualist ideology where mental illness is treated and diagnosed as something purely individual. Opposing this biomedical view, Marsella and Yamada (2000) have indicated that mental illness is closely connected to one’s

culture, poverty, and helplessness and is backed by powerful socio-political and economic structures. Thus, social constructivist frequently argues against the validity of the medical model of mental illness and claims that mental illness is a politically and socially constructed phenomenon (Szapocznik & Kurtines, 1993). These are formed in the cultural and sociopolitical context of society (Siewert et al., 1999).

It is important to note that the definition and interpretation of PND may vary according to every group of people and may depend on factors such as culture, religion, and beliefs. How mental illness is expressed as it is manifested within Africa, ranges from aggression, destructive behaviour, excessive talking, wandering around and being eccentric (Dankner *et al.,* 2000). These are the observable behaviours that are found within African cultures. The levels of sympathetic behaviour towards individuals who are mentally ill within communities appear to be low, where it is mainly females who seem to be more sympathetic in this regard.

A study indicated that literacy also has an impact on the sympathy exhibited by individuals in a community, suggesting that literate individuals within the community are more likely to exhibit positive feelings towards mentally ill individuals (Suwanwong and Jansem, 2024). Furthermore, Kubheka (2007) mention that in the Zulu culture, there is a hierarchy of vital powers that govern the manifestations of illness and disease. At the top of this hierarchy is a deity with the most incredible power, followed by lesser spiritual entities, ancestral spirits, living people, animals, plants and objects. There are also specific names and descriptions used in both the Zulu tradition and the psychiatric view to categorise disorders. The categories demonstrate a range of symptoms experienced by traditional healers (Veling et al, 2022). These include ukuthwasa (a calling to be a healer), ukuhlanya (madness) and amafufunyana (possession by evil spirits, amongst others). Healing in the Zulu culture depends on the origin of the problem or the illness (Myeza, 2025). Costa-Font, (2024) also reports that spirits of deceased ancestors are frequently held responsible for sending illness because the living have transgressed in one way or another.

Although there is now a wealth of evidence about symptoms across different cultural settings, the role of the health system in addressing these problems remains contentious. Examples of these symptoms (emotional, physical and psychosis) are as follows: the inability to manage or control one’s emotions, continuous or frequent episodes of anger or rage, the failure to manage or control one’s emotions, continuous or frequent episodes of anger or rage, excessive or

irrational fears. engaging in risky behaviour, excessive worrying and/or sadness, hallucinations, schizophrenia, depression, and bipolar disorder. These medical symptoms are indicators of Western mental health illness and challenges. Risk behaviour is associated with one wanting to harm oneself or having excessive or irrational fears that are associated with anxiety. Hallucinations are associated with psychosis, and schizophrenia is a categorised mental health illness (WHO, 2017).

The above symptoms lean towards the Westernised category of symptoms, and there is a category that links the symptom to the type of mental health illness. The African-bound mental health illness also has a category and terminology that is related to the symptom. For example, eating from the bin falls under the category of being “crazy” (Cockerham, 2020). The emotions and behaviour, such as not feeling connected to one’s child after birth or feeling down after giving birth, is a cultural shock, and the African culture is still grappling with this reality. There is a tug of war when it comes to understanding PND. Should the symptoms not “fit” into the African culture-bound category of mental health illness or not fit into the Westernised category of Western mental illness, then the symptoms or the mental illness becomes the “the other.”

Depression is undetected among people attending health facilities (Mayston *et al*., 2020). This statement is inspired by the seminal work of Marcel Mauss between 1935 and 1985; a major theme in psychological anthropology has been the concept of *‘the person’,* understood as a social and cultural construct that underlies self-understanding and self-representation,(Rathod, 2017). Implicit cultural *concepts* relating *to the person*, which are understood, shape current psychological theories of development and social behaviour, psychological assessment, psychopathology, and forms of psychotherapy (Moleiro, 2018).

The study of anthropology is interested in understanding a phenomenon from the perspective of the researched as they share their experiences. The above perspective is termed “cultural relativism.” The early anthropologist Franz Boas first used the idea of cultural relativism in 1887 (Hahn*,* 2023), but the concept did not have a name until Alain Locke coined the term in 1924. This concept is now accepted by anthropologists worldwide (Lewi et al, 2016). Cultural relativism is an idea that opposes ethnocentrism (Moleiro, 2018). As stated above, cultural relativism ‘normalises’ African manifestations of illnesses because each culture has its own belief systems. Brown *et al.* (2020) assert that medical anthropology, a distinct sub-speciality within the discipline of anthropology, investigates human health and healthcare systems from

a comparative perspective, considering a wide range of medical anthropology, a distinct sub-speciality within the discipline of anthropology, and investigates human health and health care systems from a comparative perspective, considering a wide range of bio-cultural dynamics that affect the well-being of human populations and this falls under cultural relativism. Cultural relativism is important, especially in medical anthropology, because many culturally bound illnesses are viewed as “exotic, primitive, other and abnormal” according to the standard understanding and interpretation of illnesses.

Due to the manifestation and variations of symptoms cross-culturally, especially when it comes to mental illness, cultural relativism is most important because it allows for an emic perspective that confronts the ethnocentric or Western view of understanding, but it provides for an Afrocentric approach that “normalises” and destabilises notions or dialogues that take away from being culturally sensitive and open to other people’s experiences and understanding of phenomena from their perspective. This study aims to understand postnatal depression from the viewpoints of Black African women. Cultural relativism argues that every culture, its morals, and values have its context, which must be accessed impartially. They assert that no universal values and ideas can encompass all the diversity the universe has to offer and present them on one page (dos Santos, 2019). This statement helps societies to understand culture-bound illness.

For example, Western and Eastern approaches to medicine are different: for example, they have two different conceptions of the body, mind, and disease. In general, Western medicine aims for precision, analysis, and targeted therapies, while in Eastern medicine, the mind-body system is the main focus, and medical care is aimed at harmonising it. Another big difference is that Western medicine is specialised: doctors focus on a single organ, detect the symptoms, and prescribe the tests for that system in a few minutes interview. The medical diagnosis follows from the laboratory results and completes what emerged during the interview. In Eastern countries, however, traditional medicine always considers the person as a whole, including the psychological aspect (Costa-Font and Sato, 2025). Medical anthropology, a distinct sub-specialty within the discipline of anthropology, investigates human health and healthcare systems from a comparative perspective, considering a wide range of bio-cultural dynamics that affect the well-being of human populations. Medical anthropologists study the perceived causes of illness, and the techniques and treatments developed in a society to address health concerns. Using cultural relativism and a comparative approach, medical

anthropologists seek to understand how ideas about health, illness, and the body products of particular social and cultural contexts (Brown et al., 2020).

Another example is that social and cultural determinants impact individuals' health beliefs, behaviours, help-seeking patterns, and healthcare utilisations significantly. Recognising and accounting for cultural differences is crucial as the meanings and understanding of health, illness, and well-being are shaped by culture (Rice & Liamputtong, 2023). For example, in Sub-Saharan Africa, four types of traditional healers provide health care: traditional birth attendants, faith healers, diviners and spiritualists, and herbalists. For many African American members, health beliefs reflect cultural roots that include elements of African healing, medicine of the Civil War South, European medical and anatomical folklore, West Indies voodoo religion, fundamentalist Christianity, and other belief systems. Culture influences how individuals manifest symptoms, communicate their symptoms, cope with psychological challenges, and their willingness to seek treatment (Keith, 2019).

1.2.4 Culture-bound syndromes

This study builds on the existing literature published by social work, psychology, and psychiatry scholars. The contribution is uniquely embedded in anthropological theories with a greater understanding of people's cultural interpretation of mental illness, which is also known as a culture-bound syndrome. Ogundare (2019) observes that mental health professionals are dealing with a multicultural patient population increasingly. Thus, there is an urgent need for an awareness of the influence of culture in understanding a patient's expression of distress, assigning symptoms to a diagnostic category and planning treatment in culturally appropriate ways. Cultural bias can lead to a misdiagnosis and can have devastating consequences for patients. Understanding culture helps us understand the daily behaviours on which good health and well-being depend (Napier et al., 2014)—especially postnatal depression because it is underdiagnosed and undertreated. A holistic approach that encompasses both the Western and cultural perspectives is needed to understand the illness better by health practitioners and different communities in societies. Brown *et al*. (2020) explain that medical anthropologists study the perceived causes of illness, and the techniques and treatments developed in a society to address health concerns. Medical anthropologists use cultural relativism and a comparative approach to understand the ideas about health, illness, and the body products of particular social and cultural contexts.

In the Black African body of knowledge of health beliefs, there are manifestations of illness and mental illness that are categorised as foreign or abnormal, as well as manifestations that are seen as normal and within the Black African body of health beliefs. Mental health and mental illness are areas where ethnomedicine has been particularly productive in highlighting the cultural diversity of illness, knowledge and care for those considered ill. More generally, the ethnographic description of illness experience has long been central to medical anthropology, giving rise to numerous theoretical questions regarding the ways illnesses gain legitimacy or become stigmatised (Rivkin-Fish, 2018)

Brown *et al.* (2020) explain that medical anthropologists study the perceived causes of illness, and the techniques and treatments developed in a society to address health concerns. The discipline of medical anthropology draws upon many different theoretical approaches (Jaiswal, 2018). Conceptually and methodologically, medical anthropology is well-positioned to support a "big tent" research agenda on health and society. It fosters approaches to social and structural models of health and wellbeing in ways that are critically reflective, cross-cultural, people-centred, and transdisciplinary. Medical anthropology examines how health and well-being are constituted socially and culturally in comparative and transnational contexts and how culture influences the experience of illness, the practice of medicine and the process of healing for the individual and community (Panter-Brick & Eggerman, 2018). This study looked at the relationship between culture and postnatal depression, the role that they play in influencing how mothers interpret postnatal health in general and as well as the diagnostic and treatment avenues. Medical anthropology involves an up-close, person-centred, and ethically engaged examination of the complex cultural dynamics that underpin and give rise not only to health and wellbeing, illness, and death but also the medical systems on which we rely for treatment and cure (Blackshaw, et al, 2018).

Culture plays a significant role in many aspects of mental health worldwide (Gopalkrishnan, 2018). Cultures affect how mental illness and mental health are perceived. Hence, it can shape the attitudes of mental health service users, their help-seeking behaviours, and how the mental health support system is created (Gopalakrishnan, 2018; Kotera, 2018). Therefore, the perception, understanding and view that each group of people has about mental health is important because it has the potential to influence and inform how they respond to the symptoms of mental health. It informs the individual or people which treatment avenue to consider, be it a Western (biomedical) or a traditional (cultural) treatment avenue.

1.2.5 Types of depression

The term "depression" often characterises feelings of being sad, discouraged, hopeless, irritable, and unmotivated, as well as a general lack of interest or pleasure in life. Depressive disorders fall under the category of mood disorders and include major a depressive disorder, a persistent depressive disorder, postpartum depression, postnatal depression and depression in bipolar disorder. Depressive disorders can affect people of any age, including children, teenagers, adults, and older adults (Bains & Abdijadid, 2020).

There is an ambiguity in the variation of depressive symptoms. The ambiguity can be expressed from a Western biomedical perspective and an Afrocentric ethnomedicine perspective. Some of the manifestations of depression have the same element that would be classified in the African culture under superstitions, witchcraft, ancestral worship and being bewitched. For example, bipolar disorder is a mental illness that causes dramatic shifts in a person's mood, energy, and ability to think clearly. Bipolar people experience high and low moods-known as mania and depression-which differ from the typical ups and downs most people experience (Jain, 2020). The symptoms of bipolar in the Zulu ethnic group can be interpreted with regard to a person "*oneconsi*" (who gets upset quickly) *unama* moods (a person who is moody) *unolaka* (one who has a lot of anger) or uhlanya (one who is crazy). Hence, language is extremely important when dealing with mental health because of culture-bound syndromes.

Worldwide, around 50 million people live with dementia, and this number is projected to increase to 152 million by 2050, rising in low-income and middle-income countries, particularly where around two-thirds of people with dementia live (Livingston *et al*., 2020). The word "dementia" describes a set of symptoms that may include memory loss and difficulties with thinking, problem-solving or language. These changes are often small to start with, but for someone with dementia, they have become severe enough to affect daily life. Persons with dementia may also experience changes in their mood or behaviour (Parkin & Ulijaszek, 2020). Similarly, with the bipolar condition, the African interpretation of the symptoms of dementia might be attributed to one having an ancestral calling, hallucinating because of "*ukuthakathwa*" being bewitched or hallucinating or being punished by *amadlozi* (ancestors) for not adhering to their demands or for failing to perform a ritual.

1.3 Motivation for study

What motivated me to pursue this study with a focus on postnatal depression amongst Black African women is that growing up, I have always heard the phrase "ubuntu silazane uyimboko", meaning that women are rocks. They can carry any burden without crumbling, "umuntu wesi mama uhlezi akha i-plani." In my mind, being a woman has always been associated with being strong and running a household. I watched a local South African soapie, Muvhango, where one of the character,s a Black African woman was diagnosed with postnatal depression. That was a cultural shock to me. The saying "*ayikho indlovu esindwa umbombo wayo"* came to mind. It means no burden is too heavy for the one who carries it. I grappled to understand how one can carry a child and then have no connection or bond with one's offspring.

As a Zulu girl, I have been told that marriage and having children are the most fulfilling experiences for a woman. Motherhood is something that comes naturally to a woman. It is not something learnt or a transition to which one has to adjust. Women are designed to be mothers. In my mind, motherhood was a natural phenomenon, and biology, medicine, and hormones really did not have a role to play. When I learnt the facts about postnatal depression at first, they seemed unnatural, but the more I read about it, the more I learnt about it. I realised that my cultural beliefs and African proverbs about women being strong and being able to hold the fort regardless of how strained they are, were preventing me from embracing this newfound knowledge. They had normalised "suffering." Any behaviour that indicated that one was not coping and was giving up, was viewed as "unnatural." It is unheard of, an absolute taboo. It is against the nature of motherhood. When I found out that I was pregnant and experienced morning sickness and food preferences, that alone proved to me that the pregnancy journey was a difficult one. There are so many adjustments. Numerous factors are involved: psychological, financial and cultural, amongst others. If it were not for the support of my family and spouse, I would not have coped during the pregnancy and post-pregnancy. Among the medical information, cultural beliefs about pregnancy and post-pregnancy, baby development applications, and the information available out there, I needed to find a belief that worked for me.

Most importantly, it was a belief that would not stress me out but would enable me to embrace the transition I was going through. I needed a belief encompassing the realities of being overwhelmed because I suddenly went from getting enough sleep to sleepless nights. I went from having a social life to not having one during the first year. I went from having a family of two to having an additional person one hundred per cent dependent on me. I needed a belief

that said it is normal and natural, and most importantly, what I am going through gets overwhelming, and that is fine. It is acceptable for me to ask for help. It does not make me less of a woman or a mother. Pregnancy and motherhood are challenging! It is a considerable adjustment. This prompted an urgency in me to initiate narratives with Black African women about their experiences during pregnancy and the transition to motherhood. I wanted to find out how they coped, how they view and understand postnatal depression and the role of culture and cultural beliefs during pregnancy and after giving birth.

1.4 Research problem and objectives: Key questions asked

This study aimed to probe the experiences of Black African women about motherhood and postnatal depression. Postnatal depression is a phenomenon that was thought to be a white person's illness/disease. Meaning that Black African women were immune to being diagnosed with postnatal depression. However, that is no longer the case, as a study conducted by Modjadji (2020) indicates that postnatal depression exists in the Black African community. Hence, the researcher wanted to explore the experiences of Black African women with postnatal depression. To address this knowledge gap, the symptoms needed to be known, and the treatment avenues needed to be discussed so that Black African women are not misled. Instead, they need to understand the seriousness of postnatal depression and find the help that they need. This study also anticipated gaining insight into their interpretation of health in general and specifically about postnatal depression. Furthermore, it explores if culture affects how they view or interpret their health. To examine the role of support networks for mothers, such as the KwaZulu-Natal's Mums Support Network and their role in helping mothers cope with the transition to motherhood as well as their experience with postnatal depression.

The research questions are as follows:

1. What is the understanding amongst Black African women (mothers) residing in Durban KwaZulu-Natal of postnatal depression?
2. How effective are social networks in assisting Black African mothers cope with their role as mothers and to cope with postnatal depression?
3. What is the influence of cultural beliefs in the understanding of postnatal depression amongst Black African women (mothers) residing in Durban, KwaZulu-Natal.

4. What is the role of culture amongst Black African women (mothers) in understanding their general health?

1.5 Research problem and objectives: Broader issues investigated

Postnatal depression is a lived experience that Black African women are learning to navigate. It is a cross-cultural illness that is a mental challenge that needs to be paid attention to in order to priorities the wellbeing of the mother and her newborn. The cause of postnatal depression is currently known to be multifactorial (Carlson et al, 2025). It is important to conduct such studies because it gives insight into how different ethnic groups understand and interpret postnatal depression.

This study, therefore aimed to probe the experiences of Black African women (mothers) residing in Durban, KwaZulu-Natal, about postnatal depression.

1.6 Study challenges

Under this section the challenges that the researcher faced are presented together with the resolutions. To ensure the reader that suitable resolutions were implemented and that the study remained relevant.

The researcher's first attempt at recruiting participants through purposive sampling allowed the researcher to identify five participants. These five research participants from KwaZulu-Natal's Mums Support Network referred five of their friends who were not part of the Mums Support Network but fitted the study's criteria through referral (snowballing).

The shift from freely accessing the university to online learning brought about a delay in the academic processes, specifically the data collection process. As a scholar, one prides oneself on being able to immerse oneself in fieldwork and to 'blend in' during the data collection processes such as participant observations and unstructured interviews, for example. One's presence in the field, the privilege of observing, which usually adds rich and thick descriptions, was hampered. Recruiting participants via technology was challenging and sometimes costly because it required data, airtime, creativity, and making digital posters and videos to explain the study. Technology was another challenge; not everyone had a relative application on their phone, such as Microsoft Word or Adobe, to download the documents. Hence, some mothers

had challenges opening the consent form documents and the interview schedule, and we learnt how to download the applications. Privacy at home during COVID-19 was also challenging because some people were working at home, and the schools were closed. However, the mother's family members were eager to babysit while the research participants participated in the interviews. Load shedding was a considerable challenge because I did not know about the loadshedding application. As a result, when load-shedding struck, it caused dilemmas and setbacks because the network would disappear, my laptop battery would die, and I would have to postpone and reschedule the interview. The same situation applied to the mothers; they would also postpone the interview due to load-shedding.

1.7 Structure of dissertation

Chapter 1: Introduction

The introductory chapter introduces the study and contextualises it with regard to mental health under the branch of medical anthropology. The problem statement was centred around the experiences of Black African women residing in Durban, KwaZulu-Natal, about postnatal depression and was supported by citing the relevant literature. The objectives and the research questions of the study are presented in this chapter. In addition, the ethical considerations that the study applied are explained.

Chapter 2: Literature review and theoretical framework

The literature review and the theoretical framework are combined and presented in the same chapter. The literature review of the study defines the concepts that illuminate the study, such as mental health, postnatal depression, culture and support groups. The research objectives of the study guide the discussion in the literature review. postnatal depression.

Chapter 3: Methodology

The methodology chapter presents the road map to reach the data analysis stage. The qualitative nature of the study is discussed in the title of the study. The interpretivist paradigm is defined and contextualised within the study. The phenomenology research design is elaborated upon, and semi-structured interviews are used as a form of data collection tool. The study limitations,

reflectivity and the ethical considerations of the study are discussed. Furthermore, the theoretical framework of the study is discussed by presenting two theories, namely, the identity theory and the social constructivist theory. These two theories are used to explain and understand the phenomenon of Black African women residing in Durban KwaZulu-Natal and their experiences with

Chapter 4: Postnatal depression as we know it

This is the first of three chapters on data presentation and analysis. It addresses objective number one of the studies. The participants share their understanding and interpretation of postnatal depression, their symptoms, and their treatment avenues based on their experiences. The participants also give an African and as well as a Western perspective of their understanding and interpretation of postnatal depression. Their health belief system is reflected through their perspective.

Chapter 5: Support groups and Postnatal depression

This is the second of the third data presentation and analysis chapters. This chapter addresses objective number 2 of the study, namely, to probe the effectiveness of social networks in assisting Black African women (mothers) residing in Durban, KwaZulu-Natal, to cope with their role as mothers' and with postnatal depression. The participants' responses to different types of support groups are presented: support from the KwaZulu-Natal Mums Support Network, peer support, support from family and friends, and social media groups.

Chapter 6: Black African mental health and illness

This is the final chapter of the data presentation and analysis chapter. It speaks to the psyche of Black African mental health, illness and postnatal depression. It draws on the narratives from the participants' responses and taps into their experiences. Concepts such as 'witchcraft,' 'ancestors' and 'superstition' are discussed as factors impacting mental health, illness and postnatal depression.

Chapter 7: Conclusion, contribution and recommendations

This chapter recapitulates the research objectives and research questions of the study. It also highlights the key findings of the study. In addition, the study outlines its contribution and recommendations are noted.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

The literature presented in this chapter is guided by the objectives of the study. Culture is defined and its link to the study is outlined. Mental health is defined and elaborated on from both an Africa and from a western perspective. Postnatal depression is explained from a biomedical and from a cultural perspective. The role of support networks in providing support to mothers experiencing postnatal depression.

2.2 Contextualising the study in culture

Interest in culture has traditionally been the domain of anthropology, sociology and, more recently, cultural studies rather than medicine and public health. The public health literature generally offers little in the way of a meaningful understanding of the 'cultural' concept. Instead, the idea of culture tends to be employed uncritically, with reliance on an assumed understanding of culture and the cultural practices implicated in health (Kirkbride et al ,2024). However, this study is an example of culture being employed critically as a factor in understanding postnatal depression. A medical model and the 'the person' concept exist to explain and understand illness. Furthermore, in the Eurocentric perspective, the Western belief system uses psychology and psychiatry as disciplines to study and understand human psychology and to detect mental health. From the Afrocentric perspective, the African belief system uses traditional healers, superstition and witchcraft to understand illnesses and mental.

Anthropologist Edward Burnett Tylor (Tylor, 2021) has defined culture as "that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society." Tylor was the person who used the word "culture" in the social sciences for the first time. This definition is prevalent and highly accepted and depicts culture accurately. Another definition given by the United Nations Educational, Scientific and Cultural Organization (Koçyiğit and Küçükcivil, 2022) is that culture should be regarded as the set of distinctive, spiritual, material, intellectual, and emotional features of society or a social group, and that it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions, and beliefs.

In the social sciences, culture is related to human society, including the social experiences, ethics, attitudes, values, and ways of life transmitted socially rather than biologically. Culture passes from generation to generation through members of society. It has many dimensions, including ethnicity, race, religion, age, sex, family values, the region of the country, and many other features (Eramus, 2025).

Social anthropologists distinguish between 'culture' and culture;' 'culture' signifies the social heritage of mankind, and 'a culture' signifies the social heritage of a particular person (Gündoğan, 2021). It is a way of life for a specific person or group. Culture is a learned process that changes over time and consists of tangible and intangible behaviours. Cultural traits and norms shape our normative behaviour practices and beliefs, influence our thinking processes and define the everyday activities of a specific human group. Nowadays, culture has been categorised and compared in terms of Western versus non-Western or modern versus traditional societies in the social sciences (Brenner and Schmid, 2015).

Although arguments around definitions and explanations of culture persist, this research does not intend to enter this debate. Liu (2021) argue that efforts to define the term would reify culture and fail to acknowledge the broadness and complexities of the concept. Fundamentally, the term "culture" refers to a way of life of a group of people or society that is shared and learned (Causadias, 2020). It is not a tangible or static entity nor confined to what is observable, whether that includes behaviours or belief systems. Commonly, definitions of culture tend to emphasise the shared meanings and understandings behind what is observable (Fridan and Maamari, 2024). According to (Aririguzoh, 2022), culture consists of the abstract values, beliefs, and perceptions of the world that lie behind people's behaviour and are reflected in their behaviour. Members of a society share these, and when acted upon, they produce behaviour that is intelligible to other members of that society.

Cultures are learned mainly through language rather than inherited biologically, and the parts of a culture function as an integrated whole. The role of culture encapsulates the meaning of life and the shared beliefs and knowledge in peoples' lives. The meaning of culture also trickles down to the factors that influence the belief systems of the health and wellness of people. It also informs the treatment avenue that they utilise. In the case of postnatal depression, the behavioural changes that come with postnatal depression can be a huge culture shock that contrasts African proverbs that emphasise the nature and nurture relationship between mother

and child. They emphasise the natural bond and relationship between a mother and her newborn baby that starts in the womb. Feeling disconnected from one's newborn baby is one of the psychological symptoms of postnatal depression. Hence, cultural awareness is especially essential in the medical field when treating a person because culture can shape how one interprets sickness. Cultural blindness gives rise to being biased, thus not taking time to understand the illness of a particular race. The cultural show allows us to learn about other people's way of living, which might be 'different' (Jialin, 2023).

Cultural influences on health can be viewed from two major perspectives: Cultural variations in health (health disparities) and cultural variations in approaches to health (Gurung, 2019). The healthcare professional and the patient often come from different social and cultural contexts. Cross-cultural medicine recognises that medical practice is socially and culturally "situated". This is because Western medicine itself is a cultural system. Therefore, almost all encounters are "cross-cultural" (Brailovskaia, 2022). The study of anthropology seeks to understand cultural bound syndrome based on people's beliefs and interpretations of the symptoms that people socially construct as their experienced mental illness. This study aims to understand postnatal depression from the perspective of Black African women residing in Durban, KwaZulu-Natal, and also to learn more about the variations in symptoms experienced as well as the preferred treatment avenue and the beliefs that inform how to interpret postnatal depression.

Kheir (2018) asserts that even for the elite Africans who are well-versed in the biomedical and biopsychosocial models of health, illness and health typically operate within a duality, with a spiritual current running alongside the biopsychosocial model. In contrast to the indigenous model of health and illness, the biomedical and biopsychosocial models operate with the view of health as a combined element of mental, emotional, social and physical factors (Asare & Danquah, 2017) and explain health and illness using the germ theory of disease (Mantey, 2010). As argued by Asare and Danquah (2017: 49), "for the African, however, wellbeing is not just about the healthy functioning of the body system through proper healthcare and lifestyle, but well-being goes beyond scientific causes to include spiritual involvement (Adodo, 2020) which constitutes a "modification of the biopsychosocial model to include spiritual factors" (Idemudia & Adedjeji, 2017: 49). The Black African psyche is embedded in these notions of spiritual factors when it comes to explaining the causes of illness.

2.3 Afrocentrism and mental health

Wellbeing as a subject is often looked at from a Western perspective, including definitions and measurements. This, however, ignores the sociocultural characteristics of individuals or groups that may be crucial to the subjective conceptualisation of well-being. The concept of 'well-being' in this sense also runs counter to the idea of well-being in Western cultures. The African is a 'group person,' a 'family person' and the 'we person'. These sociocultural features are presumed to affect or influence well-being, mental health and treatment (Idemudia & Adedeji, 2023). Hence, illness in the Black African community cannot be looked at in isolation of the family or the community because the African identity has a shared identity that has cultural constructs about health, mental health and illness.

Molefi Kete Asante (an American professor philosopher and leading figure in the fields of African American, African and communication studies) defined Afrocentricity as "a mode of thought and action in which the centrality of African interests, values, and perspectives predominate" (Omar, 2020). In essence, Afrocentrism asserts and celebrates the right of people of African descent to strive for self-determination, which implies a need for Afrocentric ontologies, epistemologies, methodologies, and metrics. It gives a voice to African people and allows for a shift to happen by making room for the African perspective of understanding and interpreting illness. It aims to end systemic anti-Black racism and promote and preserve Black health through an intersectional, equity-based, anti-racism and anti-oppression framework that exposes and disrupts the violent effects of racial privilege (Ujomudike, 2016). Incorporating an Afrocentric approach to ontologies, epistemologies, and methodologies is very important because it brings about cultural sensitivity and relativism into spaces such as health. A dual interpretation of mental illness is deemed necessary, especially when it comes to understanding postnatal depression (Oppong, 2022). When one visits a health facility and explain one's symptoms, health practitioners need to be culturally aware and sensitive so that the patient can understand them.

2.4 Diagnostic classifications of mental illness

Current diagnostic classifications of mental illness rely on Western worldviews of what constitutes abnormal behaviours and assume a universalist view of mental illness (Omar, 2020).). However, there are cultural variations in the phenomenology of mental illness and psychopathology, which affects the reliability and validity of these diagnostic instruments

(Adodo, 2020). Culture influences how individuals manifest their symptoms, communicate their symptoms, cope with psychological challenges, and their willingness to seek treatment (Gurung, 2019). Culture is central to the aetiology of mental disorders as it provides standards for normality and abnormality, and the definitions of what constitutes a mental disorder are socially and culturally negotiated (Idemudia & Adedeji, 2023). Culture determines the variations of normalcy in behaviours; while cultures tolerate high levels of deviant behaviours, others insist on conformity (Stamkou *et al.,* 2019). This study aims to explore the role of culture in understanding postnatal depression and to learn about the variations in symptoms of postnatal depression.

2.5 The concept of 'the person.'

Since the seminal work of Marcel Mauss (1935/1985), a major theme in psychological anthropology has been the concept of the 'person.' A person is understood as a social and cultural construct that underlies self-understanding and self-representation (Pina-Cabral, 2024). Implicit cultural concepts of the person shape current psychological theories of development and social behaviour, psychological assessment, psychopathology, and forms of psychotherapy (Delpuech et al, 2019).

Many African cultures promote a relational-oriented personhood, in which an individual manifest their personhood through connections to three distinct forms of agency: spiritual agency, including God, ancestors, and spirits that influence the person; social agency, including the family, the clan, and the community, with extension to humanity; and self-agency, which is responsible for the person's inner experience. This distinctive form of personhood underlies concepts of the "normal" person, understanding of mental illness, help-seeking behaviour, and client's needs and expectations (Teluq, 2018).

The concept of the person does not refer directly to the self, defined as the locus of self-awareness, introspection, and imagination, but to the cultural construction of the person as a social entity, along with moral and juridical notions of agency and accountability (Kuper, Adam, 2019). Persons do not exist in isolation; each of us lives and grows up in specific social and cultural setting. That setting is the context in which we develop our ideas about our own and others' personhood. Cultural systems influence individual behaviour through their effects on one's way of being in the world. Through this process of enculturation, the individual as a biological entity becomes a culturally meaningful being who is recognised as a person and,

hence, as an actor in a social world (Hammack, 2015;). One cannot be a person by oneself; one must only be about the social world (Teluq, 2018). Personhood is always grounded in the complexities of consensual understandings and customary behavioural routines relevant to being a person in a given sociocultural context. Such understandings and practices will influence the form and function of the psychological processes that comprise the person as a subject and social actor. As D'Andrade and Strauss (Gondar, 2024) note, the individual's psyche can be seen as an internalisation of culture, while culture can be viewed as an externalisation of the psyche. Personhood, then, can be understood as a dynamic recursive process in which participation in a given cultural system of meanings, practices, and institutions affords and fosters characteristic psychological tendencies that serve, in turn, Kpanake (2018) to integrate the person into the meanings and practices of a cultural community (Kuper, Adam, 2019). This study aims to explore the influence of the person on understanding postnatal depression.

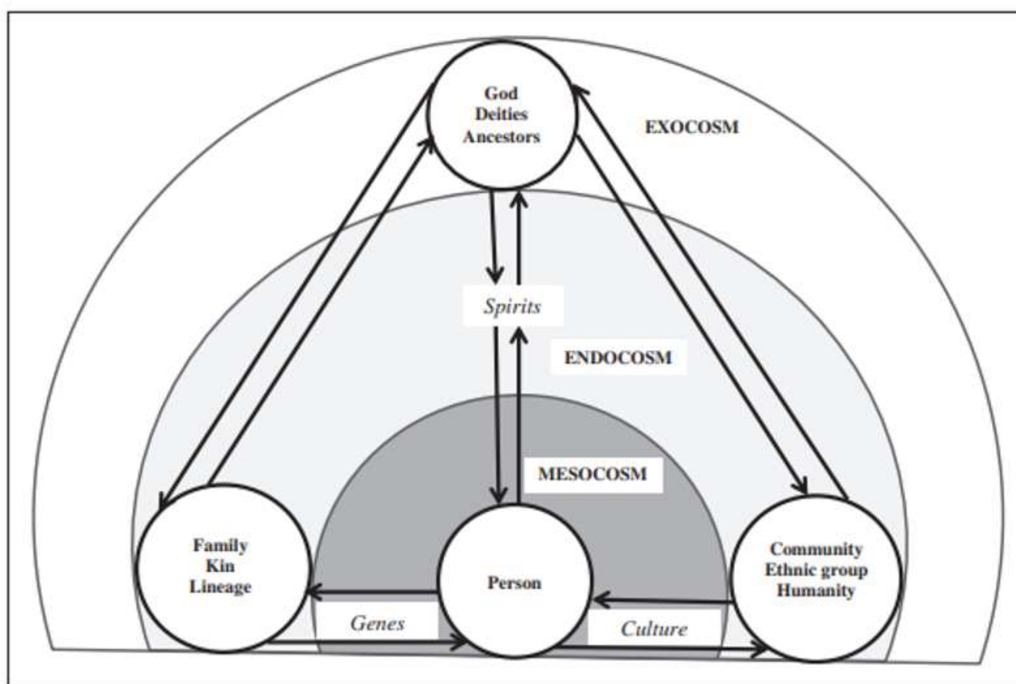

Figure 1: A model of cultural concepts of the person in Africa (Source: Kpanake, 2018)

This framework involves mutually dependent links that connect the person to their social and spiritual agencies. In this model, an individual manifests their personhood by relational means. Relational manifestations, as promoted by those cultures, are found in the connections between the person and their three agencies: (a) an intrapersonal connectedness which ties the person to

their physical self, environmental self, and invisible self; (b) an interpersonal connectedness which ties the person to their family, clan, and community; and (c) a trans-personal connectedness that ties the person to their ancestors and divinities. These agencies correspond with ontological levels or realms that have been termed the "endocosm," "mesocosm," and "exocosm," respectively (Ebigbo, Elekwachi & Nweze, 2014).

As part of the healing process, the ritual slaughtering of an animal requested by the ancestors aimed to re-establish a harmonious connectedness between the patient and his ancestors. Such healing practices emphasise the archetypal symbol of the ancestor, which may be present in invisible ways but is also tied to ritual objects, places, and practices. African mental health professionals influenced by Jung have characterised the ancestor as the expression of the African collective unconscious since this spiritual entity is a fundamental part of Africans' experience of mental illness. According to Svalastog *et al.* (2017), each group in society and culture organises itself collectively through material means. However, state medical institutions develop knowledge, practices, and specific institutions that provide health services through the health care system. Many groups do not seek medical attention about disease origins, causes, and treatments; they use folk medicine. Furthermore, others use medical therapeutic techniques- practitioners, religious systems, and others seek multiple alternative standards and agents (National Health System, 2015). For example, there are disease classifications in each social group, and they are organised according to health criteria, episodes of illness and severity, for example Their classification is not universal, and concerning the other aspects, socio-culturally, they rarely reflect biomedical definitions.

2.6 Parenting in Black African communities

Parenting has been linked to varying outcomes of child well-being and behaviour. Prolific research exists in Western countries regarding different parenting styles and practices linked to various outcomes. These are then used to understand parenting in non-Western countries such as South Africa. With a diversified population of over 50 million, South Africa has a rich socio-political history that has constantly threatened the very existence of family and parental responsibility practices (Roman and Benjamin 2022). Parents play a huge role in the upbringing of their children. Hence, their mental health is important because of their role. Parents are the primary agents in the process of socialising their children to encourage their children to become participants in a community as responsible adults (Agnafors et al, 2019).

Ultimately, how parents raise their children is related to the child's behavioural outcomes and behaviour as an adult. This calls for a bond between a child/children and their parent/s so that teaching and learning can be taken from both the child and the parent/s. Challenges like postnatal depression pose a barrier between a mother and her baby. The traditional parent is known to have a "non-lenient" approach to parenting (Anjum et al, 2019). Traditional parents spend time with and discipline their children; religion is central to the family and community. Subsequently, there are strong family beliefs, which are maintained through various cultural traditions.

Mothers do not only nurture their children, but they also hone the children's characters and educate them lovely (Aziza et al., 2020). A mother's mental state has the potential to influence how she responds, engages, bonds and raises her children. Mental health is essential, especially when children are involved because the mother is the nurturer. In the family, mothers have a crucial role. From the time of conception, the growth of the foetus in the womb to the age of the baby at the age of two is a part of life that determines their intelligence and health (Meihartati et al., 2018). They also have the most significant influence on children's achievement, both in growth and development. Mothers fulfil children's needs from an early age, provide role models, and stimulate the development of children's potential (Safarudin dan Jumanto, 2016).

Hence, a mother needs to be in the best state of mind because, as stated above, a mother plays a crucial role as a homemaker, a nurturer and an educator. Gender dichotomy roles in the home can also be guided by culture, where the woman plays the roles of a mother, a wife, a helper, a cook, and a waiter, and the list is endless. She also needs to be looked after and taken care of to perform her functions. On a macro scale, the urban public space plays a noteworthy role in forming the character of its citizens (Hantono. 2017). On a micro-scale, the home is a place to construct the children's character, accompanied by the role of parents, especially mothers, as the earliest educators (Makhmudah. 2018). In educating children, the required aspects are not only maternal instincts but also should possess knowledge and skills. This means that a mother also has a role of developing herself and her skills to be an asset and help her child and children through being able to assist with schoolwork.

2.7 Mental health: A Black African perspective

Most of us are indeed fascinated by the customs and beliefs of other people (Makhmudah. 2018). All illnesses, but especially in psychiatry, are coloured by culture. Culture-related specific psychiatric syndromes have plagued the psychiatric fraternity for many years. They do not fit neatly into the standard psychiatric classifications of the Western world and tend to be included under atypical types. There is not even certainty about them being psychotic, neurotic, or organic (Teodoro and Afonso, 2020). These conditions have been called culture-bound syndromes, folk illnesses, regional illnesses, exotic conditions, and mental illnesses peculiar to certain cultures (Ngubane and De Gama, 2024) or by their regional names like nkoro, latah and amok". This confusion indicates shortcomings in our present classification systems.

A study by (Molot, 2017) gives an example of a cult culture-bound syndrome found mainly among young women in Zulu-speaking and Xhosa-speaking communities of southern Africa and in Kenya, where it is called *saka*, attributed locally to spirit possession, witchcraft, or magical potions administered by rejected lovers or enemies, characterised by shouting, sobbing, pseudolalia, paralysis, convulsions, nightmares with sexual themes, and trance or loss of consciousness. It is feared and despised among local communities and is sharply distinguished from *thwasa* (see spell). Among Xhosa-speaking people, the plural form *amafufunyane* denotes the syndrome. From Zulu *ufufunyane*, a character or voice that has entered and taken control of a person, from *ukufuya* to possess (such things as herds of cattle) or to treat a person as a possession) (Monama and Basson, 2017).

It is important to note that it is traditionally believed that somatic treatment may be changed or discontinued if ineffective. Still, ritual and symbolic treatment must be persevered with and completed despite being unsuccessful (Ngubane et al, 2023). The Bantu divide illness into two distinct groups: the "natural illnesses", which include mental retardation, epilepsy, schizophrenia, affective psychoses, and hereditary and organic brain disorders. Western-trained doctors are generally regarded as qualified to treat these conditions but not the "African disorders", which are considered peculiar to African people and are to be treated by traditional healers.

These conditions are recognised as such by healers and patients alike, and the patients' opinions should routinely be obtained. This latter group of disorders constitute the culture-bound syndromes of South Africa. Since their Bantu names are descriptive terms, they differ widely

in the different languages. Ancestral spirit possession ("ukuthwasa") Biihrmann (Shange and Ross, 2022) describes this condition as being the result of the ancestors calling one to have treatment and training and thus to enter into their service by becoming a diviner. Traditional medicine will improve a person "called" to become a diviner, while those not "called" will worsen. Once the person accepts the call to become a (Krige 1950), they become a diviner.

This emphasises that all people understand illness and misfortune in terms of their specific cultural model. Explanations and treatment outside this model are unacceptable, confusing and ineffective. Western-oriented medical practitioners should accept this when treating people from other cultures and not merely dismiss those beliefs as without scientific foundation. (b) Alien spirit possession ("ufufunyane" and "izizwe") "Ufufunyane" is culturally attributed to possession by thousands of spirits of various races. Such possession is due primarily to sorcery and is brought about by harmful medicines which control the spirits of the dead (Nortje et al, 2016)

A person with "ufufunyane" in its worst form appears to be psychotic, with uncontrollable behaviour, running around and is often aggressive and even violent. They weep, tear their clothes, throw themselves on the ground, thrash around and may attempt suicide. There is usually violent resistance to attempts at appeasing them (Teodoro and Afonso, 2020).). This condition only appeared between 1920 and 1930 with the advent of industrialisation in South Africa. The need for mine workers caused an influx of alien people from the North who introduced this illness to the indigenous population. This condition can occur during epidemics and is most common in rural, traditional areas. "Izizwe" possession: the cause of this condition is culturally ascribed to sorcery, which causes possession by spirits of a foreign tribe, usually from the North. These patients may exhibit signs of glossolalia and rhythmic shaking of the body or may resemble a multiple personality disorder (Shange and Ross, 2022).

Traditional healers treat *"ufufunyane*" and "i*zizwe*" by forcing the possessing spirits out, sometimes replacing them with benign spirits under the control of the healer. It is important to note that the treatment of "kwanza" can only be performed by a diviner ("isangoma"), whereas "ufufunyane" and "size" may be treated by both diviners and ethno-doctors *("izinyanga") (*Ngubane and De Gama, 2024). These patients are often successfully treated by Western psychiatrists using heavy sedation with neuroleptics. This condition usually clears up quickly,

but the patient must consult a traditional healer afterwards to establish equilibrium with the ancestors, "*Indiki*" possession. Early in the twentieth century, a new type of possession appeared among the Zulu in Natal and the Tsonga in Mozambique.

It is believed to be caused by the wandering spirit of a deceased male from a Northern country who died away from home. His family, being unaware of his death, would not have performed the rituals necessary to allow his spirit to take its rightful place in the ancestral world. Such a spirit would wander around and, by chance, take possession of a person who would then become deranged (Molot,2017). The manifestation of these occurrences can be categorised under cultural bound syndrome and Western diagnostic. Hence, it is essential to look into pluralistic medical models.

2.8 Mental health in South Africa

South Africa has yet to establish mental health services that are operating effortlessly. Human resource challenges severely affect mental health service delivery in South Africa. There is an average of 0.31 psychiatrists per 100,000 people in the South African state sector, with an unequal distribution between rural and urban areas (Docrat *et al*., 2019). Predominantly rural provinces have only 0.08 psychiatrists per 100,000 people in the state sector. There is also a critical shortage of child psychiatrists, with only three of the nine provinces having any child psychiatrists in the state sector (Docrat *et al.,* 2019). Around 50% of state hospitals offering psychiatric care do not have a psychiatrist, and 30% have no clinical psychologists (Shisana, 2023). This results in mental illness not being treated.

Factors contributing to the causation and exacerbation of mental illness in South Africa include poverty, unemployment, inequality, violence, gender-based violence and political upheaval (both in the past and currently) (Shisana, 2023). Between 2000 and 2022, the unemployment rate in the country rose from 20.3 to 29.8%.4 A multisectoral approach to the aetiology and impact of mental illness in South Africa requires the participation of the South African Department of Social Development and the South African Department of Justice and Constitutional Development (Morar et al., 2024).

The most recent national prevalence study, the South Africa Stress and Health (SASH), was conducted almost 20 years ago in 2004 (Herman *et al.,* 2005.) The lifetime prevalence of any mental disorder was found to be 30.3%, with anxiety disorders being the most prevalent, at 15.8%. Substance use disorders were next, at 13.3%, followed by mood disorders at 9.8%.5 Although the SASH study found a treatment gap of 75%, a national costing study conducted in 2016–2017 found a treatment gap of 91% among those who cannot afford private healthcare (Docrat et al., 2019).

Current epidemiological data are sorely needed if adequate services are to be planned, also noting that socioeconomic factors have worsened for many since 2004. Problematic access to healthcare services occurs at both a systemic level and an individual level (SA Mental Health Conference. At the systemic level, possible solutions include (a) stratifying plans and policies in a sequential order, (b) determining costs of implementation, (c) indicating responsible persons and timelines for plans, (d) setting up monitoring teams for each step of the entire implementation programme, (e) training and retraining healthcare managers and health authorities in mental health-related matters, as these managers are the persons to turn strategy into action by providing resources for the action and monitoring it, and finally (f) providing feedback to higher authorities on the success or failure of the strategy. On an individual level, internalised and externalised stigma contribute to untreated mental health cases (Morar *et al.,* 2024).

2.8.1 Mental health stigma in South Africa

Mental illness stigma refers to the negative attitudes, beliefs, and stereotypes that exist in society surrounding mental health conditions. It involves the social disapproval, discrimination, and marginalisation experienced by individuals who are diagnosed with mental illnesses or those who seek mental health treatment. The stigma associated with mental illness poses a significant barrier to the overall well-being of individuals who experience mental health conditions (Fox et al., 2018). Stigma towards mental illness is a process of devaluation and unfavourable stereotypes of individuals who are diagnosed with mental illness and refers to negative attitudes or behaviours towards an individual based on their condition (Caddell, 2022).

The stigma surrounding mental health illnesses forms one of the most significant cultural and social challenges preventing individuals from accessing the mental health care that they need. The discrimination and ridicule of those battling with a mental illness - be it anxiety, depression

or psychosis exists globally and mainly derives from ignorance or prejudice (Egbe *et al*., 2014). In South African black communities, mental health disorders are strongly associated with the culture-bound syndrome of being bewitched, demon-possessed (amafufunyana), or journeying to become a traditional healer (ukuthwasa). These descriptions are used interchangeably to name psychosis and schizophrenia (Masondo *et al*., 2015).

People with mental illness may be characterised as being more violent than the rest of society. A person with anxiety may be labelled as being cowardly rather than having an illness. People with depression may be told to 'snap out of it'. People living with schizophrenia are incorrectly described as having a 'split personality'. These are all examples of stigma against people with mental (Sankobe, 2020). In South Africa, in addition to a lack of resources, there is a stigma attached to mental illness. People living with mental illnesses are perceived as crazy, under a spiritual curse, weak, or misunderstood.

The fact that these illnesses are often devoid of physical symptoms, combined with the lack of appropriate terminology in African languages to describe psychological symptoms, all contributes to the complexity of mental illness in the South African context, making it that much harder to grasp (Monnapula-Mazabane & Petersen, 2022). As such, there is an ongoing debate on the relevance of Western psychology, based on Eurocentric standards, applied to the South African context ref. There is essentially an agreement among field experts that a "uniquely South African solution" is required, ref. Although precise approaches and perspectives vary, the general consensus is that therapy must be decolonised, in line with a more culturally appropriate 'Africanised' psychology (Meyer *et al.,* 2019).

2.8.2 Language and mental health

Language plays a large role when it comes to understanding mental health. Without the language to identify and discuss mental health problems, adults and children alike can be labelled as lazy or scolded for "not trying hard enough." The absence of language to address mental health challenges in black and coloured communities' risks missing the opportunity to identify individuals in suffering, and out of fear of being stigmatised, they may be reluctant to seek out help, opting to rather suffer in silence (Niehaus *et al.,* 2018).

Legg (2022) supports these arguments by giving the following examples. Linguistic barriers in the lack of defining words for common mental health disorders such as anxiety, bipolar disorder

or depression in Indigenous languages like Xhosa and amaZulu, while there are widely used translations of terms such as “anxiety” *ixhala* and “depression” *ukudakumba* or *incindezi* in isiXhosa and isiZulu, it is argued that the translations do not give the impression nor relate to mental illnesses. “Ixhala” is commonly used to describe feeling nervous or anxious, while ukudakumba describes being overly sad or worried. Furthermore, using these terms does not hint at the need to seek medical or psychological help. Instead, they further feed ambiguity in religious and traditional forms of diagnoses that are often loaded with shame. This usually leads people to seek spiritual assistance as opposed to medical care. When church prayers and traditional ceremonies cannot “deliver” the “possessed” from spiritual impurities, that person is then labelled as “mad”. This mark of stigma begins to undo their position in society; it erases their agency and devalues their esteem as a functioning adult in the community. Henceforth, they are treated similarly to a child, and what they have to say is no longer valued as much, as they are labelled as “mad” and “crazy”. For example, in other scenarios, when an individual displays symptomatic behaviour of depression (feeling worthless or experiencing fatigue), these can be misattributed to other causes (Legg *et al.,* 2020).

2.8.3 Western ways of diagnosing mental illness

In the West, mental disorders are often seen as medical conditions that need to be treated with medication or other medical interventions. However, in many traditional cultures, mental health problems are seen as spiritual issues that need to be addressed through religious or shamanic rituals (Therapy Brands, 2022). A range of different models has always characterised psychiatry and approaches to mental disorders, which have sometimes effected progress in clinical practice but have often also been accompanied by critique from within and without the field (Stein et al., 2022). The shift away from psychoanalysis in the latter part of the 20th century was accompanied by critical scientific and clinical advances, including the introduction of a wide range of evidence-based pharmacotherapies and psychotherapies for the treatment of mental disorders.

However, there has also been an extensive critique of pharmacological and cognitive-behavioural interventions, whether focused on concerns about their “medical model” foundations or emphasising the need to build community psychiatry and to scale up these treatments globally Patel et al., 2018). In the 21st-century, global mental health has become an influential novel perspective on mental disorders and their treatment. This emergent discipline

builds on advances in cross-cultural psychiatry, psychiatric epidemiology, implementation science, and the human rights movement (Collins, 2020). Global mental health has given impetus to a wide range of mental health research and clinical strategies, such as task-shifting, with evidence that these are effective in diverse contexts and may be suitable for roll-out at scale (Van Ginneken et al., 2021). It is noteworthy, however, that global mental health has, in turn, been critiqued for inappropriate and imperial exportation of Western constructs to the global South (Mills, 2014).

Psychiatric nosology has been a particular focus of both advances in and critiques from the field. The 3rd edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) was paramount, providing an approach that attempted to eschew different models of aetiology, focusing instead on reliable diagnostic constructs (Wilson, 1993). These constructs became widely used in epidemiological studies of mental illness, in psychiatric research on aetiology and treatment, as well as in daily clinical practice throughout the world. The most recent editions of the DSM (DSM-5) and the International Classification of Diseases (ICD-11) by the World Health Organization (WHO) have drawn on and given impetus to a considerable body of work in nosological science (Reed *et al.,* 2019).

In the interim, evidence of the treatment gap and the research-practice gap in current mental health services has given impetus to the development of several novel diagnostic and treatment models and approaches, ranging from clinical neuroscience to global mental health. These models and approaches have recently achieved prominence, with proponents arguing that they will significantly impact psychiatric practice and research in the future. At times, advocates for these perspectives and proposals have limited aims, while at other times, they speak of paradigm shifts that will drastically alter or wholly reshape current clinical practices (Chapman et al., 2020; Penzenstadler et al., 2020; Fu & Costafreda, 2013; Leichsenring et al., 2019).

2.8.4 Cross-cultural diagnosis of mental health

The conceptualisation of mental health challenges among sub-Saharan Africans is complex and varied. In many cultures, it is understood as a supernatural or spiritual problem (Atilola et al., 2015; Labinjo et al., 2020; McCabe & Priebe, 2004; Patel, 1995) or as a social or personal problem in other cultures (Kpanake, 2018). In relation to non-Western cultures' conceptualisations of mental health challenges, specific cultures often see it as a holistic ailment affecting the mind, body, and spirit (Leckie & Hughes, 2017). In non-Western cultures,

mental health challenges may be seen as spiritual or supernatural problems, social or environmental problems, or a combination of these, and there is often a focus on the role of the family and community in the treatment (World Health Organization, 2001).

When biomedical definitions of mental health challenges are applied to people from different cultures, there is a potential for conflict. Vaka (2016) argues that the Western approach to mental health challenges may not consider cultural subtleties, which could lead to misdiagnosis and inappropriate treatment. Also, belief in ancestors is a widespread practice in Africa. Ancestors are often believed to be able to influence the lives of their living descendants, and they may be consulted for advice or guidance. In some cultures, ancestors are seen as intermediaries between the living and the spirit world, while in others, they are seen as more powerful beings who can directly influence the course of events (Morgan & Okyere-Manu, 2020).

2.8.5 Medical model in mental illness

The concept of 'mental illnesses has a variety of meanings in different discourses It is important to note that the concept of 'mental illness' is multi-faceted, and every discipline has its own viewpoints to understand this concept). Mental illness is a disease, or a disease-like entity, with a psychological, genetic, or chemical base that can be treated through medical means (Underhill and Roulkes, 2024). In the medical model, mental illness is a disease, or a disease-like entity, with a psychological, genetic, or chemical base that can be treated through medical means (Malla et al, 2015).

This model also gives you the idea that mental illness is a chemical imbalance within our brain, which is a neurotic problem. In contrast, the social model argues that it is a social dysfunction (Baltag et al, 2022). It is the deviation from the everyday life of the individual and the inability to perform the expected and prescribed social roles. Mental illnesses are illnesses characterised by the presence of mental pathology: that is, disturbances of mental functioning analogous to disturbances of bodily functioning (Bergen et al, 2022)

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by the presence of mental pathology, that is, disturbances with mental functioning analogous to disturbances with f bodily functioning (Acheson and Papadima ,2023).

Mental ill health comprises mental health problems and strain, impaired functioning associated with distress symptoms, and diagnosable mental health disorders, such as schizophrenia and depression (Malla et al, 2015). The concept and distinction between mental health and mental illness and the distinction between physical and mental illness are highly variable across cultures.

In a broad sense, we can state that where physical illness is noticeable in the body, at the same time, mental illness is noticeable in the behaviour (Vaka (2016). (David and Deeley, 2024) have argued that mental illness cannot be separated from the individual's social and cultural context, and culture plays a vital role in the perception of mental illness. Cultural anthropologists have mentioned that every society has its own culture and social norms distinct from others. These cultural and social norms define the person as normal or deviant (Malla et al, 2015)

2.8.6 Postnatal depression

According to Shaikh and Kauppi (2015), postnatal depression first began in the biomedical field by the medical community, who were left responsible for naming and classifying it as a unique condition. Given its presentation, in terms of the range of physiological and emotional responses that women displayed, postnatal depression was soon classified and recognised as either postnatal depression or major depressive disorder. Upon its classification and its diagnostic value, women began self-labelling their experiences as postnatal depression. Women's self-diagnosis was about the romanticised view of motherhood as happy and healthy (Shaikh & Kauppi, 2015). Women whose experiences of motherhood differed from the romanticised ideal sought to make sense of their experiences and, as such, labelled themselves with postnatal depression.

Women's self-diagnosis emerged through social interaction with healthcare providers, family and other mothers (Sword et al. 2008). Upon the recognition of postnatal depression, social movements such as postnatal support groups further emerged and supported postnatal depression as a mental disorder. In addition to this, the emergence of policies against infanticide and maternal suicide further legitimated postnatal depression (Shaikh & Kauppi, 2015). Given the above linear progression of postnatal depression. Shaikh and Kauppi (2015) argue that

postnatal depression is a combination of biomedical, historical, social, cultural and structural dimensions and, as such, is a socially constructed phenomenon. Thus, postnatal depression cannot be studied outside or in isolation of culture because culture is a way of life. It informs how people interpret and give meaning to life experiences.

Pregnancy, childbirth and motherhood are recognised as sensitive periods that affect a woman's mental health (Mauthner, 1998). Three types of psychological problems can impact women's mental health around this time (Chrisler & Johnston-Robledo, 2002), namely;

- The baby blues, postpartum psychosis and postnatal depression. The baby blues, which occurs between 3 to 10 days after childbirth.
- It is characterised by weeping, sadness, irritability, confusion, anxiety, mood changes, insomnia and dysphoria (Chinawa et al., 2016; Wisner, Parry & Piontek, 2002).
- Postpartum psychosis, which occurs within the first two weeks following childbirth, is characterised by disorganised thoughts, odd behaviours, hallucinations and delusions (Romito, 1990; Wisner *et al.,* 2002).
- Postnatal depression, which is the current research study's focus, is defined as "depression that occurs during the first 12 months following childbirth" (Nicolson, 1998: 27). Other definitions identify postnatal depression as a form of non-psychotic depression that occurs within the first year of childbirth (Beck, 2000; Stewart *et al*., 2003).

What these definitions have in common is the recognition that postnatal depression is depression that occurs after childbirth. Similar to depression, postnatal depression is accompanied by, amongst other symptoms, a low mood and loss of interest and enjoyment in activities (Murray, Cooper & Hipwell, 2003), sleep disturbances, excessive guilt and suicidal ideation (Canadian Psychiatry Association, 2004; Lazarus & Rossouw, 2015), fatigue and lack of appetite (Fowles, 1998; Lazarus & Rossouw, 2015).

Understanding postnatal depression

Mauthner (1998), in her study on women's experiences of postnatal depression, provided a relational perspective on understanding postnatal depression. Mauthner (1998) also illustrated that external factors contribute towards women developing postnatal depression. These factors were in the context of four major domains:

- The first is the women's expectations of motherhood which was in relation to the discursive representation of motherhood contributed to women developing postnatal depression. Women's ideas on motherhood were based on the dominant discourses of good mothering. When their expectations did not match with their experiences, the women developed postnatal depression.

- The second is the moral dimension, which refers to mothers' belief that there is only one right way to be a mother. Women believe that they should prioritise their children's needs over their own in an attempt to be perfect mothers.
- The third is the cultural context, which refers to society's values and beliefs regarding good mothering. From this domain, women believed that there is only one way to mother. When their experiences did not match their efforts to engage in mothering in the 'right way', they experienced themselves as failures, and this contributed to the development of postnatal depression.
- The fourth is the interpersonal context, which refers to the impact that other mothers and women's significant partners have on women. Women in the study compared their mothering abilities with other mothers. When they assessed that their experiences differed, the women perceived their mothering abilities as abnormal, and this contributed towards the development of postnatal depression. Furthermore, women struggled to confide with significant others regarding their struggles in motherhood due to perceived judgement and the fear that if women asked for help, they would be perceived as failures as mothers (Mauthner, 1998).

Depression whilst pregnant and after giving birth

The journey of conception, carrying the baby and delivering the baby comes with many emotions. The process of becoming a mother generally marks a wonderful event that encompasses discovery, learning, and a positive worthwhile experience; women, however, find the transition into motherhood defined by fatigue, frustration, and emotional turmoil. Feelings of loss of control and emotional distress not only affect the mother but have known adverse effects for the infant as well (Stapleton et al., 2012), for instance, adverse birth outcomes, poor mother-infant bonding, and long-term consequences for the child (American College of Obstetricians and Gynecologists, 2013).

The root cause of depression in pregnancy varies. It is likely to be a result of one's genetic make-up, family history, one's personal way of thinking and coping, and features of one's environment that influence one's mental and emotional well-being. A combination of these factors may make a person's risk of developing depression higher. However, there are also factors that protect expectant mothers, such as having good support networks (COPE, 2023). Worldwide, about 10% of pregnant women and 13% of women after giving birth suffer from a a mental disorder, primarily depression. In developing countries like India, this is even higher, that is, 15.6% during pregnancy and 19.8% after childbirth (Sidhu et al., 2019). Depression during pregnancy, also known as prenatal depression or antepartum depression, has become a serious problem, and its long-term adverse effects have been studied and documented for a long time. Evidence confirms that depression can adversely affect both the mother and the child (Benatar et al., 2020) and impact the child's cognitive ability and development of language and behaviour (Yang & Wei, 2022).

Different types of maternal depression

According to Mind (2024), there are more types of depression, namely, antenatal depression is depression one experiences whilst one is pregnant, and it can be caused by a hormonal imbalance. Although, because all women experience hormonal changes when they're pregnant, that's unlikely to be the only cause. Other things that may play a part are previous miscarriages or difficult birth experiences (Ayers & Delicate, 2016).

Perinatal depression has been associated with many poor outcomes, including maternal, child, and family unit challenges. Infants and young children of perinatally depressed mothers are more likely to have a difficult temperament, as well as cognitive and emotional delays (Muzik & Borovska, 2010). Perinatal depression occurs any time from becoming pregnant to around one year after giving birth and has been associated with many poor outcomes, including maternal, child, and family unit challenges (Gupta et al., 2023). Hormone changes that happen after birth may cause baby blues. After delivery, the amount of the hormones estrogen and progesterone suddenly decreases, causing mood swings. For some people, the hormones made by the thyroid gland may drop sharply, which can make them feel tired and depressed. Not getting enough sleep and not eating well can add to these feelings (March of Dimes, 2021).

'Baby blues' is a brief period of low mood, feeling emotional and tearful around three to 10 days after you give birth. One is likely to be coping with many new demands and getting little

sleep, so it is natural to feel emotional and overwhelmed. This feeling usually lasts only a few days and is generally quite manageable (Fields, 2023). Postnatal depression occurs during roughly the first year after giving birth (Mind, 2024). Although postnatal depression is a worldwide public health problem, it is relatively higher in developing countries, including countries in Sub-Saharan Africa. Postnatal depression is not routinely screened for in primary healthcare facilities in South Africa despite its reported compromise on mother and child health (Mokwena & Masike, 2020). However, there is a screening scale that is used to screen for postnatal depression.

Factors leading to postnatal depression

The risk factors for postnatal depression reported in low middle-income countries include socioeconomic disadvantage, unintended pregnancy, being younger, being unmarried, lacking intimate partner empathy and support, experiencing intimate partner violence, having insufficient emotional and practical support, and, in some settings, giving birth to a female baby, and having a history of mental health problems (Fisher, 2008). In Africa, the unique risk factors for postnatal depression include poor infant nutritional status, low infant birthweight, shorter duration of breastfeeding, diarrhoeal diseases, poor self-rated health, respiratory illness, home delivery, reduced quality of interaction between mothers and infants and poor HIV care (Gold et al., 2013; Målqvist et al., 2016). In South Africa, researchers have reported associated postnatal depression factors to be level of education, financial support by the baby's father, whether the baby was planned, baby's health status, partner/husband support, social support, partner/husband being violent, partner/husband (Modjadji & Mokwena, 2020).

Prevalence rate of postnatal depression

The prevalence of maternal postnatal depression varies from 0% to 60% globally. This wide variety brings up the issue of whether postnatal depression is a universal medical condition or whether it is an ideal impacted by cultural and social translations and the labelling of signs and symptoms (Arifin et al., 2018). In Africa, it was previously postulated that women were protected from postnatal depression due to traditional rituals and other cultural factors (Cox, 1998). However, it is becoming evident that all women are affected, particularly those living in socioeconomically disadvantaged regions (Tomlinson et al., 2006; Hartley et al., 2011). The overall combined prevalence of postnatal depression has been estimated to be 16.84% in Africa (Dadi et al., 2020), while a range between 6% and 50% has been reported in Sub-Saharan

Africa (SSA) (Adama et al., 2015; Odinka et al., 2018) and 16.4% to 50.3% in South Africa (Ramchandani, 2009; Stellenberg & Abrahams, 2015). Several studies in South Africa have reported variations of postnatal depression prevalence among adolescents (26%) (Stewart et al., 2003), women living with HIV (25% to 45.1%) (Peltzer & Shikwane, 2011; Mokhele et al., 2019), in rural settings (47% to 50.3%) (Stellenberg & Abrahams, 2015, Robertson et al., 2004), peri-urban settlements (30% to 34.7%) (Cooper et al., 1999; Hartley et al., 2011), urban areas (16.4%) (Ramchandani et al., 2009) and different provinces (34.7% to 49.3%) (Tomlinson et al., 2006; Mokwena & Shiba, 2014).

Debates about postnatal depression

The cultural debates around postnatal depression are culture-centred, and interpretation is a big part of it. The Western view lens of describing and diagnosing postnatal depression through a Western method is controversial. Hence, women have different views and sometimes do not identify with PND even when they have the symptoms. The concept since the seminal work of Marcel Mauss (1935/1985), a major theme in psychological anthropology has been the concept of the 'person,' understood as a social and cultural construct that underlies self-understanding and self-representation (Christopher, 2007; Knappett, 2005; Smith, 2003). Implicit cultural concepts comprise the way in which the person shapes current psychological theories of development and social behaviour, psychological assessment, psychopathology, and forms of psychotherapy (Hammack, 2008; Kirmayer, 2007).

Different cultural contexts lead to various concepts of the person, providing ways of interpreting individual experiences. Despite much evidence for cultural variation, most approaches to mental health, counselling, and psychotherapy for African peoples are based on Eurocentric concepts of the person. Hence, debates on postnatal depression revolve around cultural interpretation. For example, Chand, Arif and Kutlenios (2021) argue for the need to allow the depressed person to be depressed, keeping them alive and nursing them over time, during which they will resolve their inner conflicts with or without psychotherapy.

This also accords with Jung's view of depression as a damming up of psychic energy (Dracquer, 1998). The release of such trapped energy helps to overcome whatever is responsible for the blockage in the first place (Edwards & Edwards, 2010). This healing effect is particularly instructive within a South African cultural context (Bojuwoye & Edwards, 2011; Edwards, 2011). Another example is that of a person that does not refer directly to the self, defined as the

locus of self-awareness, introspection, and imagination, but to the cultural construction of the person as a social entity, along with moral and juridical notions of agency and accountability (Appiah, 2005; Kirmayer, 2007; Mauss, 1935). Persons do not exist in isolation; each of us lives and grows up in a specific social and cultural setting. That setting is the context in which we develop our ideas about our own and others' personhood. Cultural systems influence individual behaviour through their effects on one's way of being in the world.

Furthermore, for instance, women could not perceive their depressive symptoms as problematic due to a lack of depression literacy (Schmied et al., 2017). Women were also reported to be ashamed of and humiliated by their postnatal depression symptoms. Specifically, they worried that the symptoms would make them feel vulnerable and feared that their children might be taken away by social services (Wittkowski et al., 2017). In a particular culture (for example, Asian), women are not widely aware of postnatal depression symptoms. Therefore, they do not view PND symptoms as an illness nor do they try to be sensible about the symptoms in other ways (Schmied *et al.,* 2017) within primary healthcare settings (Arifin *et al*., 2018). It is important to note that there are currently no guidelines that explicitly focus on postnatal depression management.

Measuring postnatal depression

The Edinburgh Postnatal Depression Scale (EPDS) was initially developed as a screening tool for clinical and research purposes. Cox et al. (1987) and Levis et al. (2020) initially validated it on British women. It is a self-report scale designed specifically for the postnatal period in that it makes little reference to the somatic symptoms of depression that may be caused by the normal physiological changes associated with childbearing (Modjadji & Mokwena, 2020). The Edinburgh postnatal depression Scale is a 10-item self-report scale explicitly designed as a screening instrument for the postnatal period and has been validated in South Africa (Chorwe-Sungani, 2018).

Over the years, the Edinburg postnatal depression scale has developed, and it can pick up more information. The screening tool can assess the following: the mood of women during the first 12 months after their baby is born, as well as health problems, relationship with husband/partner, history of intimate partner violence, social support, and life stress. A score within the range of 0 - 9 may indicate the presence of some symptoms of distress that may be short-lived and are less likely to interfere with the day-to-day ability to function at home or at

work. However, further inquiries are warranted if these symptoms persist for over a week or two. A score within the range of 10 to 12 indicates the presence of symptoms of distress that may be discomforting. A score of 13 plus requires further assessment and appropriate management, as the likelihood of depression is high. Referral to a psychiatrist or psychologist may be necessary (Al-Hejji, 2019).

Critique of the Edinburgh postnatal depression scale

The literature that considers the Edinburgh postnatal depression scale to be less culturally sensitive to the needs of women from black and ethnic minority backgrounds states that it does not translate into other languages, let alone cultures (Alhakami et al,2023). These authors also cautioned against direct translations of the tool, pointing out that some cultures do not have a word for depression and suggesting that other screening methods should be considered depending on ethnicity. It is argued that the use of standardised Western methods and diagnostic classification systems, even by local but Westernised investigators, may be culturally insensitive and could increase the risk of practitioners missing symptoms or signs prevalent in non-Western cultures (Bedaso et al, 2021).

Using EPDS as the assessment tool for these women might result in them often being inappropriately diagnosed or misdiagnosed, leading to omission. Additional arguments related to this position in the literature claim that most research has been conducted in the Western developed countries (Brailovskaia,et al, 2021) and has not taken into account the range of different psychosocial experiences likely to be involved in childbirth, for example, differences in rates of lone motherhood, the nature of marriage, family kinship, and variations in the support new mothers receive in different countries and cultures. For those who consider EPDS an effective tool for diagnosing postnatal depression, the main evidence comes from some empirical studies that have screened women to check prevalence and associated factors in two groups: Nigerian and Black Caribbean women reporting a significant level of diagnosis (Adewuya, 2006; Edge et al., 2004).

On the part of the health professionals, the literature addresses various factors that could contribute to the lack of awareness, late diagnoses, undetected cases or, worse, excessive medicalisation of symptoms. Other authors (Dennis & Chung-Lee, 2006) argued that the way a person perceives and understands their health is related to the subjective cultural experience

in their society. Lewis (1976) posits the idea that all cultures are unstable and subject to daily variations, innovations, and change.

2.8.7 The need for social support

Social support is a multidimensional and multifaceted term. It refers to the assistance provided to individuals by different sources, such as parents, friends, teachers, government agencies, people in school, and significant others. Social support is defined as "continuing social aggregates that provide individuals with opportunities for feedback about themselves and for validations of their expectations of others" (Acoba, 2024).

Social support comes from different sources, such as emotional support, tangible support, intangible support, informational support, invisible support, companionship support and public aid. Emotional support entails providing love, affection, empathy, and sympathy to a person. Tangible support involves providing financial assistance and basic material aids to a person. Informational support comprises providing guidance, advice, and suggestions to individuals and helping them solve problems. Intangible support: providing personal advice to a person. Social support is a buffer that protects an individual from high-stress levels. It lowers blood pressure and the risk of other cardiovascular diseases. Past research has shown that emotional support from parents may buffer or reduce distress by bolstering one or more aspects of self that have been threatened by objective difficulty (Stensletten et al, 2016).

2.8.7.1 Support groups

Considerable attention has been given to support groups within the literature, with evidence to suggest that support groups increase availability and access to health services and are both a practical and economical method of treatment (Hauvik and Haugan, 2017). As the number and availability of support groups are growing in Australia and internationally, it is becoming increasingly important to clarify the role of such groups, particularly in health care. Since 2004, there has only been *ad hoc* academic interest in support groups despite it being such an area of growth (Grødal et al, 2019). Although there are numerous types of support groups, distinguishing between the different kinds of groups has become a challenge and remains largely unclear. This is predominantly due to the independent and non-standardised nature of

support groups (Wilson et al, 2020). As Pistrang, Barker and Humphreys (2008) explain, the term "support groups" often incorporates a range of group types and functions, leading to misunderstanding.

This is illustrated through authors using terms, such as mutual aid groups or peer support services to encompass all group types (Pfeiffer *et al*., 2011; Solomon, 2004), whilst other terms such as mutual support groups, self-help groups, peer support programmes, and consumer-run services are used interchangeably (Hildingh & Fridlund, 2001; Munn-Giddings & McVicar, 2007). It is uncommon for studies to make clear distinctions between self-help groups, peer support groups and other 'mutual aid' programmes. Thus, it is difficult to determine from the terms alone which type of group is being referred to in the literature. Indeed, this lack of clarity is well supported (Alshehri et al, 2020).

Since the 1970s, support groups have emerged as a valuable component of health care and have been found to help improve health outcomes and reduce mortality rates (Bender, 2019). The social movements of the 1970s, which bolstered equal rights for minority groups, including people with disabilities and mental health problems (notably the women's health movement), also led to a distrust of governments and well-established institutions. Hence, community-run health clinics were developed to enable autonomy over one's own health care. These clinics and community-run groups are what we now recognise as support groups (Borkman & Munn-Giddings, 2008). Support groups are founded on the premise that supportive interactions with people who have experienced similar problems can empower individuals, increase self-efficacy, and enhance coping skills (Bedaso et al, 2019). According to Helgeson and Gottlieb (2000), support groups are rarely theory-driven but are guided by the notion that people facing similar problems have a shared understanding and can offer mutual, empathic support that naturally occurring social support may not.

A person's support network may lack experience, be consumed by stressors, or feel uncomfortable responding to the issue (Helgeson & Gottlieb, 2000). Peers can, therefore, validate and normalise the problem, thereby reducing isolation and fostering a sense of belonging. Pistrang et al. (2008) describe this principle as 'socially supportive interactions,' in which the empathy derived from one's peer group can compensate for the absences in people's natural support networks. This is supported by Bryan (2013), who suggests that peers who

experience similar stressors have an exclusive capacity to respond empathically due to a shared understanding of the issue.

Two theoretical models have been posited in the literature that solidify the benefit of support groups (Stewart, 1990). Support groups are said to directly and indirectly affect physical and psychological health outcomes (Dennis, 2003; Stewart, 1990). The indirect 'buffering' model suggests that support groups act as protection against stressors and build coping skills (Dennis, 2003). This model is founded on Lazarus and Folkman's 1984 coping theory, which states that to cope effectively with challenges, cognitive and behavioural change is required (Lazarus & Folkman, 1984). However, as stated previously, support groups are rarely theory driven. As such, there are several concepts that endorse and build upon this indirect model, strengthening the role of support groups (Helgeson & Gottlieb, 2000). One of these concepts is 'vicarious learning.' Originating from Bandura's social cognitive theory, 'vicarious learning' is the concept that people learn through observing others and the outcome of others' behaviour (Bandura, 1998; Dennis, 2003; Stewart, 1990).

These interpersonal relationships are considered important in moderating how an individual interprets and responds to an event (Dennis, 2003). Another concept pertaining to Bandura's theory, earlier established by Reissman's 1965 helper therapy principle, is 'self-efficacy' (Bandura, 1998; Gartner & Riessman, 1982; Roberts et al., 1999). Self-efficacy is where individuals assess their ability to perform specific tasks or behaviours, determining whether they engage and persevere with behavioural change. The more attention given to successes or gains, the greater self-efficacy is (Bandura, 1998; Dennis, 2003). By helping other group members, they can develop insight into their own problems and build self-confidence, which facilitates behavioural change (Gartner & Riessman, 1982; Roberts et al., 1999).

As such, the indirect model considers support groups to be an avenue through which vicarious learning can occur and individuals can receive feedback from peers, enhancing self-efficacy. Dennis (2003) distinguishes these processes of vicarious learning and self-efficacy as a separate model, the mediating effect model; however, other authors contend that this process is part of the indirect effect of support groups (Cohen & Wills, 1985; Stewart, 1990).

The direct effect model proposes that social support has explicit benefits on health and well-being through encouraging social integration, fostering self-esteem and positive emotion, and reducing isolation, all of which are essential social needs and occur through the development

of significant positive relationships (Dennis, 2003; Pfeiffer et al., 2011; Stewart, 1990). Social integration has been associated with increased life span and survival from various serious health conditions such as cancer and depression (Dennis, 2003). This model can be linked to the social-inoculation theory, which suggests that social support influences the susceptibility to infections and aspects of the humoral and cell-mediated immune response (Pfeiffer *et al.*, 2011). Two types of support groups have been identified within the literature: professionally led and volunteer support groups. The latter group has been further divided into peer support and self-help groups.

Postwar, the large numbers of soldiers requiring psychotherapy in the post-war period compelled psychiatrists to try to treat them in groups, and the use of group methods proved so effective that they developed rapidly in the post-war years. The practice of group therapy expanded to clinical and counselling psychologists and social workers. Group therapeutics tend to stress either alleviating members' distress directly or creating a group atmosphere conducive to increased self-understanding and personal maturation. Some aim to raise members' morale and combat feelings of isolation by cultivating a sense of group belongingness through slogans, rituals, testimonials, and public recognition of members' intervention (The Editors of Encyclopaedia Britannic Group Therapy, 2019).

2.8.7.2 Biopsychosocial support

The existing biomedical model does not suffice. To provide a basis for understanding the determinants of disease and arriving at rational treatments and patterns of health care, a medical model must also consider the patient, the social context in which he/lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician role and the health care system. This requires a biopsychosocial model (Bolton and Gillett), 2019. As the name suggests, the biopsychosocial model conceptualises health as having multiple dimensions.

The medical or biomedical model focuses only on the physical aspect of health, but Engel's new model includes psychological and social aspects as well. It is based on the idea that humans are inherently biopsychosocial organisms in which the biological, psychological, and social dimensions are inextricably intertwined (Bolton, 2021). Engel did not reject the benefits of the

medical model completely but emphasises giving equal importance to psychological and social factors in the process of treatment. This model suggests that other than physiological abnormalities, germs and viruses, our behaviours, thoughts, and feelings may also influence our physical state (Newen et al, 2018) Furthermore, Engel also argues that physicians should also give importance to the subjective experiences of their patients (Lenderink and Balkestein, 2019)

Criticisms of the biopsychosocial model

While the biopsychosocial model may look like a promising unified approach to patient treatment, its ambiguity in terms of outcomes, the lack of unity amongst practitioners, and complexity, still, this model took a reductionist approach and only looked at the disease from an anatomical, physiologic, and chemical perspective of the body. Thus, psychological and social influences were disregarded. (Erb, 2021)

Carey et al. (2014) critiques the biopsychosocial model as follows:

- Lack of clarity and structure: One major criticism of the biopsychosocial model is its relative uncertainty and absence of structure. The lack of clear boundaries and criteria for each component (biological, psychological, and social) can make developing and evaluating standard treatment techniques challenging (Carey *et al.*, 2014).
  - Lack of unity: The biopsychosocial model is often seen as an alternative to the biomedical model but is not always integrated with it. This separation can lead to interaction problems between specialists in different fields and a lack of a unified treatment strategy.
  - Complexity: Measuring and evaluating psychological and social factors can be complex and subjective. Determining the relationship between these components and diseases can take time, creating difficulties in developing and evaluating treatment effectiveness (Carey *et al.,* 2014).
  - Resource limitations: The biopsychosocial model requires a broader and deeper approach to treatment, which can require significant resources and time. Implementing such an approach can be challenging, especially with limited budgets and overburdened healthcare facilities.

Different models of biopsychosocial support groups

Social support generally, and peer support specifically, are often described as comprising emotional, appraisal (affirmational), informational and sometimes instrumental (practical) support (Drageset 2021); and Leger and Letourneau argue that "peer support offers a fifth dimension of empathetic support" (Leger & Letourneau, 2015). One peer support intervention for high-quality expression is to bring affected women together in support groups where they can feel 'safe' to talk about their feelings of distress. In contrast, outside the support group, they may become isolated with their difficult emotions because of shame at having 'failed' at achieving an idealised version of motherhood (Jones *et al.,* 2014); there is, however, no high-quality evidence of the lasting impact of peer support groups on symptoms of depression (Haugan and Eriksson 2021,).

A second model of peer support for postnatal depression is telephone support from a briefly trained volunteer who has recovered from the condition, which has been reported as effective in preventing postnatal depression among women who are at high risk of developing it (Dennis, 2009), and potentially in assisting recovery in women who have depression (Leger & Letourneau, 2015)

A third model is one-to-one visits from trained volunteers (who may or may not themselves have experience of mental health problems). As stated in the above paragraph, there are different support methods. The KwaZulu-Natal's Mums support network provides a hybrid, safe environment for mothers to meet in person over coffee or to communicate on WhatsApp. These platforms also allow mothers who do not have someone to relieve them to engage online and mothers who can step out of the house to bring their babies to the meeting coffee shop. This provides a support system, and friendships can be formed.

2.9 Conclusion

This chapter provided literature from different schools of thought. The importance of culture in understanding mental health was explained. The African perspective and the Western perspectives of mental health were provided in the context of mental health. Postnatal depression was expounded on from its history to its current state. The role of social supports and its many forms such as peer support, online community support, family support and the KwaZulu-Natal Mums Support were elaborated upon.

The literature review chapter presented literature guided by the research objectives of the study. The literature was presented around the relevant concepts, namely, mental health, culture, postnatal depression, and social support. Literature from different scholars was used to review this study in relation to its title.

CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter discusses the methodological approaches which were used in this study. It describes the qualitative tools that were used to gather rich data on how Black African women understand and experience postnatal depression. It also provides an overview of the sampling techniques, ethical issues such as informed consent, anonymity and confidentiality which were used to protect the identity of the participants.

3.2 Methodology: Research design

Qualitative research explores and understands the meaning individuals or groups ascribe to a social or human problem. The research process involves emerging questions and procedures, data typically collected in the participant's setting, data analysis inductively building from particulars to general themes, and the researcher interpreting the meaning of the data (Creswell, 2007). Methodology encapsulates the points mentioned above and results in data collection to explore the phenomenon being studied, achieve the research aims, and engage with the research questions.

Methodology is the general research strategy that outlines how a research project is to be undertaken and, among other things, identifies the methods to be used in it. These methods, described in the methodology, define the means or modes of data collection or, sometimes, how a specific result is to be calculated. Methodology does not define specific methods, even though much attention is given to the nature and kinds of processes to be followed in a particular procedure or to attain an objective (Denzin & Ryan, 2007). This chapter will outline the strategies utilised under different headings that will serve as a map. They will be presented as steps, experiences, and concepts. Importantly, they paved the way for the research to prepare to go to the field, remain in the field, complete data collection, and analyse the data.

Qualitative research is an exploratory research methodology focused on understanding phenomena by collecting non-numerical data, such as words, images, or objects. This research approach aims to gain in-depth insights into social, behavioural, or cultural phenomena, often

in natural settings. The approach is inductive, iterative, and flexible, allowing for the development of theories and understanding as the research progresses (Merriam & Tisdell, 2016). Quantitative research, in contrast, focuses on how the world is understood in researchers' minds, usually using abstract concepts and terminology and numerical (Cropley, 2022). The qualitative approach is suitable for the study because it wants to understand the cultural phenomena being studied and gain a deeper understanding of them. The phenomenon that is being studied in this study is the experiences that Black African women diagnosed with postnatal depression experienced in Durban, KwaZulu-Natal.

Relevance of qualitative research methods in the study

A qualitative research design is relevant because it enables the simplification and management of data without destroying complexity and context. Scholars such as Yauch and Steudel (2003) and Creswell (2014) note that the major strengths of qualitative research includes the utilisation of open-ended questioning, which reveals new or unanticipated phenomena and raises more issues through broad and open-ended inquiry. Furthermore, it includes a diverse and representative cross-section of affected persons and produces rich data by capturing and detailing information about affected populations. Through qualitative research methods the study explored the views of homogenous and diverse groups of people and assisted in unpacking differing perspectives from the participants. Over and above that, the importance of qualitative research can be used to improve both the design and interpretation of traditional surveys. It is used to understand any social phenomenon from the perspective of the actors involved rather than explaining it from the outside (Creswell, 2014). Ospina (2004) assets that it assists in understanding complex phenomena that are difficult or impossible to capture in quantitative research. This is relevant to this study because the researcher sought to understand PND from the perspective of Black African women.

Qualitative research theory may often serve as a lens for the inquiry or be generated during the study (Creswell, 2007). The data collected from the research participants were rich in terms of experience and were applicable to a qualitative study, which was interested in the experiences that were shared by the participants. Two theoretical frameworks were utilised in the study, namely the identity theory and the social constructivist theory. These frameworks enabled the data collected from the Black African mothers' experiences with postnatal depression to be

explained and understood through the theories as well as the concepts associated with the theories.

If a concept or phenomenon needs to be understood because little research has been done on it, then it merits a qualitative approach. Qualitative research is exploratory and is useful when the researcher does not know which important variables to examine. This type of approach may be needed because the topic is new, the topic has never been addressed with a particular sample or group of people, and the existing theories do not apply to the specific sample or group under study (see Lim, 2024). The qualitative approach seeks to understand phenomena, while the quantitative approach seeks to explain them. The goal of qualitative research is emic (to describe and analyse the world as it is experienced, interpreted and understood by people in their everyday lives (Lim, 2024, Cypress, 2015, Creswell and Clark, 2007).

In contrast, quantitative research is frequently (although not always) etic and macro-analytic and focused on discovering new general laws of behaviour or enlarging knowledge of the existing laws. Creswell and Clark (2007) also emphasise that phenomenology focuses on individuals lived experiences regarding specific phenomena. It uses a data collection method that allows the research participants to share in-depth experiences and reflect, thus resulting in rich descriptive experiences.

In the context of this study, as discussed under the problem statement, postnatal depression is undertreated, and previously, it was believed that Black African women were immune to it due to the ritual that they could perform (Mokwena & Modjaji, 2020). However, that is no longer the case. As a result, more research and information are required to learn more about this phenomenon in the Black African community. Hence, the study implemented a phenomenological qualitative research design. Phenomenological research is a strategy of inquiry in which the researcher identifies the essence of human experiences about a phenomenon described by participants. Understanding the lived experiences marks phenomenology as a philosophy and a method, and the procedure involves studying a small number of subjects/people through extensive and prolonged engagement to develop patterns and relationships of meaning (Lim, 2024).

Research Paradigm

A common characteristic of social research is that it is located within the confines of a particular paradigm (see Cypress 2015). A research paradigm is a set of beliefs and practices guiding researchers' inquiries. It serves as a framework that influences every aspect of the research process, from formulating the research question to interpreting results (Creswell & Poth, 2018). According to Creswell and Poth (2018), the impact of a paradigm in research is seen in these three elements of research:

- Method selection: The chosen paradigm directly influences the choice of research methods. This study utilised individual interviews.
- Data analysis: Different paradigms lead to different approaches to data analysis. Thematic analysis was used in this study.
- Validity and reliability: Concepts of validity and reliability differ across paradigms. This study focused on credibility.

Research paradigms are vital in research as they help to determine the methods and techniques used to collect and analyse data. In this study semi-structured interviews were used to gain a deeper understanding of the factors that informed the Black African mothers' experiences of postnatal depression. The data were analysed using a thematic analysis, identifying themes in the responses from the research participants. According to Rahi (2017) there are four elements of a research paradigm, namely ontology, epistemology, methodology and axiology. Rehman and Alharthi (2016) defines ontology as the nature of reality. Epistemology as the theory of knowledge, especially regarding its methods, validity, and scope, and the distinction between justified belief and opinion, methodology and axiology as the study of the nature of value and valuation, and of the kinds of things that are valuable. This study embodied an interpretivist paradigm that advocates for multiple realities of realities based on the research participants' experience with postnatal depression. Whether it be from a biomedical perspective or an ethnomedicine perspective.

This study applied the interpretivist paradigm, which is used to explore the behaviour, perspectives, feelings, and experiences of people, as well as what lies at the core of their lives. The basis of it lies in the interpretive approach to social reality and in the description of the lived experience of human beings (Atkinson et al., 2001). It is suitable for this study because it enables researchers to consider different factors, such as behavioural aspects based on

participants' experiences, and this would help to describe reality given the assumptions and beliefs of the interpretivist researcher (McGlinchey, 2021).

This speaks to the nature of this study, which is to understand postnatal depression from the perspective of Black African women, their experiences, the belief systems that they base their understanding of postnatal depression and how their beliefs inform their behaviour. Furthermore, the interpretivist paradigm would enable researchers to treat the research context and situation as unique, considering the associated circumstances and the participants involved. This paradigm would also support the research to be more focused on the specific topic and abstain the research from heading towards more generalisations as given in the positivist paradigm (Mbhiza, 2024).

In addition, this qualitative research design is interesting in terms of words and experiences that correlate with the interpretivist paradigm because each Black African woman's experience of knowledge of postnatal depression is unique to her circumstances. It also encapsulates the research title and prohibits deviation from the research topic through research objectives and research questions. Hence, this paradigm was very applicable to this study because the characteristics stated complemented the study.

3.3 Sampling and selection techniques

Sampling is the process of choosing a part of the population to represent the whole. If the researcher considers a part of the population as a representation of the whole, the analysis will be more comprehensive (Moser & Korstjens, 2018). A sample is the selected (people or objects) chosen for participation in a study; it is a subset of the population (Cooksey & McDonald, 2019). There are two types of sampling in research: probability and non-probability. Probability sampling ensures that everyone in the group has an equal chance of being chosen. Non-probability sampling is the type that relies on specific criteria and personal judgment. It is more subjective (Sefcik et al., 2023). Non-probability sampling is a method where only some participants in the population have an equal chance of being selected. As mentioned above, it relies on specific criteria and personal judgment. There are several methods under non-probability sampling. Geddes et al. (2018) note that probability sampling methods include simple random sampling, systematic sampling, stratified sampling, and cluster sampling. On the other hand, nonprobability sampling methods involve samples that are available to the researcher or selected by the researcher. In quantitative research, probability

sampling is usually applied, whereas in qualitative research, nonprobability sampling is selected (Abedsaeidi & Amiraliakbari, 2015). This study falls under non-probability sampling because the participants had to fit a set criterion in order to be part of the study.

The purposive sampling technique, also called judgment sampling, is the deliberate choice of an informant due to the qualities the informant possesses (Tongco, 2007). Purposeful sampling resides on the proposition that information-rich samples are to be selected to have an in-depth view of the phenomena (Meyer & Mayrhofer, 2022). This study used purposive sampling because the purpose of this study is to gain insight on the experiences of Black African women's understanding of postnatal depression.

There is so much more than meets the eye regarding snowball sampling. It is also called "network," "chain referral," "respondent-driven," and "seeded" sampling. (Novita, 2021). Polit-O'Hara and Beck (2020) state that snowball sampling, also called the "chain method," is efficient and cost-effective for accessing people who would otherwise be difficult to find. With this method, the researcher asks the first few samples, usually selected via convenience sampling, if they know anyone with similar views or situations to participate in the research. The snowball method takes little time and allows the researcher to communicate better with the samples, as they are acquaintances of the first sample, and the first sample is linked to the researcher (Polit-O'Hara & Beck, 2006). The snowball sampling technique was instrumental in this study, because the five participants from the KZNMSN referred five of their friends that fit the criteria of the study to the researcher.

3.3.1 Participant Recruitment

Recruiting participants proved to be a challenge, however, with a gatekeeper the process of recruiting was manageable. The researcher had contacted the South African Depression and Anxiety Group (SADAG) manager and presented the proposed study. The researcher received positive feedback and the SADAG manager agreed to facilitate a Zoom meeting between the researcher and the founder of the KwaZulu-Natal Mums Support Network (KZNMSN). During the meeting, the researcher was informed that the KZNMSN is a non-profit organisation that collaborates with SADAG on various projects. The researcher was provided with an opportunity to present her proposed study. The founder of the KZNMSN showed interest in the proposed study and emphasised the importance of creating awareness about postnatal

depression in our communities. The sample population was discussed and agreed on as Black African women that are part of the KZNMSN. The inclusion criteria were also discussed, and the agreement was that the mothers participating in the study should be between the ages of 18-40, they should be part of the KZNMSN for at least two years and reside in Durban, KwaZulu-Natal. After the meeting the founder of the KZNMSN agreed to share the researcher's proposed study on the KZNMSN WhatsApp group. Three mothers responded positively and gave consent for their numbers to be shared with the researcher. This posed as a challenge to the researcher because the goal was to have a sample size of ten research participants. The researcher communicated with the founder of the KZNMSN and shared her worry about not meeting her sample target. The founder of the KZNMSN shared the information again in the KZNMSN WhatsApp group and two more mothers responded positively and gave consent for their number to be shared with the researcher. In total, five mothers had volunteered to be part of the study. The five participants assisted in referring the researcher to other potential participants who met the criteria.

Profiles of research participants

The data segment came from the ten research participants (Black African women) who were all instrumental in contributing to the findings. Five of the ten participants were from the Mums Support Network, and the other five were referred to the researcher by participants from the Mums Support Network through their friendships.

Table 1: Profile of participants

Pseudonyms	From	Age	Ethnicity	Number of children	Location of diagnoses
Sandiswa	MSN	23	Xhosa	3	Public hospital
Zipho	MSN	27	Zulu	3	Public clinic
Gugu	MSN	27	Zulu	2	Private health facility
Sindy	MSN	28	Zulu	4	Private health facility
Lulama	MSN	24	Zulu	2	Private health facility
Zethu	Referral	39	Zulu	2	Traditional healer
Sphe	Referral	25	Zulu	1	Sangoma
Zama	Referral	37	Zulu	4	Inyanga
Zinhle	Referral	30	Zulu	1	Self diagnoses
Nqobile	Referral	30	Zulu	3	Self diagnoses

The table above presented demographic data from ten participants, and the participants had a number of children ranging in age from one to four. In addition, the female participants were between 18 and 40 years old. They were located in KwaZulu-Natal, Durban. The sample population comprised mothers from the KwaZulu-Natal's Mums Support Network (KZNMSN) (five participants) and five mothers who were not part of the KZNMSN. However, the mothers from the KZNMSN referred them to the study. Pseudonyms were used to conceal the identities of the participants. The table chart illustrates that two participants were diagnosed in public health facilities, three participants were diagnosed in private health facilities, two participants self-diagnosed themselves and the three of the participants were diagnosed by traditional healers.

3.4 Data Collection

This study used qualitative data collection tools to gain insights into people's constructions of the world is obtained through narratives in which the people being studied communicate the way they understand the world (Cropley, 2022). As Glaser and Strauss (1998: 17) wrote in one of the most famous papers on qualitative methods, "…each form of data is useful for both verification and generation of theory." Data collection is the heart of the research because it produces data that answers research questions and contributes to a body of knowledge in academia. This study used semi-structured interviews as a method of inquiry to collect the data.

A semi-structured interview is conducted conversationally with one respondent at a time; it employs a blend of closed and open-ended questions often accompanied by follow-up 'why' or 'how' questions, and the dialogue can revolve around topics on the agenda (Adams, 2015). As the name implies, semi-structured interviews are more structured. The researcher will already have some knowledge about the key issues and some expectations of what might emerge or even wish to focus the interview to some extent (Cropley, 2022). This method of inquiry was suitable for this study because the researcher wanted to know and understand the 'why and the how' of the mothers' experiences in their responses to postnatal depression as Black African women about other related topics like culture, illness, and support groups. The open-ended questions gave me the 'backdrop' to the mother's views and opinions. The questions were written in both English and isiZulu. After that, the researcher and her supervisor worked through the research questions. In addition, after the research proposal was scrutinised by the School of Sciences Anthropology Department, the Higher Education Committee, and

the University of KwaZulu-Natal RIG office, the research interview schedule was finalised. The channels mentioned above ensured that the research schedule was academically sound, suitable for the study, applicable to the objectives of the study and ethically sound as well.

The interview schedule consisted of 23 questions that were guided by the objectives of the study. Each interview was 60 minutes long. Both versions of the informed consent in English and translated into isiZulu were sent to the research participant via email and WhatsApp before the interview. Their rights as research participants were read to them again, highlighting that the study was voluntary, the research participant had a right to withdraw from the study at any given point and that their identity would be concealed. The researcher recorded the responses of the research participants in her journal. Sometimes, responses had a deeper meaning and understanding. The researcher did follow-up interviews with the research participants to confirm that the researcher understood and interpreted the experiences shared by the research participants. The researcher also did follow-up interviews when a research participant wanted to think about a certain response. For example, the question of the role of culture in understanding women's health and postnatal depression. Two research participants requested an opportunity to think about the question and respond during the follow-up interviews.

It was important for the researcher to establish good communication with the research participants. She had to apply what she had learnt after the pilot study by being transparent and allow the conversation to flow from both the researcher and the research participants. Setting interview appointments with the research participants was challenging because the pandemic came with many changes, such as working from home, home-schooling, and other mothers being back full-time at work. As a result, making time for the interviews and finding privacy, be it at work or at home, to engage with me was very important for the mothers.

The researcher played it by ear and inquired from the mothers when they would feel comfortable. Hence, communication was not without difficulty as the researcher had to make sure that she was communicating at 'comfortable' and appropriate times or calling at times that did not clash with sleeping times of the babies, work time, house chores, and responsibilities. Due to the pandemic and the regulations that came with the lockdown, the interviews were conducted virtually on WhatsApp calls and video calls as well as on Zoom. The researcher asked if she could record the Zoom meetings. Permission was granted to the researcher. This allowed the researcher to take down notes on facial expressions and body language.

The participants' children’s schedules influenced and changed the interview schedule. For example, one of the mothers postponed because her child had to go to the doctor. Because some mothers were busy running the household, the appointments were rescheduled based on the mothers’ requests. The researcher had a new-born during the data collection period. The research participants found this amusing and it served as an icebreaker. Working at home was the norm because the data collection occurred during COVID-19. In addition, Wi-Fi became a way of life, and as a result, when the researcher offered to purchase data bundles for the research participants, they refused. The researcher emphasised that exploitation is an ethical violation. However, the research participants were adamant and stood their ground, saying no. This was because they were already connected to Wi-Fi at home, and at work

All the mothers expressed their preference about how and when they could do the interviews. All the mothers decided to do virtual interviews on their preferred social platforms like Zoom and WhatsApp through video calls and on Zoom and WhatsApp. The video calls allowed the researcher to observe their body language as well as facial expressions during the interviews.

The researcher conducted follow-up interviews after working with the research assistants to transcribe and the data that was recorded during Zoom interview sessions. The researcher emphasised that the follow-up interviews were also voluntary. The research participants who were working from home were more flexible, while the research participants working from the office availed themselves during their tea break/lunch break and after work hours. Babysitters in the form of family members also contributed to the availability of the research participants.

The researcher found that the research participants wanted to talk about many other related topics. They wanted to talk about their children and the emotional support they required from their partners, which might be viewed as unprecedented or culturally incorrect. Some research participants mentioned that maybe if they had waited to have children, they would have gone to Emhlangeni (reed dance) because they would still be virgins. As a result, they would stand a chance to be chosen as a wife by the reigning king, King MisuZulu kaZwelithini’. The emphasis on giving birth to a king sounded exciting and less stressful. Some mothers mentioned how watching the girls on television made them nostalgic, and they thought about their youth, who they were then, and how their lives had changed. They were mourning their youth, and the picture they had of social constructions of motherhood because the reality was totally different. Being female did not automatically make one a mother. Being a mother was also a

role that required one to learn and to adjust too. The mothers spoke about how they wished they could go back to their youth and do things differently. Some were also reminded of the fact that culture can be a double-edged sword. It has beautiful celebrations, especially when a child is born in marriage, but if not, then it can make one feel like an outcast or a failure, having brought shame to the family and oneself. That was not a good feeling at all.

3.5 Data processing and analysis

Data analysis systematically applies statistical and/or logical techniques to describe, illustrate, condense, recapitulate, and evaluate the data (Taherdoost, 2021). While data analysis in qualitative research can include statistical procedures, analysis often becomes an ongoing iterative process where data are continuously collected and analysed almost simultaneously. Indeed, researchers generally analyse for observation patterns throughout the entire data collection phase (Savenye & Robinson, 2004). The form of the analysis is determined by the specific qualitative approach taken (field study, ethnography content analysis, oral history, biography, unobtrusive research) and the form of the data (field notes, documents, audiotape, videotape) (Wickham & Wickham, 2016). Rigorous, trustworthy qualitative analysis is systematic, organised, and iterative in nature (Ravitch & Carl, 2019). Given the amount of detail and data qualitative studies produce, it can also be time-consuming and overwhelming. As such, qualitative researchers should choose analysis strategies that balance data organisation, study purpose, theoretical and conceptual concerns, and the inductive nature of qualitative work (Miles & Huberman, 1994).

The Oxford Learner's Dictionary (1999) defines a theme as the subject or main idea in a talk, piece of writing or work of art. The Cambridge Dictionary defines the same as the main subject of a conversation, book and films, for example. Judging from the above definitions, as well as from the ordinary usage of the word in daily talk, the word "theme" relates to the degree and/or intensity of occurrence of an expressed idea on a specific subject. Thus, the more expressed an idea is, the more likely that it is a theme of a subject. Using a theme, the frequency, commonality, or popularity of an expressed idea is more important than its strength, correctness, and meaningfulness. What is important is how widely it is held, as evidenced by how frequently it is expressed. It is because of this nature of a theme that it has found unprecedented importance in constructivist-based research approaches that value subjectivity

(Afregarde, 2019). The researcher worked with the research assistants to transcribe the data from recordings.

3.5.1 Thematic analysis

Thematic analysis is a data analysis procedure that centres on identifying, describing, explaining, substantiating, and linking themes. It is premised on the view that all information is conveyed with meaning, and this meaning can be deduced from identifying a central idea or a cluster of ideas that gives it a comprehensive meaning (Dawadi, 2020). Nowell *et al*. (2017) believe that its core advantage is thematic analysis's flexibility and ease of use. They assert that it is essential yet extremely helpful in querying the meaning of qualitative data. Braun and Clarke (2006) see thematic analysis as foundational in nature and can, therefore, be applied as a basis for more rigorous qualitative data analysis processes. For instance, critical discourse analysis, a more advanced qualitative data analysis process, can be applied using thematic analysis as its base.

Thus, themes and classes of data generated under thematic analysis can be interrogated. Thematic analysis was relevant for this still because PND is an emerging phenomenon in the Black African community that has triggered dialogues. Furthermore, PND is currently being interpreted from a biomedical, cultural and psychological perspective. Hence, hearing Black African mothers' experiences is needed because data gathering is crucial in research, as the data is meant to contribute to a better understanding of a theoretical framework (Bernard, 2016). It then becomes imperative that selecting the manner of obtaining data and from whom it will be acquired be done with sound judgment, especially since no analysis can compensate for improperly collected data (Bernard *et al*. 1986). This study first collected data through semi-structured interviews. I recorded the interviews where the mothers were comfortable with me doing so. Privacy and a safe space were paramount. I outlined the consent form clearly for the mothers.

The data were analysed through a thematic approach. A hematic analysis is a method for analysing qualitative data that entails searching across a data set to identify, analyse and report repeated patterns. It is a method for describing data but involves interpretation in selecting codes and constructing themes (Braun & Clarke, 2006). After data collection, I first needed to rest and step away from the research to look at it with fresh eyes. After two weeks, I reviewed the responses from the structured interviews to re-familiarise myself with the data and review

the notes I had made through reading and interviewing the participants. It gives context to this phenomenon.

Clarke and Braun (2006), who have contributed immensely to our understanding of thematic analysis, state that thematic analysis is generally a five-step process. 1. Familiarisation with the data 2. Coding 3. Generating initial themes 4. Reviewing themes 5. Writing up. During the data collection period, I conducted semi-structured interviews and noted the responses of the participants. I also used a journal to note encounters that stood out for me and would contribute to the rapport of the study. After completing the fieldwork, I embarked on the thematic analysis journey and followed the six steps as they were processed (Clarke & Braun, 2006). I transcribed the data independently in a private room using earphones to avoid the possibility of any information being leaked. The identities of the participants were removed during the data transcription. The participants were referred to by their pseudonyms in verbatim quotes. Data were shared with my supervisor to receive supervision guidance about the data and analysis chapter, which was explained to the research participants (Arifin, 2018). According to the legal and ethical guidelines, hard copies or written material were kept in a secured cabinet in a locked room. It will be stored for five years, but recordings will be disposed of once they have been used.

Firstly, I familiarised myself with the data that I had collected. That required going through the responses and reading the journal. I had to do repeat this process a number of times. The second step was coding, which entailed finding themes in words, sentences, and expressions based on the interview schedule responses. This process was remarkably interesting because of the isiZulu expressions and African proverbs that kept coming up. The next step involved generating initial themes from the data, which was a broad net because semi-structured interviews give much flexibility to both the researcher and the participants with the open-ended and follow-up questions. The following step entailed reviewing the themes provided much food for thought because the net was so wide, but after working on it for some time, I could pinpoint the themes. The write-up was lengthy, and it was interesting to see everything come together. The opinions, experiences and stories shared by the mothers came alive, and the literature that was used to write up the chapter was relevant. This form of analysis led to the formation of themes discussed in the three data presentation and analysis chapters.

<u>Credibility and Trustworthiness</u>

To enhance the study's credibility and trustworthiness, the study utilised a number of strategies including validity. Validity is concerned with replicability and repeatability of the study and obtaining results or information that does indeed confirm what was found before. Reliability concerns the faith that one can have in the data obtained from the use of an instrument, that is the degree to which any measuring tool controls for random error. An attempt has been taken here to review the reliability and validity and treat them in some details, reliability and validity are the two most important and fundamental features in the evaluation of any measurement instrument or tool for good research (Haradhan, 2017). To reach the above objectives the researcher will use a standardized interview schedule to ask all the participants the same questions and by being transparent about the data collection process through keeping a journal and recording the interview with the permission of the mothers.

Triangulation is a method used to increase the credibility and validity of research findings. Triangulation, by combining theories, methods, or observers in a research study, can help ensure that fundamental biases arising from the use of a single method or a single observer are overcome. Triangulation is also an effort to help explore and explain complex human behaviour using a variety of methods to offer a more balanced explanation to readers (Noble and Heale, 2019). The researcher will be interviewing mothers that have been part of the Mums Support Network between 2-3years from the South African Depression and Anxiety Group. Shenton (2004) discusses the characteristics of ensuring the quality of data. These characteristics will be discussed as pointers below.

Techniques like triangulation, member checking, and prolonged engagement are used to enhance the trustworthiness of the data (see Haradhan, 2017). Credibility is also achieved by ensuring honesty on the part of the participants (Shenton, 2004). This refers to the premise that participants are informed of their right to refuse to participate to ensure their genuine willingness to participate. Lastly, credibility in research is achieved by examining the previous research findings to determine the degree of congruency between the present research study and previous studies. Lastly, credibility was achieved by conducting a thorough literature review of similar and dissimilar studies to identify the gaps in the literature and demonstrate the rationale and need for the current study clearly. The findings are shaped by the data, not researcher bias, through reflexivity and peer debriefing (Shenton, 2004). Confirmability was achieved in the present study through the process of clearly illustrating participants' experiences through the provision of quotes. Furthermore, confirmability was achieved by

explaining the rationale for a small sample size under the allocated analysis method. Confirmability was further achieved by clearly documenting the study's limitations and being aware of my emotional reactions to what I read. Providing thick descriptions enables others to assess the applicability of the findings to other contexts (Shenton,2004). Transferability can be further achieved by the researcher detailing the boundaries of the study (Shenton, 2004). The present research-maintained transferability through the detailed explanations provided throughout the survey concerning the study's research topic, rationale, methodology and discussion session. The present study-maintained transferability by clearly illustrating the boundaries, including the criteria used to select each participant and their demographics to breed familiarity with each participant and allow readers to engage in perspective-taking. Furthermore, the data collection and data analysis methods were illustrated clearly

3.5 Ethical concerns

Ethics deals with moral problems related to the practice of research. Bos (2020) refers to ethics as an inquiry into what is right and wrong and what researchers ought to do. The focus is on the responsibilities of researchers towards the rights and interests of their participants, their audience, their academic community, and their society (Cameron *et al*., 1994; Judd *et al*., 1991). Researchers must maintain ethical guidelines to ensure they have adhered to the principles of good research practice (Judd *et al*., 1991). During the research journey, the researcher went through the process of working with her supervisor to write a sound research proposal. The internal committee scrutinised the research proposal and endured scrutiny from Higher Degrees and the Ethics Committee. That helped shape the research and ensure that people's rights were not exploited in any manner. The researcher prepared an informed consent form that included information about the study, and the researcher and the supervisor's details were clearly stated. The informed consent form was translated into isiZulu.

Researchers must protect their participants from harm or loss and further strive to preserve their psychological well-being and dignity (Willig, 2008). The researcher made sure she protected the research participants through informed consent forms and did not cause harm to them. This study was approved by the Humanities and Social Science Research Ethical Committee at the University of Kwa Zulu-Natal (See Appendix attached). An informed consent was obtained from each participant after they were thoroughly familiarised with the study, including its

purpose, methodology, and contribution to future research in maternal mental health. The participants were provided with consent forms to sign, which detailed their permission to participate in the study and for recording purposes. The researcher prioritised the participants' availability and did not pressurise them because the study was voluntary, and it aimed not to cause harm. The researcher communicated that they should let her know when they were free. If dates were changed for the interviews for personal reasons, the researcher informed the research participants that there was no problem at all. The researcher always emphasised that the study was voluntary and explained the consent letter. Being a new mother assisted in building a good rapport because they felt as if they were talking to a friend. Most of them referred to the researcher as 'mommy,' and they encouraged her and shared tips that could help them adjust to motherhood. Confidentiality was achieved by providing pseudonyms for each participant to protect the participants' identity. Recordings of the interviews will be kept on a password-protected computer, which will only be known by the researcher.

The data collected in this study will be kept at the university with the supervisor for five years. Transcriptions relating to the study will be stored in a password-protected safe with the researcher. Consent forms will be stored separately to maintain each participant's confidentiality.

3.6 Conceptual framework

This study was guided by the social identity theory and the social constructionism theory. The importance of these two theories in is discussed in relation to this study. As well as the debates centred around the social identity theory and the social constructivism. The critiques of the social identity theory and the social constructivism theory is discussed as well as the contributions made by these two theories.

The role of theory in qualitative research

Theory can live within us and emerge from our lived experiences, moving "from our lips to the streets" (Zita, 1998: 207). We resonate with the following expression of gratitude by Hooks (1991) for those theory makers who have risked exploring and disclosing painful lived experiences. A theory is an explanation of the way things work. Those explanations' source, size, and power vary, but they all link back to an attempt to understand some phenomena (Anfara & Mertz, 2015). In qualitative research methods, various approaches have been

outlined in the literature using the terms conceptual framework, theoretical framework, paradigm, and epistemology. While these approaches are helpful in their own context, we summarise and distil them to build upon the case that a balanced and centred use of the theoretical framework can bolster the qualitative approach (Collins & Stockton, 2018). In this study, the two theories mentioned in the introduction serve as the bolster as they explain the behaviour and thinking of the phenomenon being researched.

A theoretical framework is the use of a theory (or theories) in a study that simultaneously conveys the deepest values of the researcher(s) and provides a clearly articulated signpost or lens for how the study will process new knowledge. A theoretical framework is at the intersection of:

- Existing knowledge and previously formed ideas about complex phenomena.
- The researcher's epistemological dispositions.
- The lens and a methodically analytic approach.

Working through these three components renders theory a valuable tool to the coherence and depth of a study. Although there may be instances where the exploratory nature of a study overrules the benefits of a theoretical framework, theory-free research does not exist (Lincoln & Guba, 1994).

A theory, according to Saldaña and Omasta (2018: 257), distils research into a statement about "social life that holds transferable applications to other settings, context, populations, and possibly time periods," These "big truths" have four properties and an explanatory narrative:

- Predicts and controls action through an if-then logic.
- Accounts for variation.
- Explains how and why something happens through causation.
- Provides insights for improving social life.

Discussions of theory in qualitative research related to the theories that ground a methodological approach (e.g., phenomenology, ethnography, narrative) or the epistemological

paradigms that guide a study (e.g., postpositivist, constructivist, critical). Understanding theories that influence methodological and epistemological decisions for a study is critical. Still, there may be room for more clarification between the use of theories of method and the theoretical framework (Glesne, 2011).

3.6.1 Social constructivism theory

Social constructivism is a learning theory propounded by Lev Vygotsky in 1968. The theory states that language and culture are the frameworks through which humans experience, communicate, and understand reality. According to Vygotsky (1970), language and culture play essential roles both in human intellectual development and in how humans perceive the world. This is to say that learning concepts are transmitted by means of language, interpreted, and understood by experience and interactions within a cultural setting. The theory of social constructivism is relevant to the objectives of the study because this study incorporates culture. Culture informs how people perceive the world; thus, it influences different aspects of one's life. Language is an important element of culture. Each culture has a language that it uses to term illnesses. These illnesses fall within the bounds of their culture. If an illness occurs, and the culture does not have a terminology for that symptom or illness, it becomes a problem. Furthermore, a treatment barrier is created if a patient goes to a health practitioner and struggles to express his or her symptoms or to explain their experience.

Knowledge is socially constructed and co-constructed since it takes a group of people to have language and culture to construct cognitive structures. The link here is that while the constructivist sees knowledge as what students construct by themselves based on the experiences they gather from their environment, the social constructivist sees knowledge as what students do in collaboration with other students, teachers, and peers (Holes, 2015). Social constructivism is a variety of cognitive constructivism that emphasises the collaborative nature of learning under the guidance of a facilitator or in collaboration with other students (Amineh & Asl, 2015). This speaks to how culture evolves since postnatal depression is now considered to affect Black African women, and the rituals that they perform are no longer effective.

The human experience of living with postnatal depression and sharing experiences with family, friends and social support systems can help find solutions either from a cultural or a medical perspective as people have dialogues and talk more about postnatal depression. In social constructivism, children's understanding is shaped not only through adaptive encounters with

the physical world but also through interactions between people about the world that is not merely physical and apprehended by the senses but cultural, meaningful, and significant, and made so primarily by language (Hein, 1991). Culture is packed with many elements, such as the spiritual world of ancestors and witchcraft, and all these factors shape the cognitive thinking of the people in society.

Vygotsky believed that the lifelong development process depends on social interaction and that social learning leads to cognitive development. In other words, all learning tasks (irrespective of the difficulty level) can be performed by learners under adult guidance or with peer collaboration. This theory helps to support the establishment of opportunities for students to collaborate with the teacher and peers in constructing knowledge and understanding. Kapur (2018) observes that the social construction of knowledge takes place in various ways and at different locations.

Social constructivism upholds that knowledge develops because of social interaction and is not an individual possession but a shared experience (Kelly, 2012). Social constructivism shifts the responsibility of knowledge acquisition from the teacher to the student. It transforms the student from a passive listener to an active participant and a co-constructor of knowledge among co-learners (Akpan et al., 2020). Knowledge acquisition is particularly important because culture practices enculturation, and with pandemics like postnatal depression rising, yet being underdiagnosed and undertreated. Both the health practitioners, the Black African community as well and the mothers coping with postnatal depression must co-construct and co-learn.

The theory of social constructivism was developed by Soviet psychologist Lev Vygotsky (1896-1934). At the foundation of this theory is the belief that knowledge is not a copy of an objective reality but the result of the mind selecting and making sense of and recreating experiences. This means that knowledge results from interactions between subjective and environmental factors. The reality of being able to choose what makes sense and recreating experiences speaks to the evolving of mindsets and belief systems because of different experiences encountered or changes in perspective that once made sense but no longer make sense. In this study, it is important to understand how Black African women interpret and understand postnatal depression. Furthermore, the old and the new generation know what their

reactions are when a friend or a family member is diagnosed with postnatal depression. How does that factor shape or reshape their reality and their belief system?

In terms of this view, processing new knowledge involves three steps (Vygotsky, 1928). The construction entails building an understanding of a new concept by drawing on many separate pieces of knowledge. This is relevant when it comes to the pandemic of postnatal depression. Because there are so many separate pieces of knowledge on what causes postnatal depression, be it a medical model, a cultural model and psychology, for example. This leads to the second step, which is storage, the mental process of putting new information into memory. As Black African women, the question of being open to differentiating postnatal depression from other lenses. Lastly, there is retrieval, finding and using information that is already stored in the memory and that gives the right to dual or pluralistic approaches to health treatments.

While social constructivism has been considered a leading metaphor for learning since the 1980s (Gergen, 1985; Mayer, 1996) and has received praise for its appreciation of both the internal subjectivity of the learning experience in the individual and the appreciation for the importance of the interactive socials' environment, it has more recently received several critical challenges (Fox, 2001; Philips, 1995). Phillips (1995), who praised social constructivism for its appreciation of the value of active participation in the learner and the social nature of learning, criticised the epistemological relativism of the doctrine. In other words, the nature of knowledge exists only in relation to culture and society. Particular difficulties arise in the debate regarding the relative nature of knowledge construction between the personal and the communal.

Social constructivism has been criticised for emphasising the social and collective role while ignoring the individual's role (Resnick, 1996). Further criticism of social constructivism comes from Fox (2001), who contends that social constructivism is too quick to dismiss the role of passive perception and memorisation in learning. It is suggested that not all surface learning is necessarily of a poor quality and may sometimes be meaningful. Fox also contends that social constructivism fails to address how the external world is bridged to the internal mind (Fox, 2001). Other researchers (Biggs, 1998; Jin & Cortazzi, 1998) have noted that social constructivist teaching approaches, for example, small group interaction, do not always guarantee teaching effectiveness and, in contrast, that large class teaching of 50 to 70 students in China does not always mean that teaching is bound to fail.

3.6.2 Social identity theory

The social identity theory developed from a series of studies, frequently called minimal-group studies, conducted by the British social psychologist Henri Tajfel and his colleagues in the early 1970s. Participants were assigned to groups designed to be as arbitrary and meaningless as possible. Nevertheless, when people were asked to assign points to other research participants, they systematically awarded more points to in-group members than to out-group members. The minimal-group studies were interpreted as showing that the mere act of categorising individuals into groups can be sufficient to make them think of themselves and others in terms of group membership instead of as separate individuals. That finding deviated from a common view at the time, namely, that an objective conflict of interest is a central factor in the emergence of intergroup conflict (Wetherell, 1987).

Thus, social identity theory originated from the conviction that group membership can help people find meaning in social situations. Group membership helps people define who they are and determine how they relate to others. The social identity theory was developed as an integrative theory, aiming to connect cognitive processes and behavioural motivation. Initially, its focus was on intergroup conflict and more broadly on intergroup relations. Therefore, the theory was originally called the social identity theory of intergroup relations (Cole,1996).

The social identity theory was proposed by Tajfel and Turner (1986), and it suggests that individuals experience collective identity based on their membership in a group, such as racial/ethnic and gender identities. This theory (Tajfel, 1978; Tajfel & Turner, 1979) begins with the premise that individuals define their own identities about social groups and that such identifications work to protect and bolster self-identity. The creation of group identities involves both the categorisation of one's "in-group" regarding an "out-group" and the tendency to view one's own group with a positive bias *vis-a-vis* the out-group. The result is an identification with a collective, depersonalised identity based on group membership and imbued with positive aspects (Turner *et al.,* 1987). This is a major reality with regard to perspective when it comes to the belief system of the cause of PND. Also, in the literature review, cultural relativism is discussed as a remedy to cure ethnocentrism regarding health treatment.

This theory is relevant to the study because the research design of the study is qualitative in nature. It uses an emic perspective to capture the experiences of people in their natural settings.

It is looking for knowledge and information in the context of culture about people's beliefs, the genesis of their belief system, peoples' opinions, people's views, and ideologies. Furthermore, it seeks to understand the "when, how and why" of their experiences. This study is about the emerging pandemic of postnatal depression that is becoming a reality in the Black African community. In contrast, before, it was viewed as a "white person's illness." Using the data instrument tool, namely the semi-structured interview, allowed the researcher to ask open-ended questions and to do follow-up questions about the understanding of postnatal depression amongst Black African women. Furthermore, it made it possible to investigate the role of culture in how women generally interpret their health, be it from a medical or cultural model or if they utilise a pluralistic model to interpret and understand their illness.

The concept of a 'collective identity' is very much a reality regarding culture and a tribe. Addressing these conceptual issues takes us back to Vygotsky, whose work focused on how development occurs through social interaction and involves regulating one's own actions by using cultural tools, especially language, in culturally particular ways (1986/1987). Sociocultural perspectives in developmental psychology have advanced Vygotsky's enterprise and echo throughout the current series (Rogoff, 2003; Valsiner, 1997; Wertsch, 1998). One of the definitions of culture "it is that complex whole which includes knowledge, belief, arts, morals, laws, customs, and any other capabilities and habits acquired by man as a member of society" (Taylor, 1871: 1).

Looking at the beliefs mentioned above, belief is the crux of the problem statement of the research is embedded in a cultural belief that stated that African women were immune from postnatal depression because of the rituals that they could perform. However, this belief is being revisited because postnatal depression is becoming a topic and a reality in Black African women. It is no longer a "white person's illness," but it's a multicultural pandemic that is now rooted in medical anthropology as a phenomenon that is being studied. The definition of culture also mentions the word "knowledge;" each culture has long-standing cultural elders and members that practice enculturation. A few more words from the definition of culture that will be mentioned are "laws and customs." Each culture has laws that guide and inform certain behaviours, practices, and rituals. For example, there are laws and customs that fit into how a woman carries herself while pregnant and after giving birth. These laws and practices are complimentary of one's cultural beliefs.

A tribe is defined as (a) a social group made up of many families, clans, or generations that share the same language, customs, and beliefs and (b) a group of persons with a common character, occupation, or interest (Merriam-Webster, 2024). The important element in a tribe is having a collective identity. When one finds one's identity in the cultural group one is part of, there is also an element of pride that creates a line between this cultural group and that cultural group. In the Black African community, there are different cultural groups with different cultural upbringing and cultural belief systems. These cultural beliefs are like symbols of the cultural group one is part of.

One of the traits of a cultural belief can be the ritual that one practices or a belief system that exists in the culture to interpret illness. This research aimed to understand postnatal depression from the perspective of African women through a qualitative research approach to learn about their experiences with coping with postnatal depression. The researcher was interested to learn which treatment avenue they utilised to cope with postnatal depression, how they understood it and if they recognised it as an illness or if they credited superstitions. Furthermore, support is an important element of experiencing a stressful situation, being part of a support group, or receiving support from family and friends. The research was interested in learning what happens when there are different beliefs about postnatal depression and treatment avenues in a family, in a tribe and in culture.

In addition, the nonmaterial culture is a component of culture that consists of the intangible human creations of society (such as attitudes, beliefs, and values) that influence people's behaviour (Idang, 2015). It is important to understand what influences or informs people's attitudes, beliefs, and values, especially about their health, especially in the Black African community, because of their belief in cultural rituals, superstition, and ancestors. There already exists a categorisation of symptoms, diagnoses, and interpretations that have long been standing.

The characteristics of culture are the following (Mahmood, 2017):

- Culture is learnt; it is not inherited biologically but learnt socially by man. This means that enculturation is a big part of culture. The knowledge of health and cultural belief systems is passed on from generation to generation.

- Culture is social. It does not exist in isolation. This means that culture comprises different components such as a belief system, rituals, practices and language, for example.

- It originates and develops through social interactions. It is shared by society's members. This study will be interesting in learning about the role of culture in interpreting illnesses (Glesne, 2011).

Culture is dynamic and adaptive (Shafie et al., 2017). Though relatively stable, it is not altogether static. It is subjected to slow but constant changes. Culture is responsive to the changing conditions of the physical world as it assists us in surviving and adapting to these changes.

- This confirms the problem state of this study, where there has been an evolutionary evolution around the viewing of postnatal depression as a pandemic that is multicultural. Some people might be open to pluralistic intervention to prioritise their mental health.

Also, regarding a cultural lag, coined by William F. Ogburn, an American sociologist in 1922, it is stated that a material culture tends to develop and advance faster than a non-material culture (Ogburn, 1922). A cultural lag is a gap between the technical development of a society (material culture) and its moral and legal institutions (nonmaterial culture). The term "cultural lag" refers to the notion that a nonmaterial culture takes time to catch up with technological innovations and the fact that this lag causes social problems and conflicts. What the Black African community is experiencing is culture shock about the reality of postnatal depression.

The social identity theory was developed to explain how individuals create and define their place in society. According to the theory, three psychological processes are central in that regard: social categorisation, social comparison, and social identification (Vaughan *et al.,* 2023).

> (a) Social categorisation refers to the tendency of people to perceive themselves and others in terms of particular social categories, such as relatively interchangeable group members, instead of as separate and unique individuals. An example of this is being part of a cultural group or a tribe and identifying with their belief system and cultural practices.

(b) A social comparison is the process by which people determine the relative value or social standing of a particular group and its members. This creates different groups and tensions if one group believes in one thing and the other group believes in something else. In this study, we sought to understand PND amongst Black African women. Blacks, including different ethnic groups, were willing to participate voluntarily in the study should they meet the study criteria.

(c) Social identification reflects the notion that people generally do not perceive social situations as detached observers. Instead, their own sense of who they are and how they relate to others is typically implicated in how they view other individuals and groups around them.

The social identity theory is a classic social psychological theory that attempts to explain intergroup conflict as a function of group-based self-definitions. SIT grew out of Henri Tajfel's early work, which attempted to apply cognitive grouping and gestalt phenomena to social groups (Hogg & Williams, 2000). Cognitive grouping involves "judgmental accentuation," where cognitive categories lead to the increased salience of distinguishing features between categories, exaggerating category differences. Applied to social groups, this principle could be used to explain biased and exaggerated perceptions of differences between groups. Tajfel (Tajfel 1970; Tajfel *et al*., 1971; Tajfel & Turner, 1979).

Different social groups believe in the cause and diagnoses of postnatal depression that vary. The variation in thinking might cause the opposite of cultural relativism and bring about an ethnocentric cultural view of "other" social groups with different beliefs. They divided people into two groups based on arbitrary criteria. They showed that even this "minimal" group basis led people to form psychological groups, exaggerating the positive qualities of one's own group while exaggerating the negative qualities of the out-group. Subsequent studies have attempted to demonstrate the wide range of socially important phenomena that result from such a categorisation, such as negative evaluations of the out-group (Dovidio, Gaertner & Validzic, 1998), stereotyping and failure to allocate resources to out-group members (Sidanius, Pratto & Mitchell, 1994).

However, more recent research has questioned whether social identification leads to out-group degradation and tends to emphasise positive in-group regard more than out-group degradation (e.g., Reynolds, Turner & Haslam, 2000). Positive in-group bias can be explained because the

in-group takes on a self-relevant role, where the person defines themselves through the group. Thus, comparisons between groups are emotionally laden and equivalent to self-other comparisons, with group threats interpreted as threats to the self (Smith, 1999). Turner (1975, p. 10) describes the in-group-out-group relationship as entailing a "competition for positive identity," out-group categorisations strategically framed to maximise self-evaluations. Thus, the treatment of out-group members is directly related to the motive to protect or enhance the self (Tajfel & Turner, 1979).

Because social identity effects are based on the protection and enhancement of self-concepts, a threat to the self-concept would intuitively be related to the strongest identity effects. Several laboratory and field studies have empirically confirmed that when groups pose a threat to one another, the impact of identification increases. For example, negative out-group characterisations can result from perceptions of out-groups as competing for resources (e.g., Cooper & Fazio, 1986) and when groups view the out-group as having a history of tense relations (e.g., Duckitt & Mphuthing, 1998). This factor has made social identity theory useful in political psychology. Self-threat is a big deal regarding long-standing traditions and remedies used from the olden days that have been passed on. For example, a Black African would point to biological factors as the cause of postnatal depression and refuse to use traditional remedies that have long been standing. This has the potential to create segregation between her and her community. She might be viewed as part of "another" group because she no longer shares the same collective thinking regarding traditional health beliefs.

Critical debates from a critical psychology perspective show that the social identity theory offers important insights regarding the social identity bases of discrimination, prejudice, and intergroup conflict by identifying these phenomena resulting from group-based categorisation and self-enhancement motives. However, the historical evolution of the theory itself also offers an interesting case in which intergroup conflicts become redefined as aspects of individual identity. As social identity theory became more focused on self-verification as an epistemic need (e.g., Hogg & Williams, 2000), rather than self-enhancement as a motivational driver of identification, the conflictual bases of social identity became less central to the identity literature than the formation of a stable self-concept.

While both of these bases were apparent in the original theory, critical scholars may question whether such a development leaves social identity theory less able to unpack the psychological

bases of conflict and more focused on individual psychology of concept formation. In this respect, the social identity theory may have developed increasingly in the direction of an individualist cognitive approach at the cost of its sociological origins. Yet, the diversity of current approaches using the term "social identity" belies simply diagnoses, and the story of the theoretical evolution of the social identity concept is far from over. More generally, this evolution reflects wider concerns over the role of the "social" in social psychology, a question central to critical psychologists' concern with linking cognition, attitude, and emotion with more significant social phenomena (Smith, 1999). As postnatal depression emerges and becomes more researched according to current affairs, the cause and effect of intergroup prejudice and intergroup conflict is yet to be unravelled.

The social identity theory is not without critics. According to the Theory Hub (2024), these are the criticisms of the social identity theory:

(a) Deterministic: Some critics argue that the social identity theory is overly deterministic, implying that individuals have no agency in shaping their own identities and are solely driven by the need to form positive identities for themselves.

(b)Limited scope: The theory focuses on the role of social comparison and group membership in shaping individuals' self-concepts and sense of self-worth. However, it does not address other factors that can shape an individual's identity, such as personal experiences, culture or personal characteristics.

(c) Lack of empirical support: Despite its popularity, there is limited empirical research to support Social Identity Theory. Some studies (Harwood, 2020) have found that the theory does not always align with the findings of real-world situations.

(d) Limited applicability: The theory has primarily been applied to issues of prejudice and discrimination, intergroup relations, and the formation of stereotypes, but its applicability to other areas, such as consumer behaviour, organisational change or political persuasion, is less clear.

(e) Limited guidance for practitioners: the social identity theory provides a valuable framework for understanding social identity. However, it does not offer clear guidance

for practitioners on how to use the theory to develop interventions or strategies that target social issues such as prejudice and discrimination.

Social identification is important because it influences how people see themselves and how they interact with others. If people have a positive view of their identity within a group, they are more likely to relate well to others in that group and feel positive emotions about themselves (Cruwys et al., 2014). A sense of belonging is essential, especially in the Black African community, and culture brings togetherness. Cultural systems include cultural health systems in society that make up a society's diagnosis system, as well as the cultural pharmacy for remedies that are used to heal people as well as

3.7 Conclusion

This chapter has discussed the methodologies and methods that have been used in this research study. It motivated for the use of the qualitative research method in an attempt to understand the experiences of Black African women diagnosed with postnatal depression. It highlighted the importance of detailed documenting of the perspectives of the participants. This chapter also highlighted several research methodological tools that were used in collecting data, including focus structured and semi- interviews. It further gave an account of and motivated for the research design, sampling techniques, methods of data collection, procession and analysis and ethical issues that were considered for this study. The discussions in the chapter situate this study within a critical and interpretive perspective where both the researcher and the participants are involved in constructing meaning.

CHAPTER 4: Postnatal depression as we know it

4.1 Introduction

Women's understanding of postnatal is complex. Postnatal depression can be understood and interpreted from a biomedical and from a cultural lens. Using the narratives collected through open ended interviews, the chapter discusses the women's understanding of PND and the sociocultural constructs that they use to understand the medical condition. The chapter begins by discussing the mothers' understanding of PND, this is followed by the symptoms of postnatal depression, furthermore, the diagnoses and treatment of postnatal depression.

4.2. 'What am I feeling?': Mothers' understanding of postnatal depression

Diseases and illness manifest themselves differently. As a result, it becomes a personalised experience that is understood from an emic perspective. The journey of motherhood encompasses a profound array of emotions, experiences, and challenges that extend beyond the surface of joy and elation (Modak *et al.,* 2023). The experience of postnatal depression is uniquely felt by the mother experiencing the symptoms. Hence, it is essential to be culturally relevant in understanding postnatal depression from the Black African women who participated in the study. In the African culture, this is a culture shock because young girls are raised to be mothers and wives. Motherhood is viewed as a "natural process, " not a transition that requires adaptation and adjusting. Childbearing is an essential factor in African marriages, and infertility is attributed to cosmology or ancestral factors. Children are deemed to be "isipho esivela kuMvelinqanga noma kwabaphansi (children are a gift from the Creator, God and from the ancestors) (Pettersson, 1969).

Motherhood is a transformative journey that brings joy, challenges, and profound changes to a woman's life. Amid the joyous moments and new beginnings, it is essential to acknowledge the less-discussed aspects of motherhood, particularly those related to mental health (Javadifar *et al.,* 2016). Postnatal depression is under-detected by health practitioners, and new knowledge has emerged that Black African women are no longer protected from postnatal depression by the cultural rituals that they can perform (see problem statement). Maternal mental health is not just an individual concern but has far-reaching implications for the child's emotional, cognitive, and social development. Furthermore, the effects of maternal mental health reverberate through the family, influencing partner relationships, sibling dynamics, and the overall family environment (Satyanarayana *et al.*, 2011).

Postnatal depression does not only affect the mother, but it also touches those surrounding the mother. The diverse tapestry of cultures across the globe contributes to a fascinating array of

perspectives on motherhood and mental health. Cultural norms, traditions, and beliefs play an influential role in shaping how these topics are understood, discussed, and approached (Wong-MingJi *et al*., 2014). When the researcher asked the question of 'how mothers understand postnatal depression,' it was like casting a nest in an ocean. There were no wrong answers because it was the Black African mothers interpreting how they experienced postnatal depression.

In response to the question posed regarding the Black African women's understanding of postnatal depression, the following responses were recorded.

Consider the following narratives from three participants:

> *Postnatal depression is something that you cannot identify as the mother, but people around you seem to see it. You think you are parenting, yet people see that there is an emotional distance between you and the child. [Lulama]*

> *Postnatal depression is not being able to identify with your child; you are there for them, but there isn't much to look forward to. You don't understand what is happening, especially if you are a first-time mother. [Sindy]*

> *Postnatal depression is a condition where your mind is not fully able to develop affection for your child. It is not your fault as a mother; it happens, and you cannot control it. [Sandiswa]*

The mother's understanding of postnatal depression occurs from a Western perspective. It is understood to be a phenomenon that is not selective of any race. Hence, it can be documented as a universal pandemic. It is understood from a biomedical and a psychological perspective. In addition, it is viewed as an illness that can affect a person.

Consider the following responses about the mother's understanding of postnatal depression.

> *Postnatal depression is what that you experienc after giving birth. It can be caused by several factors, from hormonal changes to stress factors during the pregnancy and a lack of support from family and friends prenatally or postnatally [Gugu]*

> *It is changes in behaviour like having mood swings, not feeling like yourself, having trouble sleeping and connecting with the baby [Zipho]*

The mother's understanding of postnatal depression is further discussed from a Western perspective through the lens of hormonal changes and stress factors such as a lack of support. It is also explained by having mood swings and having trouble sleeping. This emic perspective is critical because postnatal depression is an experience, and each person has a narrative to share. Their construction of the knowledge that they are sharing is based on their personal experience. The above experiences are concurred by Hendrick et al. (1988:26), who put it like this: 'dramatic hormonal shifts accompany the journey of pregnancy and childbirth. The abrupt decline in oestrogen and progesterone levels after delivery is particularly significant. These hormonal changes can have a profound impact on mood regulation mechanisms within the brain. The intricate interrelationship between these hormonal fluctuations and neurotransmitter activity can potentially render individuals susceptible to mood disorders during the postpartum period. The abruptness of these hormonal changes further underscores their potential influence on mood regulation.' The common factor in Black African women's understanding of postnatal depression is that it affects the ability of the mother to care for herself, her baby, and her family (Netsi *et al.,* 2018).

Consider the following mothers' understanding of postnatal depression from a cultural perspective.

> *Wothi ngiku xoxele indaba oe! [Let me tell you a story, girlfriend] I was excited; I had been dating my baby daddy for three years. We were planning on getting married. My family was planning on doing umemulo [umemulo is a traditional ceremony equivalent to a 21st birthday celebration in the Western standard] for me. I had told everyone, and I was super excited, but when I discovered ukuthi ngizithwele [that I am pregnant], that all changed. I was so heartbroken. Anginana hloni nginqena ngisho ukuphuma endlini. [I was ashamed to step out of the house.] I had even posted about umemulo on Facebook. By the time my baby was born, anginganawo amandla [I did not have strength]. I had no inspiration to name my baby. I turned down the offer to even make a birth certificate when the people from Home Affairs came to the hospital. I even bought all the baby clothing online ngoba ngingafuni ukubona muntu [because I did not want to see anyone]." I felt down, unworthy, emotional, lost and disconnected from the world. I knew that something was wrong with me. [Zinhle]*

Consider the following response:

'Umfazi,' [a woman] 'imbokodo' [a rock], I dislike these two words. This learnt reality of social constructions is the cause of postnatal depression amongst Black African women. We are constantly being told that a woman is strong and it's her job to carry her family. Kumele ubekezele, uyibamba ishisa [You have to hang in there and hold on regardless of how challenging the situation is]. I have three children that I have to prioritise over myself. That is a lot. [Nqobile]

Zinhle continued to assert:

Expectations, societal expectations and cultural expectations are the causes of postnatal depression amongst Black African women.

The above responses from Nqobile and Zinhle confirm that culture plays a considerable role in how motherhood and women are expected to act and conduct themselves culturally. There are cultural expectations and social constructs embedded in how a Black African woman and mother should conduct herself in society. In addition, there are certain socially constructed customs, both culturally and societally, rooted in how she should present herself and show up both as a woman and a mother. There are notions of being expected to be strong and handle anything life throws at them. They are being excluded culturally because they are not conforming to the customs of the culture. These social constructions and cultural expectations contribute to the stressors that cause postnatal depression.

4.3 'Should I be feeling this way?': Postnatal depression symptoms

While there may be a generic way of understanding postnatal depression, how people experience the symptoms in their bodies varies. This is because the manifestation of symptoms can be felt, interpreted and understood in various ways. Each society has symptoms that are viewed as normal. This means the symptoms displayed are within the cultural framework of health beliefs. Some symptoms are viewed as 'other' symptoms, which means that the symptoms are not recognised within the cultural framework of health beliefs. Anthropologically speaking, 'the other' is the opposite of the Westernised standard symptoms that are recognised. It is important for mothers living with postnatal depression to be understood from their own perspective. It is equally important for the health practitioner to be medically aware of symptoms presented by some and to be culturally sensitive towards Black African patients.

Symptoms are also indicators of an illness or a disease that requires tests to diagnose the person experiencing the symptoms. After the diagnosis has been made, the treatment options are explained. Furthermore, the benefits and the side effects of the treatment are discussed. This usually occurs within a health facility, be it a public or private health facility or through a traditional healer. The availability of resources to help mothers living with postnatal depression varies at each health facility. As a result, health facilities cannot accommodate patients displaying postnatal depression. In some instances, as in the case of some of mothers who were part of this study, a referral letter was issued to the patients by their local clinic to a hospital with the capacity to treat them. Traditional practitioners also have their own way of identifying symptoms and treating patients. Examples of this will be illustrated through the responses from the participants.

The symptoms of postnatal depression can be spotted by those around the mother, and they can also be noticed by the mother. The following are symptoms are as follows: expressed mood or severe mood swings crying too much, difficulty bonding with your baby, withdrawing from family and friends. loss of appetite or eating much more than usual, inability to sleep, called insomnia and sleeping too much (Mokwena and Modjaji,2021).

Consider the following three narratives about the symptoms of postnatal depression:

> *I am naturally an anxious person and when I heard about the looting it triggered my anxieties. I could not sleep at all. I worried about how I would go to the shop to get formula milk. I even detached from my baby because I was afraid, she would die of hunger! [Lulama]*

> *The was already financially strained and with the looting people started selling things they had took from the shops for double the amount. That made me so moody, and I cried a lot. My mother had to remind me to feed the baby because I was not coping. [Sandiswa]*

Based on the above narratives, it is evident that the environment that the research participants found themselves in caused reactions that are associated with symptoms of postnatal depression. Symptoms include going crazy and being anxious because of the fear of not having formula milk to feed the baby (Sli). According to Sandiswa's experience, shame was caused by not being able to afford it. Lulalama also spoke about being unhappy, and so did Zipho. This

illustrates that there is a relationship between a mother being able to provide for her child and her happiness. Furthermore, this also deconstructs the social construction that all women want to breastfeed their baby. It further highlights the truth that breastfeeding is not an easy process. It also dismantled the unity of the social identity of good mothers being the ones who breastfeed. On the other hand, bad mothers are the ones who use formula milk. The above narratives display a mother willing to withstand the pain of breastfeeding. A mother who put her life in danger in the middle of chaos because she wanted her child to be fed. Lastly, a mother went into debt because she did not want her child to starve.

Consider the following two excerpts about the symptoms of postnatal depression:

> *I was not excited to see my baby after he was born. There was no connection because all I could think of was how having a child ruined my relationship with my boyfriend, it cost me my memulo and it brought about humiliation in my life. I felt resentment towards the child. [Zinhle]*

> *I was having difficulty sleeping, I was tired, and I had mood swings. As a result, I went to stay with my mother, hoping that she would help me with the kids. [Nozipho]*

The symptoms that the above research participants share is validated by Langdon (2024); for most new mothers, these feelings and symptoms develop within the first few weeks after childbirth and can last up to six months. In some cases, symptoms may develop in the months before birth. The withdrawal from friends and family, loss of appetite, feeling lonely and guilty, the inability to enjoy themselves and their lives, mood swings, trouble sleeping, inability to bond with their new baby, anxiety, worry, and/or fear are all symptoms of depression.

The research participants continued to talk about their symptoms. Consider the following three responses.

> *I felt depressed, I could not sleep. I did not feel like myself and I felt down [Zethu]*

> *I was informed that my baby had the Down' syndrome, so it was a difficult pregnancy. After giving birth, I felt disconnected from my baby. I found it difficult to bond with my baby. I felt like a bad mother who could not bond with her baby. [Gugu]*

The above responses exemplify living in a society and experiencing life. Knowledge is constructed, applied, and compared through the gathering of experiences. At the foundation of this theory is the belief that knowledge is not a copy of an objective reality but is instead the result of the mind selecting, making sense of, and recreating experiences. This contributes to the characteristics of the social constructivist theory, which asserts that knowledge results from interactions between subjective and environmental factors (Vygotsky, 1928).

4.4 'Help! I want to feel like a mother': Diagnoses and treatment process

Nature insinuates that after a mother gives birth, she will atomically share a bond with her newborn baby. However, one of the symptoms of postnatal depression states that a mother struggles to connect with her baby.

Getting a diagnosis for postnatal depression is not always a linear process. Culture can play an important role in women's experience of pregnancy and after childbirth as it is comprised of several shared ideas, values, perspectives, beliefs, and perceived standards for emotional and behavioural responses (Haviland, 2000).

Within the postnatal period, there is an increase in the physical and emotional demands on the woman. The debility associated with postnatal depression may impinge on her capacity as a mother for example, to care for and bond with her new-born. In some instances, the woman may be less engaged and may even react negatively towards the child (Lovejoy *et al*., 2000). Without a diagnosis and treatment, maternal postnatal depression may affect her ability to participate in normal activities and interfere with her family and other social relationships. These problems can compromise maternal-infant relationships which may be associated with poor child cognitive and behavioural and social development (Beck, 1999; Milgrom *et al.,* 2011). The partners of women with postnatal depression have also been shown to be at risk of poor mental health (Cameron *et al*., 2016; Paulson& Bazemore, 2010). Although these experiences are commonly shared by women across cultures, experiences of postnatal depression are not shared fully or expressed similarly by women across the world.

4.5 Western diagnoses

The majority of research examining postnatal illness has been conducted in Western cultures (Oates, 2004). There is a growing awareness that the physical and affective symptoms

associated with the Western concept of postnatal depression may be present in many more mothers. However, its manifestation interpretation and management is different in each community (MacLachlan, 2006; Bugdayi, 2004). For example, an exploration of women's postnatal experiences in areas such as Turkey, India and Zimbabwe has shown that whilst overarchingly, women may experience symptoms such as a loss of pleasure, anxiety and physical symptoms, the way in which these manifest themselves, are labelled or treated may be affected markedly by the cultural context and beliefs (Bugdayi *et al.,* 2004; Chandran *et al.,* 2002; Nhiwatiwa, Patel & Acuda, 1998).

There are a many societal stigmas that is attached to mental health and condescending labels and terminology such as "ukuhlanya" meaning one is going crazy. Such labels can act as a barrier to seeking medical treatment. It can victimise people resulting in their isolation, and it can affect one's self esteem.

Consider the following narratives as examples of the above literature:

> *Mina angitatazela in hospital. I would over dress my baby, be the first to sleep and the last to sleep. I was anxious yazi. The shock of having given birth via a C-section when I thought I would have a natural birth. I was still in shock and scared about the healing process. I was so emotional about it because natural birth meant I am strong and brave. I also wanted to be part of that group of mothers who could brag about a natural birth. It was something I had told everyone about, and when my best friend learnt that I had a C-section, she saw how I was not really enjoying motherhood. She told me about counselling that is available in the public hospital. I first saw a counsellor in the hospital. The process was a bit long, from waking up early, standing in a long queue, getting my file, and then finally going to queue to see the counsellor. I thought I would see a psychologist. Anyway, I learnt that people that come to the psych department do not stand in the line. That gave me a bit of confidence because I was getting weird stares from people I knew because they saw me in the psych department. They said "sengiyahlanya" (I am crazy) and they thought I had come to get medication for ukuhlanya (psychosis). [Sandiswa]*

> *Getting diagnosed with postnatal depression was a very simple process for me. My medical aid assigned me to a midwife to talk to and to journey with me. I found out that my child would be born with Down's syndrome. When he was born, the nurses were*

already there hands-on and helping me. But emotionally, I was not okay. My mother moved in with us. But the visits from the relatives, the name calling and sick humour now that is what made me depressed. My mother banned them from ever coming again. My gynaecologist referred me to a psychologist and made an appointment for me. She also does house calls for people who cannot make it to the office. So, it really helped. But I enjoyed going to the psychologist's office. I found it therapeutic. [Gugu]

4.6 Traditional diagnoses

Culture is an important context for most experiences, shared beliefs, attitudes, and norms for emotional response and therefore affects how individuals experience mental health disorders, and the need to seek help (Bina, 2008). It has been suggested that, in resource-constrained countries, women are protected from experiencing perinatal mental problems through the influence of social and traditional cultural practices during pregnancy and in the postpartum period (Fisher et al., 2010). However, as stated in the problem stated according to Mokwena and Modjadji (2021), this is no longer the case. Postnatal depression is a universal pandemic that can affect women from all races.

There are variations in how postnatal depression is encountered and treated cross-culturally. For example, in the Arabic mythology, the phenomena of the Jinn possession are widely accepted. The Jinn are supernatural spirits created from a smokeless flame of fire which have a negative influence on the mind and the body. The Jinn possession is considered an affliction over which the recipient has little or no control (Ghubash & Eapen, 2009). Once within the body, the Jinn alters mood states instigating anxiety, weeping, anhedonia or emotional lability (Al Bahrani, 2004). Although the Jinn can present at any time of vulnerability, possession during the postnatal period is common. Notably, the symptoms of Jinn possession mirror those experienced by women suffering from postnatal depression in Western cultures (Oates, 2004). However, these symptoms are rarely considered to be due to postnatal illness but instead the result of the Jinn's influence (Ghubash & Eapen, 2009).

According to Ladha *et al.* (2018), understanding these cultural variations is pivotal for delivering effective and culturally sensitive care. Healthcare providers must be attuned to the nuances of each culture, recognising how perceptions of motherhood and mental health intersect. This awareness allows for developing strategies that break down barriers, encourage open conversations, and provide tailored support to mothers in a way that respects their cultural

backgrounds. By embracing these diversities, we can bridge the gap between awareness and destigmatisation, ensuring that all mothers receive the comprehensive care they need while respecting their cultural contexts.

The respondents shared the following:

> *I grew up in a traditional community, so I am a proud Zulu woman. I practise our cultures and duties, and I take them seriously. My first pregnancy was very smooth but the second was tough. After giving birth, I was not myself. I heard mothers talking about postnatal depression when I was in hospital. When my mood did not uplift after giving birth, I suspected that I had postnatal depression. But because I had never heard of it in my culture, I was not sure. My mother suggested that I go to a traditional healer. I went there and he was very friendly. His hut was very modernised. We sat across each other in a very formal study setting and he offered me something to drink from his kitchen. He told me that everything I would share would be in confidence. He asked why I had come and after listening intensively. He told me about postnatal depression. My mouth was hanging open. He explained that he is actually enrolled for a master's degree in clinical psychology after years of pleading with his ancestors to grant him permission to further his studies. They only agreed if he would not neglect his call. He gave me traditional herbs to calm me down. And he referred me to a qualified clinical psychologist. [Zethu]*

Mental health specialists, mainly those skilled in perinatal and postpartum care, offer a unique and specialised support layer. Their expertise is finely attuned to the emotional intricacies of the transition to motherhood. With comprehensive knowledge of the hormonal, psychological, and sociocultural factors, these specialists possess the insight to diagnose and treat postpartum mood disorders accurately. Their guidance is instrumental in tailoring treatment plans, whether that involves psychotherapy, pharmacological intervention, or a combination of both (Malata & Chirwa, 2011).

Consider the following narrative.

> *I knew for a fact that there was something culturally wrong with me. Someone was bewitching me. My face changed completely; I would have dreams of urine. That is traditional a sign that someone is casting a spell on you. Especially if your partner is*

cheating on you. I was even stress eating and over thinking. Ebusuku (at night) I would have insomnia. I went to consult with a sangoma. I was told that she would start working at ten because she just came back from her morning shift. After ten she indeed did start. I was number four in line. When I entered, she asked me to sanitise my hands, the windows were opened, and it was so clean! She was warm, welcoming, wearing a pretty dress and her sangoma head doek. She had a bed like the one I have seen in clinics, and hospitals. She asked to check my vitals, BP, my high blood pressure was high and because of all the unhealthy eating I was at the risk of being obese. The scale does not lie. She referred me to the clinic where she works as a qualified nurse, they have a chronic department where I would get tested again. I told her about my experience, and she listened intensely. She told me about postnatal depression, and I was shocked. But she did give me umuthi to cast out witchcraft spells but also suggested that I go to the clinic they have a counsellor there. I would have to arrive Thursday because that is the day, they align the dates for people under the category of mental health. That is how I was diagnosed. [Sphe]

Understanding these cultural variations is pivotal for delivering effective and culturally sensitive care. Healthcare providers must be attuned to the nuances of each culture, recognising how perceptions of motherhood and mental health intersect. This awareness allows for developing strategies that break down barriers, encourage open conversations, and provide tailored support to mothers in a way that respects their cultural backgrounds. By embracing these diversities, we can bridge the gap between awareness and destigmatisation, ensuring that all mothers receive the comprehensive care they need while respecting their cultural contexts (Ladha *et al.,* 2018)

The diagnostic process is influenced by different cultural beliefs. The symptoms and causes of mental health have both Western as well as cultural manifestations. Zethu was diagnosed by a traditional healer, yet she had never heard of postnatal depression in her culture. In the African culture, mental illness is believed to be the work of witches, demons or as the result of some action that offended the gods or the ancestors (Brady et al., 1992). But we see that both the nurse and the inyanga that diagnosed Zethu and Sphe have knowledge of postnatal depression from a cultural perspective, from a psychological and a biomedical perspective. This dissembles the stereotypes of traditional healers not being educated or up to date with medicine.

Sphe was diagnosed by a professional nurse who treated her traditionally (bewitchment) but also referred her to a health facility for counselling for her mental health.

Consider the following response.

> *My dad is inyanga and we know all about traditional medicine. Years ago, he started joining the meetings with the South African Depression and Anxiety Group where different practitioners from different races and belief systems advocate for support systems for people with mental health challenges. So, I used both my dad's herbs to chase any evil that might try to weigh me down because I was feeling very sad after giving birth for no reason. My dad also referred me to his friends that he meets with at their meetings, a psychologist and we chat about postnatal depression. Hence, both the traditional and the Western methods work for me to cope with postnatal depression. [Zama]*

4.7 Self-diagnosis

Self-diagnosis content on social media is a phenomenon that has been progressively emerging in recent years. Previous research identified benefits, like social support, and the shortcomings of self-diagnosing but failed to indicate its impact on the mental health of young adults specifically (Dewak, 2023). In 2020, the pandemic caused a shift in people's social lives due to social distancing, which caused self-isolation and loneliness (Hwang *et al.,* 2020). Consequently, many young adults have been suffering from depression and anxiety (European Commission, European Education and Culture Executive Agency, 2022). At the same time, there has been an availability crisis and long waiting periods for psychotherapy. Since the start of the pandemic, it has been reported globally that waiting lists constitute access barriers for treatment, resulting in the perceived ineffectiveness of psychotherapeutic treatment (Punton *et a*l., 2022). During the pandemic, many people started sharing their stories about their mental health and its stagnancy (Caron, 2023). On the one hand, these conversations contributed to destigmatising mental illness among the general public. On the other hand, it also created a safe space for many young individuals to share their vulnerabilities and see a way of getting social support, which is also expressed through self-diagnosis content (Caron, 2023). The variety in content ranges from comedy skits to political activism (Heiss & Matthes, 2021).

Self-diagnosis is defined as "the method by which an individual perceives and interprets experienced symptoms to form a definition for the existing health state. Available diagnostic tools may be used to measure physical parameters to confirm suspected conditions." (Hatfield, 1996: 18). Grounded in an accumulation of symptoms, individuals can check if their experiences match those and draw their own personal diagnostic conclusions. The considerable influence of the digital age is apparent in the way it facilitated various self-diagnosing possibilities. Dr Google and internet forums were prevailing self-diagnosis methods, but more recently, social media offered other ways of self-diagnosis, such as interactive challenges or informational text posts on various platforms (Aboueid *et al.,* 2021; Mackintosh *et al.,* 2020). Thus, the Internet offers content and information on various medical and psychological conditions.

Past research has identified many benefits stemming from the implementation and use of self-diagnosis (Ryan & Wilson, 2008). There have been shortages or availability crises in certain health sectors in various countries, making it challenging to obtain urgent medical care (Punton et al., 2022). In contrast, digital content is always easily accessible for everyone seeking treatment. Furthermore, it offers information that provides an impression of a disorder for laypeople to use when they are indecisive about a doctor's visit.

As mentioned previously, social support plays a crucial role in self-diagnosing matters. A study involving content analysis by Prescott *et al.* (2017) examined how forums provided peer support and a sense of community by allowing like-minded people to share their experiences. Consequently, people suffering from certain conditions feel acknowledged and less alone with their conditions. An interview study revealed that influencers, in particular, affect which pharmaceutical prescriptions are bought and consumed by their followers (Willis *et al.,* 2022). The study concluded that although influencers have no medical training nor do they disclose their relationships fully with the advertising companies, users are prone to develop high trust in the advice of influencers. Trust-increasing factors are the open sharing of their experiences and, thus, perceived support.

Similarly, many impairments could also be identified with self-diagnosing mental disorders. An interview study by Ahmed and Samuel (2017) concluded that mental health self-diagnosing resulted in adverse effects such as emotional distress and behavioural abnormalities like sleep disturbances. Besides, while some self-diagnoses are accurate, misdiagnosing oneself is likely.

Misdiagnosing oneself can also lead to emotional reactions such as anxiety. In addition to misdiagnosing, over diagnosing has been influential. According to Thombs *et al.* (2019), overdiagnosis indicates the diagnosis of individuals with slight or short-lived symptoms that do not require medical intervention. In mental health, over diagnosing has been growing due to the significant amount of information existing on the internet (Cortez, 2023). Many individuals identify with a disorder, which can create a sense of belonging to that particular cultural or societal group. As a result, labelling oneself with a mental disorder can lead to emotional distress, feeling stigmatised and amplified emotional reactions (Cortez, 2023).

In this context, digital self-diagnosis has expanded from websites to the social media, like TikTok and Instagram. Previous research has investigated the effects of self-diagnosing on mental health diagnosis, such as the study by Gilmore *et al.* (2022). The qualitative research used content analysis to examine how social media, specifically TikTok, affects the increasing number of ADHD self-diagnoses. They used Twitter posts, including the terms "TikTok" and "ADHD", to analyse if there is a link between these two concepts. The results showed that there is an apparent connection between using TikTok and self-diagnosis with ADHD. Other articles have pointed out that the social media are increasingly advocating mental health themes to consumers (Caron, 2023).

Today, technology provides new potential channels for interaction. New ways of making meaning and emerging modes of communication and interaction known as 'new media' or 'digital literacies' suggest a significant change and demand fresh thinking about formal educational settings (Merchant, 2012). As Wodak (2011: 2) states, "we no longer communicate only in 'traditional' written and spoken genres, but also [by]using new ones." In recent years, among those new communication tools, social network sites have been very popular amongst the youth and spending time on social networking sites appears to be part of most young adults' daily activities. More and more young people are interacting on those sites. Social media have radically transformed the nature of modern communication and introduced ways of interaction which, are "fundamentally different from those found in other semiotic situations" (Crystal, 2001: 5). Social media refers to several social networking sites such as Facebook, LinkedIn, Twitter, Foursquare, and Myspace, in addition video sharing sites like YouTube. They are virtual communities that allow people to connect and interact with each other on a particular subject or hang out online (Doğruer *et al.,* 2011). Generally, a social media platform provides its user with a profile, a friend list, a chat option and the ability to send private or public

messages, create events, comment or get feedback, for example. Different SNSs (social network sites) share many of those key features with one another; Facebook, which is of interest to this study, can be used for different purposes by users with differing interests and purposes, to cite a few: maintaining contact with friends, developing a network with other people around one, reuniting with old classmates or friends, meeting people with similar interests, networks for groups and organisations, sharing recent news about a person's life or getting the latest news, and so forth (Doğruer *et al.*, 2011).

Here are a few examples of respondents that self-diagnosed themselves:

> *After experiencing shame and guilt for having a child out of wedlock I maintained a low social profile. I created a fake Facebook account and looked around for groups for mothers. I found a few and I started reading their stories as well as their experiences. I have one persistent friend that bulldozed her way even when I ignored her. She told me about KwaZulu-Natal's Mums Support Network. But I was not yet ready to share my story. But I enjoyed hearing her experiences about KwaZulu-Natal's Mums Support Network. I followed another Facebook page about postnatal depression and the more I read about peoples experience the more I saw myself in them and how I felt. I self-diagnosed myself and started sharing bit by bit and the emotional support I got (still get) has been helping me. [Zinhle]*

Stigma prevents mothers from seeking help, delaying intervention, and exacerbating emotional distress: The stigma surrounding mental health issues often casts a shadow of shame and embarrassment, leading mothers to internalise their struggles and refrain from seeking professional help. This delay in seeking intervention can prolong their emotional turmoil, potentially worsening symptoms and impeding their ability to care for themselves and their new-borns effectively (Dolezal, 2022).

> *My diagnostic process has two sides, I knew I was experiencing symptoms of postnatal depression, and I read about it. I read journals, articles and joined pages on social media and I self-diagnosed myself which is why I was hoping to spend time at home and gather my thoughts. I didn't tell my mother. She viewed it as laziness, unorthodox for umuntu onengane [a person that has a child] not to be active. It was so stressful! I went back to my place earlier than planned. I also joined Facebook pages that are support groups for mothers and mothers coping with postnatal depression. There is*

no judgement there, no stigma because your Facebook account is personal to you and the mothers understand how tough it is to have a newborn. [Nqobile]

The word "stigma" is derived from a Greek term that refers to marks or signs cut or burned into people's bodies to indicate that something immoral, unusual, or bad about them should be avoided (Goffman, 1963). Thus, stigma is an attribute that discredits an individual, makes the person different from others, and essentially reduces the person's status from a "whole and usual person to a tainted, discounted one." (Goffman, 1963: 3). Pescosolido *et al.* (2008: 431) defined stigma as "a mark separating individuals from one another based on a socially conferred judgment that some persons or groups are tainted and "less than" Zinhle and Nqobile experienced different types of stigmas and victimisation due to their experiences. Zinhle had a child out of wedlock, and her partner could not afford to pay 'inhlawulo' (damages) that resulted in her being named and shamed culturally. There was a stigma on her as a woman who had a child out of wedlock.

Perhaps the most thorough definition describes a stigma as a pervasive and global "devaluation of certain individuals based on some characteristic they possess, related to membership in a group that is disfavoured, devalued, or disgraced by the general society" (Hinshaw, 2007: 23). The above definition captures Zinhle experience to the point where she even used a fake Facebook account to join pages on Facebook that would help her cope with PND. She was so ashamed after she could not have a baby shower or continue dating her partner. Stigma has also been thought of as an attribute that associates a person with unfavourable stereotypes (Jones et al., 1984) and subsequent discrimination (Link & Phelan, 1999) and as a combination of labelling, stereotyping, separation, status loss, and discrimination (Link & Phelan, 2001). Applied specifically to mental illness, stigma then refers to the social judgment, degradation, or devaluation of individuals because they have mental illness symptoms or have been labelled as having a mental illness. Nqobile was labelled as 'lazy' during her postnatal period with is against the societal and cultural expectation of a mother. Her adaptation to motherhood was not taken into consideration hence she was judged unfairly.

Consider the following narratives:

I was very irritable because of a lack of sleep. Three children are no joke. When my newborn cried, sometimes, I would lie in bed and not go and attend to him. The exhaustion started making me feel like a robot. I felt numb. [Sandiswa]

The age gap between my firstborn and my second born is 15 years. The times have changed, during my pregnancy I had high blood pressure, because of my age, I gave birth via a C-section and my body was barely carrying both of us. It was exhausting and very uncomfortable. By the time I gave birth I was exhausted, and I had no idea how to create a bond with the baby or what to do. I was clueless and I felt no connection with the baby. It felt strange that I was a mother again. [Zethu]

All four the participants share their narratives about the different risk factors as well as the contributing factors that led to them experiencing postnatal depression. As stated by Myers, (2008), Saunders *et al* .(2012) and Bhattacherjee (2012) there are different factors depending on one's life experience(s). In addition, interpretivism considers differences such as cultures, circumstances, as well as times leading to the development of different social realities (Myers, 2008; Saunders et al., 2012; Bhattacherjee, 2012).

Consider the following responses about the symptoms of postnatal depression.

After giving birth via C-section in summer, I was discharged after three days, there were no nurses to help me with the baby. The hospital staff was so friendly; they would bathe my baby for me even. When I went home, I had to form a routine of my own. It was tough because my husband went back to work after two weeks. The operation made it difficult for me to move around. I could attend to the baby, but I did not have time to bath, rest, catch up on TV or sleep. That made me sad and depressed. I would cry all the time when my husband was at work. I felt very unhappy. [Lulama]

My symptoms were all over the show. My hormones were not balanced ngoba [because] I was not myself. My mood would change; one minute, I was sad and the next, gaze noma [I don't know]. Also, I could not feel the connection between my husband and I as we were sleeping in separate rooms. I also felt guilty about paying attention to my newborn and was not always being able to take the older kids to daycare. It was a tug of war. On top of that I would have strange dreams and hear things outside at night. My mother said maybe the witches were trying to harm the baby. I don't know. [Sandiswa]

Pphenomenology seeks to understand the world through direct phenomena being experienced (Littlejohn & Foss, 2009). The variation in symptoms is so diverse it cannot be generalised. Each participants explained their symptoms according to their personal experiences. They have constructed this knowledge through the lens of their reality.

The respondents continued to share information about the risks as well as the contributing factors of PND.

> *The root of my postnatal depression was disappointment, shame, and guilt. My symptoms were anxiety about going outdoors. Fear of being judged when I went to the clinic. I did not get help from my family; I felt so down, man. They pointed to my son as having destroyed my life. That made me feel negative about my image. [Zinhle]*

> *After giving birth, there was a lady who was very uneasy, and she kept asking to use the bathroom that was not in ward 10 with her baby. She would pace to and fro. I did not make much of it. I do not know how the nurses figured her situation out. But the next thing they called her kindly to feed her baby in a room where some mothers that do not have breast milk sat to feed their baby. When the mother returned from feeding her baby the nurses had phoned her next of kin, her sister. It turns out she was thinking of going to leave her baby in the toilet and then escaping. Her sister came and she was so relieved that they phoned her. They are foreign nationals, and she did not know how she was going to take care of the baby. [Zipho]*

The support network and environment in which a new mother finds herself are influential determinants of her mental well-being. Adequate social support can act as a protective buffer against developing postpartum mood disorders. Conversely, a lack of support or strained relationships can magnify a new mother's challenges, making her more vulnerable to emotional distress. Isolation, whether physical or emotional, can compound the risk, as it restricts the availability of sources to seek comfort, understanding, and guidance. The absence of a strong support network can amplify the feelings of inadequacy and overwhelm that often accompany the transition into motherhood (Corrigan et al., 2015).

In addition, the social identity theory provides a framework for explaining intergroup behaviour and intergroup communication based on the inherent value humans place on social group memberships and their desire to view their specific social groups in a positive light. This desire

can lead to intergroup prejudice and conflict (Harwood, 2020). Zinhle experienced shame and guilt because she deviated from the Zulu cultural norms of not having a child in marriage. Due to Zinhle's partner not being able to afford to pay for the 'damages and honour the Zulu intergroup cultural norms,' Zinhle was ashamed. Zipho witnessed a situation where a mother who could not afford to look after her baby, was thinking of leaving the baby in the public hospital toilet, luckily, the nurses suspected what she was up to, and they phoned her emergency contact number. A mother wanting to neglect her baby is a cultural shock because society views motherhood as something that comes naturally, not as a transition with challenges. An inherent value is placed on being able to carry a baby. There is not much room in society to see motherhood in a negative light or as an experience that can be difficult. Society values mothers that 'hold the knife' on the blade regardless of their circumstances and look after their children even if they are unable to.

4.8 Treatment for postnatal depression

The treatment avenue for postnatal depression is informed by the person's belief system be it Western or African. Both choices come with challenges as well as side effects. used for depression (antidepressants) can effectively treat postnatal depression when used alone or in combination with psychotherapy. (National Institute of Mental Health, 20203) Antidepressants work by changing how the brain produces or uses certain chemicals involved in mood or stress In, addition, Antidepressants take time usually 4−8 weeks to work. Problems with sleep, appetite, and concentration often improve before mood lifts (Sonmez and Hocaoglu, 2024) It is important to give a medication a chance to work before deciding whether it is right for you. The road to finding the suitable treatment for the mother is a process.

Consider the following narratives.

> *Having medical aid was an answered prayer. My gynae immediately referred me to psychologist when I found out that my baby would be born with down syndrome. Talking to someone really does help. The psychologist referred me to a psychiatrist that prescribes medication for me. The medication makes me feel drowsy and sleepy. (Lulama)*

> *I was hallucinating, hearing things at night and my face was covered in spots. I knew that I was being bewitched because people are jealous of my romantic relationship. The*

educated sangoma who is a nurse by profession referred me to the clinic for counselling to talk to someone and she gave me traditional muthi to chase away the works of being bewitched. The muthi is very bitter and it gives me a runny tummy. But I spots on my face are facing and I sleep peacefully at night [Sphe]

Above we witness mothers taking different treatment routes from talking to some (psychologist) to being prescribed medication (psychiatrist) to using traditional muthi from a sangoma and being open to counselling.

Consider the following narratives

I learnt about postnatal depression and the different types of treatment from the KZNMSN. I just could not connect with my baby. As a mother that disconnect after carrying the baby for nine months felt wrong. I visited a counsellor at the local clinic, and she confirmed my symptoms (Sandiswa)

I read up about postnatal depression whilst I was pregnant. I was very mindful of the possibility of experiencing it. When I saw a mother in hospital neglecting her baby, being anxious and pacing up and down. I recognized the symptoms. The nurse called her next of kin and a social worker. (Zinhle)

The above narratives speak to unique experience that each women encounters. As well as their responses to the symptoms. Their source of knowledge about postnatal depression informs where they go to for help and the type of treatment that they are open too.

4.9 Conclusion

This chapter focused on the Black African women's understanding of postnatal depression. The finding presented revealed that postnatal is understood through both a biomedical and a cultural perspective. The symptoms described by the participants are twofold; some of the participants described their symptoms in such a way that a traditional healer was the suitable healer to diagnose and to treat the participant. Whilst some of the participants described their symptoms in such a way that a medical practitioner was suitable to diagnose and to treat them. In some cases, collaboration between the traditional healers and the medical practitioners also took place. This further emphasises the complex nature of postnatal depression.

CHAPTER 5: SUPPORT GROUPS and POSTNATAL DEPRESSION

5.1 Introduction

Social groups are important because they provide a sense of belonging, companionship and common ground for people needing support. This chapter illustrates the role that social groups (online and physical) play in helping new mothers transition to motherhood as well as to cope with postnatal depression. The different types of supports discussed are as follows, the KwaZulu-Natal's Mums Support Network, peer support, online support groups and family support. In addition, the experiences of having a lack of the above-mentioned supports are included.

5.2 Understanding support groups

Since the 1970s, support groups have emerged as a valuable component of health care and have been found to help improve health outcomes and reduce mortality rates (Munn-Giddings & McVicar, 2007; Pfeiffer et al., 2011). A support group is a community of individuals united by common struggles and working to deal with life's stresses together. Support groups are an appropriate way of providing psychological, emotional, and educational support to people affected by health emergencies (Dayton, 2022). According to Helgeson and Gottlieb (2000), support groups are rarely theory-driven but are guided by the notion that people facing similar problems have a shared understanding and can offer mutual and empathic support that naturally occurring social supports may not be able to do. A person's support network may lack experience, be consumed by stressors, or feel uncomfortable responding to the issues that arise (Helgeson & Gottlieb, 2000). Today, different types of support groups cater to people who are experiencing other challenges. Support groups act as an anchor for people with similar experiences. In this study, support is contextualised in the form of the KwaZulu-Natal's Mums Support Network (KZNMSN), peer support, dualistic support, and online support through social media.

Consider the following responses, as Black African women who are part of the KZNMSN share their understanding of the KZNMSN.

> *"I would say the KZN Mums Support Network is both an online support group and a physical support group that gives emotional support to new mothers and to mothers*

that are living with postnatal depression. It is also a physical support group where mothers come with their children to a safe place to talk through their hardships and challenges in a coffee shop. I was overwhelmed, I needed support, emotional support. The KZN MSN taught me about motherhood and how to cope with stress and anxiety. [Zipho]

The KZN Mums Support Network enlightened me about adjusting to motherhood. We chat online on the WhatsApp group, and we meet in person for coffee. It is a support network for mothers! You learn how to solve parenting dilemmas and to cope with motherhood challenges [Sindy]

Through the experiences shared above the KZNMSP can be viewed as a safe space for mothers living with postnatal depression to gather and to talk without judgement. It is a place where knowledge can be gained when other mothers share their experiences. It is a place the same threat of motherhood bonds the Black African women, and this has become their social identity as a collective. The KZNMSP plays both a role in helping the participants to cope with the challenges of motherhood and to cope with postnatal depression.

The researcher found that the participants loved engaging with this particular question. Their responses were filled with gratitude and warmth. They could not stop sharing about the positive impact that the KZNMSN has had on their own personal lives, the lives of their children, and their families. This is because their families were not always equipped to understand what they were going through.

A support group is a meeting of members who provide help and companionship to one another. Support groups comprise people who have been through the issue at hand. In such groups, they feel more comfortable sharing their experiences and expressing their feelings and concerns in the open with others who have experienced similar situations, people generally feel less isolated while sharing their experiences. Group therapy involves group discussion and other group activities in treating psychological disorders (County of Monroe Michigan: Commission on Aging. Support groups, 2019). Both Zipho and Sandiswa were happy to share their understanding of the MSN and the personal role it had played in their motherhood journey. The understanding of the MSN is accompanied by an experience that reveals the personal need it met and the kind of support it provided for them. A familiar trait is the comfort and the safety that both these mothers feel in expressing how they felt and in receiving comfort from reading

or listening to the lived experiences of other mothers adapting to motherhood whilst others cope with PND.

The following responses were from the mothers about their understanding of the KZNMSN.

> *It is a lifeline for new mothers, mothers struggling with postnatal depression and for mothers that have overcome postnatal depression that share their lived experience. I like the fact that mothers can bring their babies to the meeting place. Some mothers also need time to step out of the house [Sindy]*

> *Yangisiza kakhulu, angidinga abantu abandlula kwisimo esifana nesami. Akuba umama akukho lolu. Futhi kuthatha isikhathi esininga ukuba uMama. Kuyasiza ukuthi siyatholana e grouphini futhi siywakwazi ukuhlangana. Ukuxoxa nabanye omoma kuyaphilisa. [Lulama]*

Support groups are founded on the premise that supportive interactions with people who have experienced similar problems can give individuals a sense of empowerment, increase self-efficacy, and enhance coping skills (Pistrang et al., 2008). The aim of the founder of the KZNMSN was to share her knowledge and experiences of coping with postnatal depression and that is how the KZNMSN was formed. Both Lulama and Sindy reiterated that shared experiences are a form of comfort and empowerment for some mothers in the group.

Consider the following narrative as Gugu shared her story:

> *'It takes a village to raise a child-' that is the KZNMSN in a nutshell. If something is wrong with my son, I'm free and not scared to ask in the group. I feel free to tell them how I'm feeling. Nobody judges me or my child. Wothi ngikuxoxela ngengane yami nesimo engabekana naso khathi ngikhulelwe. Isimo esangi cindezela kakhulu. Angingakholwa, angisaba futhi inhliziyo yami ibuhlungu. Ingane yami ngoba iyenzeni? Isipho isono sami esingaka? Angixeka uNkulunkulu. Ube kuthi udokotela wami eyengasiyena umunto onesineke futhi osizanayo ngabe ngasikhipha isisu. Ukuba ne medical aid kwangisiza ngoba wakwazi ukungi xhumanisa nomuntu engizokhuluma naye. Angikwazi nokumfonela noba sibonane kuZoom. Kanye nama ofisi akhona ashayisana nomona. U-private uyenza yonke into ibelula ngoba awulibe ulinda. umtwana wami une Down's syndrome. [Gugu]*

> *Let me tell you a story about my baby and the situation I faced when I was pregnant. A situation that made me depressed. I could not believe it; I was scared, and my heart was sore. What did my child do? What is my sin? I criticised God. If my doctor was not a person that is patient and helpful I would have aborted the baby. Having a medical aid helped because my doctor was able to find someone for me to talk to (psychologist). I would phone the psychologist, and we would meet up on Zoom. Their offices are also very refreshing. The private sector makes everything easy because you do not have to wait. My baby was born with Down's syndrome.*

When Gugu shared her story on Zoom, she told the researcher how her mother had supported her from day one. Gugu asked if the researcher had children, and the researcher shared her current experience that she was also expecting a baby. Gugu squealed with excitement. She further asked about the gender and offered if the researcher would be open to accept hand-me-downs and new baby clothes because she had gone overboard with shopping. The researcher shared that she was actually in the same predicament. The non-invasive test that the researcher had done for Down's syndrome had come back intermediate. Meaning that there was a chance that her baby could have Down's syndrome. Gugu and her mother asked about the next appointment and the name of the gynaecologist. The researcher had to do another non-invasive test that is 99 percent accurate to find out if her baby would be diagnosed with Down's syndrome. It was an emotional moment, and it was Gugu's baby that eased the emotional moment with his sweet baby cries in the background. The researcher was taken by surprise when she went to her next appointment. The researcher found Gugu waiting for her with a bouquet of flowers, a card and chocolate. Gugu asked to remain in the waiting room. Before the researcher went inside the consultation room Gugu asked to pray with the researcher and her spouse. She laid hands on the researcher's womb. After that, they said their goodbyes and Gugu walked out of the office.

It was at that very moment that the researcher realised that social capital is an anchor. It presents the opportunity for a person to be supported. People do not have to know each other or be close. A similar experience can act as glue that makes people stick together and share in a difficult moment. Anguish and difficult circumstances can bring out kind behaviour in people. The researcher made a note to allude to Down's syndrome in her research because of Gugu's story. Not forgetting the profound moment that the researcher had shared with Gugu and her mother through their compassion. The literature asserts that support groups are developed to join

people together who are dealing with similar difficult circumstances. A support group offers a safe place where you can get information that is practical, constructive, and helpful. You will have the benefit of encouragement, and you will learn more about coping with your problems through shared experiences. Hearing from others facing similar challenges can also make you feel less alone in your troubles (Strozier, 2012). Some mothers shared their experiences of the benefits of being part of the KZNMSN.

The respondents stated the following about the benefits of being part of the MSN:

> *Angifuna uxhaso kokusekelwa ngokozwelo ukuze ngazi ukuthi kwenzakalani emqondweni wami ngaleso sikhathi. Umnyeni wami uyena owangitshela ngesifo sencidezlo emva kokuteta. Mina anginganalo ulwazi olubanzi mayelana nesifo sencidezelo emvakoku teta. I-KZNMSN yangisiza ukuthi ngibone ukuthi kwenzakalani kimi. [Zipho]*

> *I wanted emotional support to be aware of what really was going on in my mind at that moment. My husband told me about it, but I did not know much about postnatal depression. The KZN Mums Support Network helped me to understand what was happening to me. [Zipho]*

> *Anifuna uxhaso kokusekelwa ngokozwelo, abantu abandlula kwizimo ezicisha zifane noma ezifana nezami ngoba lokho kwenze uzizwe ungekho wedwa. Kunikana isiqiniseka ukuthi ungenza konke ekusemandleni, kodwa akudingi ukuthi umuntu aphelele (angabinawo amaphutha). Lokhu kungasiza ukwehlisa ukukhathazeka okuhambisana nokuba umama kanye nendidezi emvakoku teta. Ukuteta ngomthungo bese uqhubeka unakekela ikhaya ngoba umkwenyana wami akufanele aphindele emsebenzini akungelula. Nga gcosha ama thipsi ngokuhlela usuku lwami futhi noku bhekana nesimo sokuba umama. [Lulama]*

> *Emotional support, the sharing of similar experiences that make you feel that you are not alone. Being given the reassurance that you are doing your best and you don't need to be the perfect mom. This helped decrease the anxiety that comes with being a mom as well as with postnatal depression. Having a C-section and then running the household because my husband had to go back to work was not easy. I received a lot of tips about structuring my day and coping with motherhood. [Lulama]*

Zipho and Lulama shared their experiences of how being part of the KZNMSN had benefitted them. Zipho benefitted by learning more about postnatal depression whilst Lulama stated that she gained tips about structuring her day as well as coping with motherhood. This shows how support can be found in many different forms depending on the circumstances that one is going through.

The support group was said to be a source of information for the young mothers. Sandiswa shared that she felt a sense of belonging in the KZNMSN. She was always empowered and amazed at the wealth of information she gained at each session.

Consider the following narratives about the benefits of being part of the KZNMSN:

> *Getting more information, to be with women that have experienced postnatal depression, to share what we all have been through and to see how one can learn and overcome the same challenges. Because I would just lie there while my baby cried. I was exhausted. I learnt how to cope, [and] ways of communicating if I needed help with the baby and knowing that there are other some mothers doing this really uplifted me. [Sandiswa]*

Gugu also highlighted the sense of belonging and shared the following:

> *Being able to talk to other mothers going through postnatal depression and talking to other mothers whose children also have Down's syndrome was comforting. There is absolutely no judgement*

Similar to the other participants, Sindy shared that she

> *"...benefitted through the shared experiences in the group. It uplifted me, eliminated myths and it encouraged me.*

The respondents above shared about how they benefitted from being part of the KZNMSN. Sandiswa mentioned that she learnt to cope with postnatal depression through the shared experiences and that gave her hope. Especially, being able to ask questions and get answers. Gugu expressed how she gained a community that was on her and her baby's side regardless of the mean words her extended family would use when referring to her child. She gained a family of sisters that uplifted her. Sindy shared how she gained truth and perspective from the

KZNMSN about the reality of motherhood and the reality of postnatal depression. Emotional support, shared experiences and the open communication meant a great deal to the above-mentioned participants.

The researcher noticed a pattern in the responses from the participants from the KZNMSN. This pattern revealed how shared experiences and emotional support are needed in a support group. People need to know that they are not the only ones going through their situation and they also need to engage with people that have overcome their circumstances. In addition, the mothers do not have to know each other but having common grown (shared experience) helps to build a bond between the mothers.

5.3 Peer support

Peer support is critical because sharing knowledge and experiences is a form of empowerment. The mothers that were referred to the study by the mothers from the KwaZulu-Natal's Mums Support Network experienced support in the following ways: peer support through a kind health practitioner, a Facebook page and through a friend.

As stated previously in this chapter, support comes in many forms, sometimes it is formal and sometimes it is informal. A person can utilise the social capital that they have in their life to lean on for advice, emotional support, information, and their current information, for example. Support is not limited to professional health practitioners, the people that a person lives with on a day- to- day basis can also serve as a support system. Dennis (2003) defines peer support as "the provision of emotional, appraisal and informational assistance by a created social network member." This social network member must be a person who has personal experience of the health-related concern, and will, hence, be considered a peer who can offer reciprocal support (Dennis, 2003; Oades, Deane & Anderson, 2012). In terms of health and well-being peer support groups have a variety of aims, including illness-prevention, disease management, and health promotion (Cohen & Mullender, 2005; Oades et al., 2012). In this study, peer support is contextualised in the setting of the KZNMSN and their friends.

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terms of health and well-being, peer support groups have a variety of aims, including illness-prevention, disease management, and health promotion. Cohen Mullender (2006) and Oades et al.(2012) state that the three distinct aims of peer support groups are:

- To offer a remedial function by focussing on recovery and interaction by centring on personal experiences and relationships, as well as serving a social function through encouraging personal growth and empowerment.
- Peers are therefore able to validate and normalise the problem, thereby reducing isolation and fostering a sense of belonging. Pistrang *et al.* (2008) describes this principle as 'socially supportive interactions,' in which the empathy derived from one's peer group can compensate for the absence of support in people's natural support networks.
- This is supported by Bryan (2013) who suggests that peers who experience similar stressors have an exclusive capacity to respond empathically, due to a shared understanding of the issue.

Peer support within mental health can be defined as support or services provided to individuals experiencing mental health problems by others who have experienced similar problems (Davidson *et al.,* 2006). Peer support is not based on psychiatric models or diagnostic criteria but can be understood as an extension of the natural human tendency to respond compassionately to shared difficulties (Penney et al., 2008). Peers, seen as equals, use their lived experiences to provide "been there" empathy, insight, encouragement, and assistance and to inculcate hope in a reciprocal relationship (Chinman *et al*., 2014). The participants that were part of the KZNMSN and who referred their friends to the study, stated that they shared information about postnatal depression with the intention of equipping one another.

In recognition of the importance of social relationships, peer support has been recognised as a solution to reach socially vulnerable people to prevent catastrophes and excesses, to improve equity and individuals' connection with the community, to facilitate psychosocial adjustment (emotional, healthy behaviour and disease management) and to support and to empower individuals (Cohen & Gottlieb, 2000). Peer support is a powerful tool regarding human behaviour, health and social inclusion (Perry *et al.,* 2014), and is stressed in the WHO's Global Health Workforce Alliance (Bhutta *et al.,* 2010). Peer support will be discussed below based on the responses of the participants.

Consider the following responses:

> *Having a friend that is part of the KZN Mums Support Network has really helped me. Having someone to talk to and to share knowledge with as well as the day-to-day challenges of living with postnatal depression as well as being a mother. My biggest challenge is that my mother does not understand mental health let alone postnatal depression [Nqobile]*

> *I noticed that it's not because my mother is being mean to me but because she does not have the knowledge. We have different beliefs; old people are not like us because they grew up during the apartheid era, so hardship is something that that they had to endure. As a result, they are used to experiencing hardships. This thing of breaking down emotionally, they view that as being a cry-baby or as being childish because life is hard in general. Old people hang in there and endure. Our generation, we talk about our emotions, we want to know about mental health, and we are adamant about it. [Nqobile]*

The researcher noted from Nqobile' response that different generations have different responses depending on how much knowledge they have been exposed to and their backgrounds. That determines if they have the emotional capacity to accommodate someone who is experiencing mental health challenges. For example, Gugu's mother was able to support Gugu as she had navigated postnatal depression and being a mother to her baby diagnosed with Down's syndrome.

5.4 Pluralistic support

The support system journey is not one-dimensional, but it encompasses many routes to help the person needing support. It is up to the individual to choose if they want support from one avenue or from more than one avenue. Each avenue has multifaceted roles that can appeal to the person in need of support. In addition, there are different forms of support, such as doctors, psychologists, psychiatrists, and traditional healers.

Many studies have assessed traditional African health-seeking behaviours, but few have examined the beliefs and practices (Galvin *et al.,* 2024). Religion is a powerful social force in sub-Saharan Africa today (Bosire *et al*., 2021; Mzimkulu & Simbayi, 2006). Religion and

spirituality are powerful social forces in contemporary South Africa. Traditional health practitioners are commonly consulted for both spiritual and medical ailments as a first line of care. After the arrival of Christianity in the late nineteenth century, African countries have been the site of religious syncretism and fusions of Christianity and African traditional practices and beliefs (Thornton, 2017). The belief systems of the research participants varied across African traditions, Christianity, and biomedicine.

In Africa today, these syncretic religious practices have given rise to pluralistic medical fields with newly emerging constellations of healing modalities that meld Western biomedical and traditional forms of diagnosis and treatment (Bosire *et al*., 2021; Hampshire & Owusu, 2013; Moshabela *et al.,* 2016). Medical pluralism refers to the concurrent usage of multiple treatment modalities and is common in places where biomedical and alternative treatments coexist, such as in sub-Saharan Africa (Sundararajan *et al.,* 2020). In recent decades, this encounter between "traditional" and "biomedical" healing practices has attracted significant interest from researchers. Hence, this study explores the perspectives from which the participants understand and interpret postnatal depression, be it traditional or biomedical.

This distinction is influential with regard to the foundational distinction between "natural" illnesses and "supernatural," "man-made," or "African" illnesses (ukufa wa Bantu or imisebenzi yabantu) (Ashforth, 2005). While natural illnesses are susceptible to treatment by Western medicine, supernatural illnesses are thought to only respond to the intervention of healers deploying spiritual powers. In this sense, even THPs hold multiple explanatory models when it comes to illness, as they refer patients who are afflicted with "natural" illnesses to doctors for treatment (Sorsdahl *et al.*, 2010). Thus, as we saw with the THP, who also worked as a professional nurse, the possibility of simultaneously subscribing to and participating in disparate healthcare systems is commonly accepted. Below is an example of pluralistic intervention.

Consider the following narratives of the mothers sharing their experience of dual support:

> *My support system is both medical and cultural. My dad supports me through his traditional knowledge of inyanga, and I also talk to a psychologist. It keeps me balanced. [Zama]*

This is an example of how progressive African traditional healers are and the stereotypes of African traditional healers being backwards, uninformed and only open to indigenous knowledge is not entirely true. Collaboration is an approach that honours both Western and Afrocentric views regarding diagnoses and healing avenues. Zama's father was a traditional healer who also attended workshops hosted by the South African Anxiety and Depression Group. He also allowed his daughter to speak to his psychologist friend because he understood that each healer has a different role to play on the healing journey.

Consider another example of a progressive traditional health practitioner:

> *I was diagnosed by a woke sangoma who happens to be a nurse by a professional. I killed two birds with one stone. I got support from her as a sangoma and support from her as a health practitioner when she made a referral for me to go and see a counsellor. To assist me in coping with postnatal depression. She did a cleansing ceremony to get rid of the fatigue and the bad luck. [Sphe]*

In another study examining medical pluralism among psychiatric nurses in South Africa, researchers found that the nurses subscribed to pluralistic systems, which drew on both African and Western cultural worlds without an absolute allegiance to them (Kahn & Kelly, 2001). This reflects the view that different practitioners can fulfil various needs. An additional distinction may be the role THPs play in African societies, which not only work to assuage the symptoms of the illness but also provide an "explanation" for the illness (Wreford, 2005a). Some experts argue that this may justify the continued popularity of THPs even in places where biomedical treatment is relatively easy to access (Crawford & Lipsedge, 2004; Mbwayo et al., 2013). Due to the strong tendencies towards medical pluralism already in place among THPs in this region, collaboration between doctors and THPs is overwhelmingly supported by the latter, as evidenced by the results of this study.

5.5 Online community

Living in the 21st century has afforded social media platforms where people going through the same experiences can form a community and support one another. This is convenient because people can be supported from the comfort of their own homes. They can use pseudonyms because they do not want to be labelled or experience stigma from those around them, and they

can also read up about other experiences and find comfort. Online support groups have contributed a lot to people's healing process.

An online support group or community is defined as “any virtual social space where people come together to get and give information or support, to learn, or to find company” (Berger et al., 2005: 3). Predictors of participation in online peer support are (i) limited access to adequate support within traditional social network(s), (ii) living with health-related stigma, (iii) perceived similarity and credibility of support providers, (iv) and convenience and other features of computer-mediated communication (Wright, 2017). The predictors of participation will be contextualised according to the participants' responses.

Several studies have found that people are more willing and feel more comfortable sharing sensitive information or asking sensitive questions on the Internet (Berger et al., 2005; Cline *et al*., 2001). Studies of online peer support groups find many positive aspects that resemble those of line peer support groups, including social connectedness (Highton-Williamson et al., 2015), helping cope with day-to-day challenges and stigma reduction (Smith-Merry *et al.,* 2019), and facilitating insights into health care decisions (Naslund *et al.,* 2016), empowerment (Barak 2008), and recovery processes (Smith -Merry *et al.,* 2019). Additionally, online peer support groups have been found to provide emotional support, insights, and experience about living with mental health problems, which are not typically available through traditional mental healthcare (Wright & Bell, 2003).

Through online support groups, face-to-face contact is no longer a requirement for support groups, with online social networks becoming increasingly common, providing more accessible forms of health service delivery (Magnezi, Bergman & Grosberg, 2014; Medina, Loques & Mesquita, 2013). For example, a randomised control trial investigated the benefit of online heart disease support groups in bringing about behavioural change in patients with coronary heart disease (Lindsay *et al.,* 2009). This study compared moderated online groups, that is, online groups facilitated by health professionals, to un-moderated online support groups based solely on peer interactions (Lindsay *et al.,* 2009). Lindsay *et al*. (2009) found that moderated online support groups help increase social support, build motivation and self-confidence, and reduce risky behaviours such as poor dietary intake, outcomes not replicated in the unmoderated support group phase. Overall, the literature suggests there is a growing

movement towards online support groups, and there is a potential for research to be focused on this growth area.

Please consider the following narratives from the participants who are friends of the mothers from the KwaZulu-Natal's Mums Support Network.

> *I was not keen at all to join any support group because I was so ashamed and embarrassed after the whole memulo and baby daddy saga. I spoke to my friend Sandiswa because she would not stop checking up on me. I was ignoring all my friends. She told me about KZNMS., She would send me voice notes on WhatsApp sharing what she had learnt. The new information that she learnt from the KZNMSN group about postnatal depression and coping with being a mother. I secretly started reading up about it on Google and finally I created another account on Facebook. I looked for pages that speak about motherhood as well as postnatal depression. I found so many of them. At first, I just read the stories that women shared about the hardship of motherhood as well as their experiences of postnatal depression. The comment section was so comforting because people wore their hearts on their sleeves, and they confirmed that indeed I was not the only one going through a difficult time alone. I could relate to stories of strangers in other parts of the world. I even came across similar experiences to mine. [Zinhle]*

Nqobile also shared her experience with online peer support and having a friend from the KZNMSN.

> *My friend Zipho gave birth a few months before me and when I went to visit her after birth, she told me about her diagnoses of postnatal depression and being part of KwaZulu-Natal's Mums Support Network and her diagnosis of postnatal depression. This was a foreign concept to me but the more she shared the more curious I became. I gave birth a few months later and because of the experiences that she had shared a seed of curiosity was planted in me. I had to do more research as an individual because I could relate to some of the symptoms that Zipho had shared. I read a lot of journey articles and magazine articles, and they confirmed that indeed I was experiencing postnatal depression symptoms. I also use social media platforms to follow personalities that share information about postnatal depression. There is something*

comforting about knowing that you are not the only one going through something. [Nqobile]

Zinhle, continued to share her experience.

The interesting thing about online communities is that they are cross-cultural, yet the experiences that I read intersect. This reality has a way of removing the shame and the stigma that one carries. And the option of using a fake account to hide one's identity is such a great thing because not everyone is ready to speak out publicly. [Zinhle]

Consider the following responses about online support on WhatsApp.

Travelling with a baby is a lot of hard work. The prospect of having to leave the house with a baby is overwhelming. The KZNMSN WhatsApp group makes everything easier. I used it a lot to ask questions about coping with motherhood. I read a lot about the experiences of postnatal depression that mothers shared in the group. Receiving help in the comfort of my own home and in the privacy of my phone is wonderful.

Online support communities are accommodating especially to mothers with newborns because they do not have to leave the house. They can utilise the KZN MSN WhatsApp group and not feel left out. It also accommodates mothers who are not ready to have face-to-face encounters with the real world and to share their experiences in person. It is a great protective wall between the mothers and the world. Support groups on social media are also a great community that the mothers engage in in the comfort of their homes, simultaneously relating to other mothers who are going through the same challenges as them.

Consider the following excerpt about the KwaZulu-Natal's Mums Support Network WhatsApp group:

I could not make the coffee meet up with the KZNMSN because my maternity leave was up. But I enjoyed reading on the WhatsApp group about the experiences on the WhatsApp group. I also heard that some mothers are friends in real life now. How amazing is that! [Lulama]

Consider the following response:

> *My favourite thing about being part of the KZNMSN is getting real time responses. There is always someone ready to jump in, to sympathise and to share their experience. It is so comforting knowing that one is not alone. [Gugu]*

The following literature supports the above responses. Peer support in mental health care, whether provided one-on-one or in groups, is defined as "a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement on what is helpful" (Mead *et al.,* 2001**)** and involves people with lived experiences of mental health problems supporting others in their recovery process (Davidson & Guy, 2012; Repper & Carter, 2011). An underlying premise for peer support is that individuals facing a similar life event or health-related problems are in a unique position to understand one another in ways that one's professionals, friends, and family may not (Helgeson & Gottlieb, 2000).

5.6 Reflections written by the mothers

The mothers wrote letters and poems to reflect on their experiences with coping with motherhood, postnatal depression, navigating myths and reality of motherhood and celebrating their support networks. Most importantly, it also signified a journey of healing and restoration.

Becoming a mother can be seen as a profound moment of personal change that ties women to the past, the future and each other. Yet what it means to be a mother is shapeshifting in line with women's increased participation in work and education and household chores (Adkins, 2009). Motherhood, the socially constructed role of caring for others is culturally derived. Each society (past, present, and future) has and will have its own ideology regarding motherhood (Thurer, 1995). These ever-changing ideologies encompass beliefs, norms, symbols, rituals, ideals, and expectations. According to Birns and Hay (1988: 141):

> The ideology of motherhood operates under the following central points: all women want to be mothers, a biological mother always loves her biological children, the biological mother is the best caretaker for her children, mothers know intuitively what their children need, infants need the constant presence of their mothers, love and marriage and motherhood are naturally linked, and motherhood within the heterosexual structure of marriage is the best way to raise children.

The above paragraph contextualises motherhood as a social construct embedded in cultural expectations.

Motherhood, a socially constructed role involving nurturing and caring for others, has been portrayed in a myriad of ways throughout history, and these portrayals function as dominant narratives in our society (Arendell, 2000; Uttal, 1996; Vandenberg-Daves, 2014). The media, including broadcasting, publishing, and the internet, is mass communication that plays a role in shaping reality and identity. Real-life mothers' identities are simultaneously shaped and overshadowed by the representations of motherhood in the media (Forcey, 1994) that become "culturally constructed consensuses" (Lang, 2006: 15). These representations communicate various ideals and expectations of what is called good mothering that are often not attainable because they are so "formidable, self-denying, elusive, changeable, and contradictory" and are not reflective of real life, but yet play a pervasive role in shaping the actions and mindsets of real-life mothers. (Thurer, 1995: xvi). Hence, the importance of this study is to attain an emic perspective from the participants to deconstruct oppressive social constructs. Hence constructing new knowledge that helps one to heal comes in different forms and writing is one of the many ways the healing journey can take place. Writing your true story can heal you, both physically and emotionally. Expressive writing, writing that integrates your emotions and insights with memories of events that occurred in your past, has been shown to improve the immune system and positively affect diseases such as the chronic fatigue syndrome, arthritis, and asthma. Self-disclosure and confessions have long played a role in relieving stress and promoting health. Writing letters that will never be sent is a way of expressing your feelings to particular people without blasting them in real life with the force of your emotions (Myers, 2021). Motherhood comes with many changes and waves of emotions. The mothers wrote the letters as a form of exhaling, getting in touch with realities, reclaiming their identities, and reliving their expectations of motherhood and the reality they experienced. They are celebrating themselves for enduring and not giving up. Lastly, they show appreciation for health practitioners.

As a researcher, listening to the mothers share their reflections was heart-warming because the mothers viewed being able to reflect as the process of conquering their 'Mount. Kilimanjaro's' (postnatal depression).

Tributes to the KwaZulu-Natal's Mums Support Network from the participants

Sindy shared this tribute; she said it was part of her diary entry. Reflecting helped her to appreciate the journey and her resilience regardless of the circumstances. She shared that she had also shared the tribute with her friends as a form of encouragement.

Tribute 1

> *"Lost" is the best word that describes how I felt. I did not know that one could experience a miracle through birth yet feel so disconnected. The ache in my heart could not be filled, and I did not have any peace. I searched for a safe landing until I came across the KZNMSN.*
>
> *Knowing that I am not the only one going through this was comforting for me. The stories that the mothers told helped me to see myself through their realities. That normalised what I felt, and it removed the stigma I had put on myself. The open communication gave me strength each day to wake up, to show up not just for my baby but for myself. I could also explain it better to those around me and that helped a lot. Because they were very confused about my symptoms.*
>
> *I now live with hope because I have a support system that is so kind and welcoming. I can ask questions freely because there is no room for judgement.*
>
> *Thank you KZNMSN. [Sindy]*

Tribute 2

> *Ngiswele izibongo zokubonga umphakathi owanginika ithemba ngingazi noma liya shona noma liyaphuma ilanga. Njenge'skhukhukazi nangifukamela nanginakekela.*
>
> *Ngiyabonga khaya lami lemfundo malo ngokungiseka.*
>
> *Sengiyazi manje ukuthi incedezelo emva kokuteta yinto ekhona engakhethi bala noma ulimi.*
>
> *Nangiwqeqesha ngamazwi futhi nangesi piliyoni senu.*

Manje sengishayela phezulu futhi nami sengiyisi bani sethemba kwabanye omama abasando kungena kulomphakathi. [Lulama]

I am at a loss of words to show my gratitude to the community that gave me hope when I was not sure if the sun wass rising or setting.

Like a mother hen hovers over her children, you took care of me.

Thank you, my home of warmth, for supporting me.

Now I know that postnatal depression is something that exists. That it is not limited to any race or language.

You alerted me with your words and with your experience.

Now I am walking tall.

I am a beacon of hope to other mothers that have recently joined this community.

Tribute 3

What a comfort it is to find common ground, to hear similarities in the stories and in the experiences. That has given me freedom and liberation to not shy away from how I feel. But to acknowledge it and to get all the help that I can get. I love the KZNMSN, mothers you are hope and strength! You share your journey with so much grace and that gives me strength. It confirms in my heart that indeed, I too, will see the other side.

Like a candle in the dark, you have been my hope.

Like fertile soil that feeds the erosion of hard ground you have softened my heart.

Like shelter under the harsh summer rain, you have been a refuge.

Like a cold glass of water on a hot day you have quenched my longing to be part of a community that knows about postnatal depression. [Sandisiwa]

Consider the following narrative by Nozipho. Nozipho shared how she started writing the tribute bit by bit every night for a week. She expressed how feelings of victory would overcome.

Tribute 5

Uyalazi igumbi lemfundomalo?

Into ekufica usesemeni esibu cayi kodwa ikushintshe ufunde ukuphila nencindezelo.

I-MSN yangenzela isimanga, wena owabona uDladla uphenduka uDludla?.

Noma angine nkani ekuqaleni ngingabaza ukuba yinxenye ngoba ngingana mahloni.

Usiszo ngalithola futhi ngiyaqhbeka ngiyaluthola.

Kwaze kwayisibusiso ukuxox nabanye abesifazane ababhekane nenqinamba ezifana nezami.

Siyakhana futhi sinikwana ulwazi mayelanae nencindezela eyehlela omama emva koku teta.

KZNMSN, ngiyabonga angiphezi. [Nozipho]

Do you know a corner of warmth?

A situation tha tone finds in a place that is critical, yet this places changes things, and you learn to heal from depression.

The MSN did wonders for me. Have you ever seen a situation miraculously changing?

Even though, at first, I was stubborn and didn't want to be part of the MSN because I was nervous.

But I did receive help, and I continue to receive help.

It is a blessing to talk to other women facing the challenges as mine.

We encourage and build each other up; we share knowledge amongst ourselves about postnatal depression.

KZNMSN, thank you endlessly.

Gugu shared that one of the homework exercises her psychologist gave her was to keep a diary. She would read it out loud during the session as a form of self-awareness and self-actualisation. The day she read this aloud, her psychologist applauded her for her resilience through this journey and her gratitude attitude.

Tribute 6

Shine, KZNMSN, shine!
You ray of hope.
This network is such an anchor in our community.
It's a safe place for all e mothers experiencing postnatal depression.
I love it, and I appreciate it.
I had no idea how I'd cope on a day to day with postnatal depression. But this support platform has been my consistent saving grace time and time again.
I love the conversations there.
I love hearing about the stories of conquering.
KZNMSN, you are my hope.
I am so hopeful, not just for me but for my baby as well.
Thank you. [Gugu]

5.7 Conclusion

Social support groups are an anchor for new mothers diagnosed with postnatal depression. The KwaZulu-Natal Mums Support Network provided both an online and a physical support group for the new mothers. They were able to share their experiences and also learn and be empowered by the testimonies of other mothers in the group. The online community also provided support and granted the new mothers the option of remaining anonymous. Furthermore, peer support as well as family support proved to be equally effective. On the contrary, the lack of support experienced by the new mothers added to symptoms that the new mothers were experiencing.

CHAPTER 6: BLACK AFRICAN PERSPECTIVES on MENTAL HEALTH and ILLNESS

6.1 Introduction

Culture shapes our beliefs and behaviours as human beings. In this chapter mental health is discussed within the South African context. The role of culture in how illness is interpreted through language and symbols is explained. In addition, the role of culture in how women understand illness and in how women relate to postnatal depression as a new phenomenon in the Black African community.

The relationship between culture, health, and mental health is one of the oldest relationships. Culture is at the centre of understanding illness through the customs and traditions embedded in the African health belief systems. The manifestation of illness symptoms and mental health vary according to each person's experience. The person's belief system can shape how they recognise and understand the symptoms they experience. Cultural relativism goes hand-in-hand with enculturation because indigenous knowledge about African cosmology, witchcraft and ancestral worship plays a tremendous role in how each generation views sickness. In addition, culture bound illness is the differentiating factor between an illness being recognised as an illness in a culture and it being viewed as foreign to culture.

6.2 Mental illness

Mental disorders are considered to be among the most poorly treated illnesses in sub-Saharan Africa (Nkulu Kabamba, 2014). In South Africa, while over 16% of adults are estimated to suffer from a common mental disorder, just over 5% of those with a disorder receive treatment from a clinic or hospital (Audet et al., 2017). Previous studies estimate that between 70% and 80% of South Africans consult traditional health practitioners for the treatment of illness, with higher rates for psychological ailments, although these figures are largely estimates, as most traditional health practitioners do not keep records of the patients who make use of their services (Ashforth, 2005; Crawford & Lipsedge, 2004; Kahn & Kelly, 2001; Mzimkulu & Simbayi, 2006; Thornton, 2009). This study found evidence of traditional health practitioners still being the first place of consultation.

While some researchers have characterised mental healthcare in South Africa as composed of two 'duelling' and 'largely incommensurate paradigms' when describing Western psychiatry and traditional healing traditions, noting the 'discordance between cultural beliefs and conventional psychiatric concepts of disease' (Kahn & Kelly, 2001: 35; Ojagbemi & Gureje, 2021: 455). Others have posited that these paradigms are not necessarily incommensurate as some traditional health practitioners incorporate ideas regarding the causation and treatment of mental illness that are borrowed from biomedicine (Galvin *et al*., 2023; Hampshire & Owusu, 2013; Mendu & Ross, 2019**).** Historically, relatively little attention has been paid to the unique sociocultural elements of mental disorders and their treatment in Africa. Recent research has shown that even when receiving effective hospital treatments, roughly 60% of mental health service users in contemporary sub-Saharan Africa will simultaneously consult traditional health practitioners for mental health treatment (Ojagbemi & Gureje, 2021). This study found otherwise. A pluralistic approach was noted through the responses from the participants.

While some writers predicted in 1960s and 1970s that traditional belief systems in Africa would disappear with 'modernization' (Ashforth, 2005). Many indigenous Africans continue to embrace and promote traditional African worldviews which inform health seeking and healing practices. This includes beliefs and practices related to sorcery and bewitchment (Nkulu Kabamba, 2014). In addition, other studies in South Africa have noted the increasing numbers of people becoming traditional healers in recent years (Campbell & Amin, 2014; Thornton, 2017**).** In many traditional African belief systems, mental health issues are among the most commonly perceived problems related to bewitchment or ancestors, and traditional health practitioners and religious advisors are viewed as experts in these realms (Kpobi *et al.,* 2019; Ngobe, 2015). Many researchers have realised the importance of religious-cultural elements related to mental illness causation and treatment in sub-Saharan Africa in recent years. In this study the African belief system is captured through the experiences of the participants.

6.3 Mental illness and other forces

According to Farreras (2019), references to mental illness can be found throughout history. The evolution of mental illness, however, has not been linear or progressive but somewhat cyclical. Whether a behaviour is considered normal or abnormal depends on the context surrounding the behaviour and thus changes as a function of a particular time and culture. Throughout history, there have been three general theories of the etiology of mental illness: supernatural,

somatogenic, and psychogenic. Supernatural theories attribute mental illness to possession by evil or demonic spirits, the displeasure of gods, eclipses, planetary gravitation, curses, and sin. Somatogenic theories identify disturbances in physical functioning resulting from either illness, genetic inheritance, or brain damage or imbalance. Psychogenic theories focus on traumatic or stressful experiences, maladaptive learned associations and cognitions, or distorted perceptions. Etiological theories of mental illness determine the care and treatment mentally ill individuals receive. In this study, the cause of mental illness varies according to each person's beliefs and background.

Culture is an important context for most experiences, shared beliefs, attitudes, and norms for emotional response. It, therefore, affects how individuals experience mental health disorders and the need to seek help (Bina, 2008). It has been suggested that, in resource-constrained countries, women are protected from experiencing perinatal mental problems through the influence of social and traditional cultural practices during pregnancy and in the postpartum period (Fisher *et al.*, 2012). For example, in Pakistan (Rahma *et al.,* 2019) and Vietnam (Fisher *et al.*, 2010), social support from caring parents and adults within the community or family can be a protective factor for adolescents. It could compensate for the absence of other protective factors and promote resilience (Fisher *et al.,* 2012). This was noted in the responses of the participants about the role of support uplifting them.

Traditional health practitioners identified eight primary treatments that they use for treating mental illness. Among these were the throwing of bones (tinhlolo) to start communicating with ancestors, steaming (ukufutha) to begin a cleansing process, sneezing (umbhemiso) to forcefully dispel the spirit causing the illness, induced vomiting (phalaza), and the administration of laxatives (mahlabekufeni) to remove the spirits poisoning the body as well as animal sacrifice to purge spirits and communicate with ancestors (Galvin et al., 2023). The participants in the study narrated their preferred treatment avenues.

Consider the following excepts about understanding mental health.

> *Mental health can be anybody's friend. Who knew that I could suffer from postnatal depression after getting pregnant out of wedlock? Mental health is a state of mind that can happen anywhere and anytime. [Zinhle]*

My marriage was shaky after I gave birth. I saw the signs of my husband cheating. When he could not tolerate me, then ngasolo isichitho [I suspected a spell]. My mental health challenges were a combination of real-life issues and a bit of voodoo. [Zama]

Participants Zinhle and Zama had similar stances about their understanding of mental health, namely that mental health is something that can happen to anyone and circumstances can cause distress that can lead to mental health. Nobody is above being diagnosed with any mental health illness. Zinhle expressed shock at having suffered from depression during her pregnancy, which resulted in postnatal depression after she gave birth. Zama also shared two factors that contributed to her mental health challenges. Firstly, her circumstances in her marriage (infidelity) as well as her belief that she was bewitched through *isichitho* (spell). We see that circumstances and life events can cause anxiety, resulting in mental health challenges. In addition, cultural perceptions also impact how one interprets their experiences and symptoms.

6.4 Culture-based symbols and language to interpret and explain illness

Northouse and Northouse (1992) and others (Dainton & Zelley, 2005; Rothwell, 2004) have defined communication as the process of information sharing where those involved in the communication share a common set of rules. The common symbols and language may be obscured by special professional jargon, including using medical terms to describe the condition and treatment options available to the patient. All these communication processes are dynamic, ongoing, and ever-changing transactions that involve human feelings, attitudes, knowledge and behaviour. Thus, in an interaction between two or more individuals representing divergent cultural orientations and where different rules may govern the communication process, the opportunity for miscommunication is significant. Variations in symptoms and cultural beliefs may also cause miscommunication. Thus, resulting in an illness being undertreated.

Brislin and Yoshida (1994) comment that the typical Western medical model for communication in healthcare encounter is the direct question-and-answer method, which seeks to establish the facts of the case and often relies on the use of negative and double-negative questions, for example, “ You don’t want to get a heart disease, do you?” For the culturally diverse individual or family, this approach to the communication process may be seen as cold and too direct or otherwise in conflict with their more traditional beliefs, values, and ways of seeking, communicating, and receiving healthcare. Most of these trends have local cultural

names and are regarded as "diseases" or at least ailments in their native populations (Goyal, 2023). Hence, a collaborative effort is required from both health and traditional health practitioners.

The respondent shared the following narrative.

> *Physical attributes or physical appearance are automatically linked to one's health. If you are plump or ukuluphele [you are chubby] they will say you are healthy. Or you are happy, or you are pregnant. 'Unonile, ukhululekile [you gained weight], you are not stressed by anything. However, some people eat a lot because of depression, and they end up overweight. So, you can be depressed and still gain weight, but Black people think it means you are happy, which is not true. It is a misconception. If they are skinny, they assume you are sick. [Zama]*

> *I know that being pregnant with a child with Down's syndrome was viewed as an illness and a sign from the ancestors. As Black people we always point to ancestors, witchcraft and superstition. But I do not believe in that [Gugu]*

Zama's response is an example of enculturation of what the norm is and what is not the norm in terms of physical attributes. The following literature agrees with the above analysis. The variation may be equally significant across ethnic, class, and family boundaries in our own society (Suchman, 1965). Importantly, doctors' explanations and activities, like those of their patients, are culture-specific (Freidson, 1974). Healers seek to provide a meaningful explanation for illness and to respond to the personal, family, and community issues surrounding illness (Zola, 1972). Gugu's response was in line with the literature mentioned above.

6.5 The role of culture in understanding women's health

According to Hesperian (2023), when people are healthy, they have the energy and strength to do their daily work, fulfil their many roles in the family and community, and build satisfying relationships with others. In other words, health affects every area of our lives. Women are more likely than men to have certain health problems because of poor nutrition, too little rest, or the type of work they do. A disease can also cause a different kind of harm to a woman than a man. For example, a disease that changes how a woman looks may make her husband or

family reject her. Women's health problems are often taken less seriously than those of men. Women are less likely to seek and receive treatment until they are very ill. Certainly, with certain traditional belief systems, illness is often understood as an omen or as a sign of Karma where the person who has that illness has an ancestorial debt to pay, these debts manifest themselves through the mind and body making postnatal depression no exception (Patel *et al.,* 2013).

Illness is shaped by cultural factors governing perceptions, labelling, explanation, and valuation of the discomforting experience (Fabrega, 1972), processes embedded in a complex family, social, and cultural nexus (Litman, 1974). Because the illness experience is an intimate part of social systems that have meaning and rules governing behaviour, it is strongly influenced by culture: it is, as we shall see, culturally constructed. Illness is culturally shaped in the sense that how we perceive, experience, and cope with disease is based on our explanations of sickness, explanations specific to the social positions we occupy and systems of meaning we employ (Kleinman, 1975). These have been shown to influence our expectations and perceptions of symptoms (Mechanic, 1972), the way we attach particular sickness labels to them (Waxler, 1974), and the valuations and responses that flow from those labels (Waxler, 1974). Those labels inform the treatment avenue chosen by the patient,

How we communicate our health problems, how we present our symptoms, when and to whom we go for care, how long we remain in care, and how we evaluate that care are all affected by cultural beliefs (Kleinman, 1975). Illness behaviour is a normative experience governed by cultural rules: we learn "approved" ways of being ill. It is unsurprising that there can be marked cross-cultural and historical variation in how disorders are defined and coped with (Yap, 1974). This informs what is accepted as an illness and what is viewed as abnormal by society.

Consider the following responses about women's illness and the causes.

> *Sickness in the Black African community is based on existing African categories. For every symptom or experience there is a name for what you are going through or a remedy or a person that you can go to in the community for help. There is also someone in the community that has gone through it. There is also a category for women and sickness. There are culture bound syndromes that are closely related to ancestors and witchcraft. Yabona njena if uyumuntu wesifazane ungakwazi ukuthola ingane hawu ukhona umama endaweni o dila nalezizimo. If uya kuma period waya-way hawu*

kukhona umama uzokuthsela ukuthi uphethwe yini, ibangwa yini futhi uzolugwema kanjani. There is a very solid relation and correlation between spirituality and the understanding of sickness amongst us Black African women. There are cultural gynaecologists as well. Kuya ngenkolo yakho. Wena uthi [You say] I missed my period omunye uthi uvaliwe khona ungeke uyithole ingane. Wena uthi miscarriage omunye uthi bayithwebulile ingane yakho. Wena uthi isistroke oumunye uthi bakushaye uhlangothu ngokuku loya. [Zinhle]

You see if a women cannot have children, then automatically there are particular women in the community that deal with cases like that. If you have your periods non-stop, automatically there is a mother that will tell you what is wrong, what caused it and how you can prevent it. It all depends on your belief system. You say I missed my periods, and another person believes that someone made your periods stop so that you cannot have children. You say that you had a miscarriage, and another person says they killed your baby. You say it's a stroke and another person say they caused your side to be affected by a stroke through witchcraft. [Zama]

The womb not opening had me absolutely stricken with fear. I was so confused; I thought the date that the doctors gave me for my birth was accurate but no angibuzanga elangeni [I did not see it coming]. My family was so stressed and traumatised. They thought that someone was bewitching me and was making sure that my womb does not open so that I do not give birth, or my baby dies. I was anxious and paranoid and basically going crazy. We did it all! We prayed, we consulted with midwives, we used traditional medicine. Only to find that when I spoke to other mothers and read up on Facebook in the mom's groups that I have joined, that there are people that have gone through what I went through. [Sphe]

The above responses are an example of cultural social constructions about health belief systems passed on from generation to generation. It is noted through these responses that living opens up the mind to new knowledge construction through interacting with other people. The role of having previous knowledge also allows one to negotiate what they choose to believe. Sphe was shocked that the date of birth date given by the doctor was not correct because her womb refused to open. Her family that this because of witchcraft. Zama's experience shows the relationship between health and superstition in the Black African context. Both superstition and

the belief in witchcraft and evil powers play a role in women's understanding and interpretation of their illness. Because there are different belief systems everywhere in the world, different religions, myths, and legends that people may believe. These belief systems can be information passed down from past generations or new ideas thought up by somebody in today's world (Schiffer, 2017).

6.6 Understanding Women's Health

As a social determinant, gender impacts health through the differential power that men, women, and gender-diverse people hold in the various spaces they occupy; differential access to resources such as healthcare; the different prevalence of risk-taking behaviour between and among genders; as well as different occupational and behavioural roles, constrained by social norms, that can impact exposure to various health risks and illness (Heise *et al.,* 2019; Phillips, 2005). African women have highlighted that culture plays a dominant role in their lives and therefore shapes them (Reddy, 2011).

Healthcare-seeking behaviour (HSB) has been defined as "any action or inaction undertaken by individuals who perceive themselves to have a health problem or to be ill to find an appropriate remedy" (Olenja, 2004). Health-seeking behaviour can also be referred to as illness behaviour or sick-term behaviour. Health-seeking behaviour is situated within the broader concept of 'health behaviour,' which encompasses activities undertaken to maintain good health, prevent ill health, as well as deal with any departure from a good state of health (MacKian *et al.,* 2003) Studies that have attempted to describe factors that affect health-seeking behaviour significantly during illness episodes can be broadly classified into two groups (Moye *et al*., 2014).

The first group are studies which emphasise the utilisation of the formal system or the health care-seeking behaviour of people. The studies that fall under this category involve the development of models that describe the series of steps people take towards health care. These models are sometimes referred to as 'pathway models' (Rosenstock *et al.,* 2005). While there are several variations of these models, the health belief model and Andersen's health behaviour model are often used as a basis in discussions involving health belief model (Andersen, 1995). The second group comprises those studies which emphasise the process of illness response or health-seeking behaviour. These studies demonstrate that the decision to engage with a particular medical channel is influenced by various factors such as the socio-economic status,

sex, age, social status, type of illness, access to services and the perceived quality of the service (Webair & Bin-Gouth, 2013). The majority of the studies under this second category focus on specific genres of determinants which lie between patients and services, such as geographical, social, economic, cultural, and organisational factors (Worku *et al*., 2013). It is important to consider all the factors that inform the preferred treatment avenue.

Consider the following responses about understanding Black African women and their general health:

> *Mina ngikholelwa ukuthi usiko nama namadlozi kudlala indima kuyo yinke into epilweni. Ukugula kuhambisana nosiko. Mangigula, ngiyahamba ngiyohlola ngoba ngiyazi ukuthi abaphansi bangale babona izinto thina esingaziboni futhi bayangilwelwa. Izinto ezinje ngezifo indlela yabaphansi yokuthi bexhumane nami. [Zama]*

> *Mina ngiyakholwa, imimoya into ekhona, ngingum Kristu futhi. Mangigula ngiyakhuleka ngicela ighazi lemvani lingivikele kanye nama nxeba aKristu angipholise. Ngiyacela futhi nabasekhaya abangasekho emhlabeni ukuba bangivikele. Ngiphinde futhi ngisebenzise o grandpa no panado mangiphethwe ikhanda, ngiyathoba ngama khathatha makubuhlungu idolo ngiphinde futhi ngiphuze amaphilisi.[Zipho]*

> *Mina njengomuntu wesifazane, mangigula kuya ngokuthi ngiphethwe yini. Kukhona izinto ezamabomi, kukhona izinto ezivela kwesitha bese, kube khona izifo ngoba phela siphila emhlabeni bese kuba khona izinto zabantu abadala. Kuya ngokuthi yini engiphethe. [Sphe]*

Black African narratives about mental health and illness are pointed to the following causes:

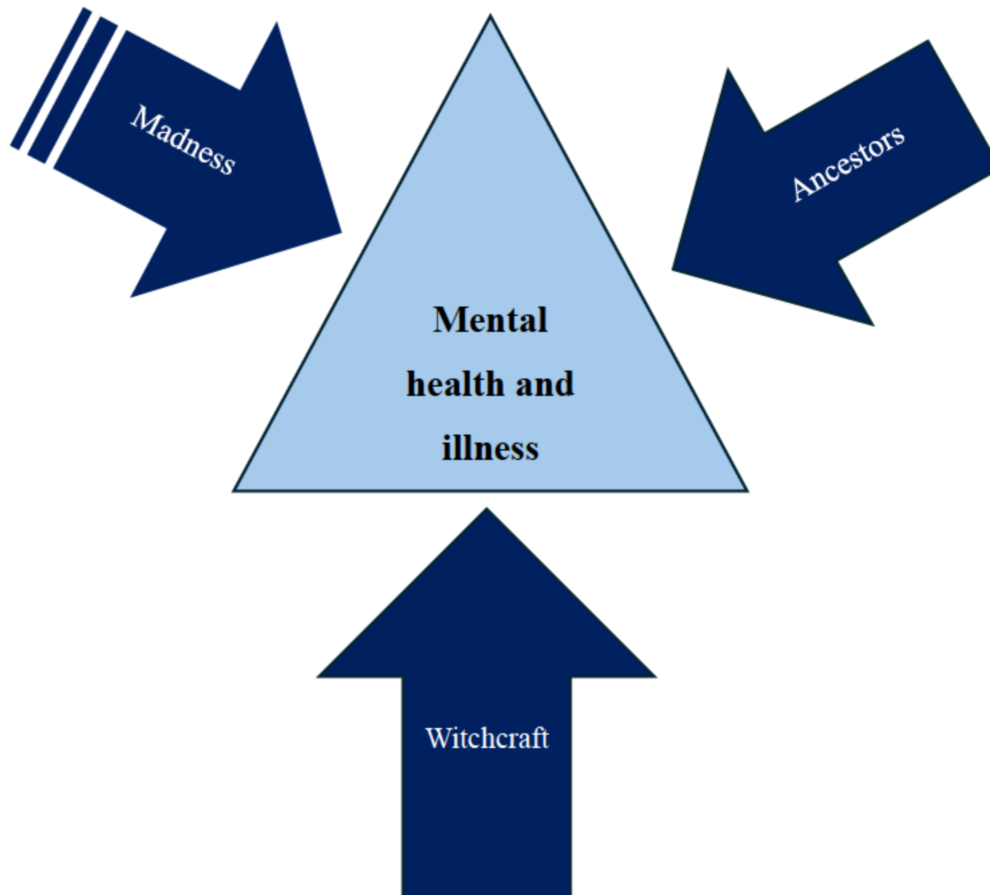

Figure 2: Black mental health and illness narratives

6.7 Women and Mental Health

Mental health has multiple biological, psychological, and social determinants. These determinants interact in a complex manner to provide protection for mental health or increase the risk of the development of mental illness. For example, a combination of genetic vulnerability, childhood trauma and adverse living circumstances brought about by poverty may predispose a particular woman to a major depressive episode. Conversely, a combination of genetic resilience, a supportive and stimulating childhood environment, and opportunities for learning, work and fulfilment of social roles are protective of a particular person's mental health. A person with mental illness may experience episodes of mental ill-health, which interrupts that person's capacity to do their work, family, social, academic and community roles. For example, they might hallucinate, have episodes of being in and out of reality or be in a depressive state and not willing to talk. The mental disorder might follow a chronic, episodic

course or may be resolved after one or more episodes (Shisana et al., 2024). Postnatal depression is a mental health challenge that can be traumatic to experience.

Consider the following response:

> *My mother-in-law uhlushwa amathambo [struggles with arthritis]. She has got a sore knee. So, she was sent her son to the pharmacy to buy her medication. The pills did not work, so she is back to having pain again. So, she is like; she thinks umeqo [illness from walking over the works of witchcraft that affect the bones]. I think that maybe she needs to go to the doctor and get a proper diagnosis, not just the pharmacy. The pharmacist is not the doctor. Perhaps she needs a different type of medication after examination. Then mhlambe uzoba ncono [maybe she will get better. She is old, ugogo and she has diabetes, so she is very fragile and frail. Ukugula kuyamthanda' [she often gets sick], she is old, I mean knee problems are normal at that age. This is an example of how older African women would attribute arthritis or feet or pain, or foot pain both umeqo illness from walking over the works of witchcraft that affect the bones], you stepped over something that was put there for you to trap you ukuthi rule [so that you become ill]. [Sandiswa]*

Sandiswa offered another example:

> *A person that does not have access to a medical aid will go to a traditional healer first and foremost. And obviously, healers will never say go to a psychologist, or you have mental health problems, no. It's only these, ngingathin?I [what can I say?] Very few traditional healers, I would say that probably from our generation, would say are both aware of mental health illness, but if you are an open-minded person and I feel you are of our generation. You will most likely go with a natural or herbal remedy, depending on what your issue is. Mhlambeke [Maybe] your last resort will be if you believe in these things, then you will go to a traditional healer. The older generation tends to start the traditional healer route and if the traditional healer does not work, then they will move on to Western medicine. [Sandiswa]*

The above narratives are an example of a shared identity of Black Africans and the common knowledge shared about interpreting illness and mental health. Some belief systems are embedded in cultural and social constructs. Other beliefs are deconstructed by new knowledge

with each generation. Mental health is also informed by one's psyche. An African psyche views mental health through the lens of ancestors and witchcraft.

Consider the following three narratives:

> *Ukuhhlanya is a big part of living in a community and being a woman. Normally, when a woman tries to stand up to patriarchy, society might use words like "useyahlanya", meaning she is crazy. There are many degrees of mental health amongst women. [Sindy]*
>
> *I was definitely going crazy; I could not believe how God would bless and yet make me carry a child with Down's syndrome. I was so stressed and anxious. I would not have kept the baby if it were not for my gynae, mother and psychologist. My cousins said I am crazy as a woman for not aborting the baby. [Gugu]*
>
> *Women and mental illness are actually foreign concepts; women are viewed as losing their marbles when they act out of character of what society expects of them. When they do go crazy then ancestral calling is one of the first culprits. The signs of ancestral calling are similar to ones associated with mental illness, like hallucinating, screaming, seeing things and so forth. When I experienced heaviness, depression after giving birth and anxiety I consulted with a traditional healer because I wanted answers. I did suspect that I had a calling or was bewitched, but luckily, I was not losing my mind. The traditional healer knew all about postnatal depression, and he gave me a concoction to chase out any bad spirits. [Lulama]*

The above narratives display a different understanding of being "crazy." This perspective is rooted in a feminine perspective, and it addresses patriarchy. For example, when a woman acts outside societal expectations or cultural expectations, then that behaviour is viewed as her 'losing her mind' because it is a culture shock. In addition, some of the manifestations of having an ancestral calling are similar to those of mental health. Hence, when women manifest these signs then, they are viewed as 'losing their marbles.'

6.8 Women and postnatal depression

Pregnancy and the first year after childbirth involve significant changes in a woman's life and can be associated with emotional distress of varying types and degrees. For some, worry and mood disturbances are natural and transient reactions to the challenges of a new life situation.

For others, symptoms can persist and develop into a condition where support or treatment is needed. Depression is one of the most common postpartum mental disorders during this period (Massoudi *et al.,* 2023). Women with previous mental health problems are more at risk, as well as women with previous or current stressful life experiences, especially being exposed to interpersonal violence, partner relationship problems, migration, and lack of support (Howard & Khalifeh, 2020). Narratives from the participants will share their experiences below.

Consider the following three narratives:

> *Culturally. I did not think that I could experience postnatal depression because, as Black African women, we are raised to be mothers. By nature, we are nurturers. Postnatal depression and its characteristics are "un-African" but the support group made it very clear that postnatal depression is not selective of particular races. It is universal. [Sphe]*

> *When I experienced a disconnect with my baby and the feeling of being overwhelmed, I was so worried. I thought there was something wrong with me. But I knew that this was abnormal, and I needed help. It did make sense when it was explained to me at the hospital when they explained it from a medical perspective and also spoke about how our hormones change post-birth. [Zipho]*

The above narratives illustrate the emic realities of the mothers' experiences with postnatal depression. It displays the variation in responses and reactions. It shows that interpretations and experiences are unique to each individual depending on their circumstances.

Consider the following responses:

> *The fear of being labelled was one of the subconscious reasons that made me choose to join a support group on social media. It allowed me the freedom to disguise myself because as a black African woman, ngiyimbokodo (I am a rock). How could I possibly be cracking and experiencing postnatal depression? it made me feel helpless and weak. But I knew that I needed help and support, most importantly, a community of women who understand postnatal depression. [Zinhle]*

I was convinced I was being bewitched or that the ancestors were trying to get my attention. The symptoms of postnatal depression are abnormal in terms of the natural nurturing nature of mothers [Zethu]

Ase ngimbona umthakathi, angiyiqala into enje, izimpawo zakhona ninxamashe nobizo, kanye nokuhlaselwa immoye emibi. [Zama]

I was ready to have a culprit in mind that was bewitching me; the symptoms of PND are similar to one of having an ancestral calling and being attacked by evil spirits.

The above responses speak to the Black African mothers' responses to experiencing the signs and 'abnormality' of this phenomenon; hence, the qualitative approach to this study was suitable because the mothers' experiences were journaled and captured in their own words. In addition, many traditional societies consider that illness and disease stem from spiritual disharmonies. The belief in the ancestral spirits' power to heal or afflict has a powerful placebo effect that the diviner utilises to heal. This is supported by the often-made statement by diviners that "one must believe in the medicines and the ancestors for them to work." The research indicates that, cross-culturally, people find healing in religion and spirituality (Ivey *et al.*, 2002). Among Nguni peoples, the notion of disease encompasses both physical illness and misfortune. Anything that brings intrapsychic, interpersonal or social disharmony, be it with the environment or others, can be perceived as potentially disease/illness-causing. This is evidenced in the narratives shared above.

6.9 Conclusion

This chapter is contextualised in Black African mental health. The Black African belief systems about the root causes of mental health such as witchcraft and ancestral calling are discussed. The role that culture plays in understanding illness through signs and symbols were explained. Signs and symbolised that originated from Black African folktales. Furthermore, the function of culture to interpret and understand women's health based on their cultural health beliefQ2S system. As well as the response from the Black African community about their experience with understanding postnatal depression being a foreign and a new phenomenon.

CHAPTER 7: FINDINGS, CONTRIBUTION AND RECOMMENDATIONS

7.1 Introduction

This chapter reviews the fundamental findings and arguments of the study illustrating that the study successfully achieved its primary objectives which were to:

1. To probe the experiences of Black African women (mothers) residing in Durban, KwaZulu-Natal, about postnatal depression.

2. To probe the effectiveness of social networks in assisting Black African women (mothers) residing in Durban, KwaZulu-Natal, to cope with their role as mothers' and to cope with postnatal depression.

•

3. To investigate the influence of cultural beliefs in understanding postnatal depression amongst Black African women (mothers) residing in Durban, KwaZulu-Natal.

4. To probe the role of culture amongst Black African women's (mothers) understanding of their general health.

7.2 Summary of Findings

At the beginning of this study, it was mentioned that there is very limited literature concerning Black African women. Available studies have focused on other ethnicities; these include Howard et al, (2024), Mkhize (20020), Akinmolayan (2024). These studies having limited inclusion of the topic pertaining to how Black African women cope with postnatal depression and with motherhood. While there is a rich pool of studies pertaining to postnatal depression as a whole which focuses on treatment and its effects, there was little dedicated to Black African women. Even on the topic of Black African women, Black women's views have not been represented. This led to difficulty in comparing other studies and with the women's experiences in this study, but it also served to make this study's contribution more appreciable. This study's first academic input can be linked to its focus on Black women. Choosing Black African

women was a conscious decision which was led my own observations and interpretations on how Black African women understand postnatal depression. To provide a unique contribution, I felt the need to focus on Black African women specifically. Through the literature review, I realised that postnatal depression not only affects women's emotional and psychological state but their ability to look after their children. Hence, it was important to uncover the relationship between postnatal depression and culture because culture is part of everyday life.

It was interesting therefore to explore how Black African women understand and feel about motherhood after they are diagnosed with postnatal depression. In this aspect, I believe this research has made a significant contribution. However, there is limited representation of Black African women cope with postnatal depression.

The study has also explored the role of traditional beliefs in engaging with illness. This was the main objective of this study, it contributed to the uniqueness of experiences that are shared by Black African women. In listening to the women attesting to how they looked or guidance from their ancestors, this study deduced that in general, ancestor worship is important as are the powers of traditional healers for Black African women. This was found to be unique when compared to the majority of patients in other studies who only used western medicine to find answers and healing for their illnesses. This study therefore also makes a valuable and unique contribution to anthropological studies which consider the role of culture in understanding illness.

By strictly focusing on Black African women who are diagnosed with postnatal depression, this study was able to explore in detail the link between postnatal depression and African women. As there are already libraries of research comparing men and women's experiences in health, this study prioritised women. While it may have enriched this study to discuss the experiences of men diagnosed with postnatal depression, it may have diverted the focus from the Black African women's understanding of postnatal depression. Hence, through this study Black women alone were given an opportunity to express themselves.

This study focused on how women understand postnatal depression and motherhood before and after they diagnosed. It emphasized and prioritised women's perceptions over the researcher's. In reading and summarising the research gaps that were revealed through collecting and reporting on this research, I have developed three major recommendations which

I believe would make a healthy contribution to understanding challenges faced by Black African women with respect to postnatal depression.

The findings of this study revealed that there are a number of topics and demographics that need further attention in the study of women. This study sample was limited to women aged between 20 to 40 years. In looking for potential young Black African women to recruit, I realised that the majority of postnatal depression victims were from various age groups. There were also potential participants younger than 20 years old.

Also, in conducting this study I realised that studies concerning diseases such as postnatal depression should not be limited to certain cities. A group beyond the province of KwaZulu-Natal could have shared the experiences of women who believed in a greater number of cultural and traditional belief systems. The findings of this study also revealed that it would benefit the discipline of anthropology and enrich the anthropological discourse to engage further with this topic of the sociocultural and traditional beliefs of women. There is also room for studies that focus on the influence and impact of traditional medicine in dealing with postnatal depression for Black African women who experience baby blues. This theme resonated extensively in this study but due to time constraints, I could not probe it fully.

The study provided a contemporary contextualisation of the challenges that young Black African women face once they are diagnosed with postnatal depression. It focused particularly on young Black women between 20 and 40 years living in Durban, South Africa. Using the social identity theory and social construction theory, this study analysed the young women's understanding of postnatal depression. The study revealed that young women understand postnatal depression differently after they are part of a support group be it an in-person support group or an online community. Due to limited knowledge, most of the women consulted with a traditional healer for their first diagnoses. As result, all the women had a different diagnoses and treatment journey.

During the course of this research, the Black African women revealed that prior to being diagnosed with postnatal they possessed a sense of confidence and self-worth about being new mothers. While this may be true for some women, the participants of this study illustrated that this self-worth as mothers was linked them being able to cope with motherhood. This was mainly constructed by their sociocultural upbringing, which emphasised that being a mother is naturally embedded in the African identity.

Chapter four revealed that the Black African community can still benefit from the phenomenon of postnatal depression being looked at and studied in terms of different dynamics within the context of different communities. The study acknowledged that the understanding of postnatal depression is not homogeneous. It is rooted in the belief system of the individual experiencing the symptoms. It also explained that postnatal depression can be understood by viewing it through different lenses, namely from a biomedical, psychological and cultural perspective. Furthermore, the study demonstrated that signs of depression during pregnancy can result in postnatal depression. The study informed us of variations in symptoms of postnatal depression. Also the study reported on traditional health practitioners who have knowledge of postnatal depression as a biomedical and mental health challenge.

Chapter five of this study described the role of social support networks and their role in assisting women to transition to motherhood and to cope with postnatal depression. It revealed the importance of having support as a mother and when coping with postnatal depression. The study announced that support groups can be both formal and informal. The study affirmed that social support can be virtual or in person. The study acknowledged that both health practitioners and traditional healers play a role in providing support. There is room for both practitioners and for pluralistic interventions. The study revealed that a lack of support can result in symptoms of depression and postnatal depression. It illustrated how having family or friends who are aware of postnatal depression can be helpful. Being surrounded by family and friends that are not aware of postnatal depression can affect a person negatively.

Chapter six of the study revealed that the study revealed that there is room for culture and Western diagnoses when it comes to the Black psyche of understanding mental health, postnatal depression and illness. The study illustrated that the Black African community has a social identity that is embedded in a health belief system. Even if Black African women do not resonate with it, they do have knowledge of it. The study demonstrated how knowledge constructed about illness can be deconstructed with each generation being exposed to new information. It revealed how Black African women still view culture, superstitions, witchcraft and ancestors as the source of their illness. The study highlighted how postnatal depression is a phenomenon that is still a culture shock in some households and a new concept. It revealed that it is possible for health practitioners and traditional practitioners to collaborate and assist patients experiencing illness, mental health challenges as well as postnatal depression.

7.3 Contribution of the study

The study provided a contemporary contextualisation of the challenges that young Black African women face once they are diagnosed with postnatal depression. It focused particularly on young Black women between 18 and 40 years living in Durban, South Africa. Using the social identity theory and social construction theory, this study analysed the young women's understanding of postnatal depression. The study revealed that young women understand postnatal depression differently after they are part of a support group be it an in-person support group or an online community. Due to limited knowledge, most of the women consulted with a traditional healer for their first diagnoses. As result, all the women had a different diagnoses and treatment journey. During the course of this research, the Black African women revealed that prior to being diagnosed with postnatal they possessed a sense of confidence and self-worth about being new mothers. While this may be true for some women, the participants of this study illustrated that this self-worth as mothers was linked them being able to cope with motherhood. This was mainly constructed by their sociocultural upbringing, which emphasised that being a mother is naturally embedded in the African identity.

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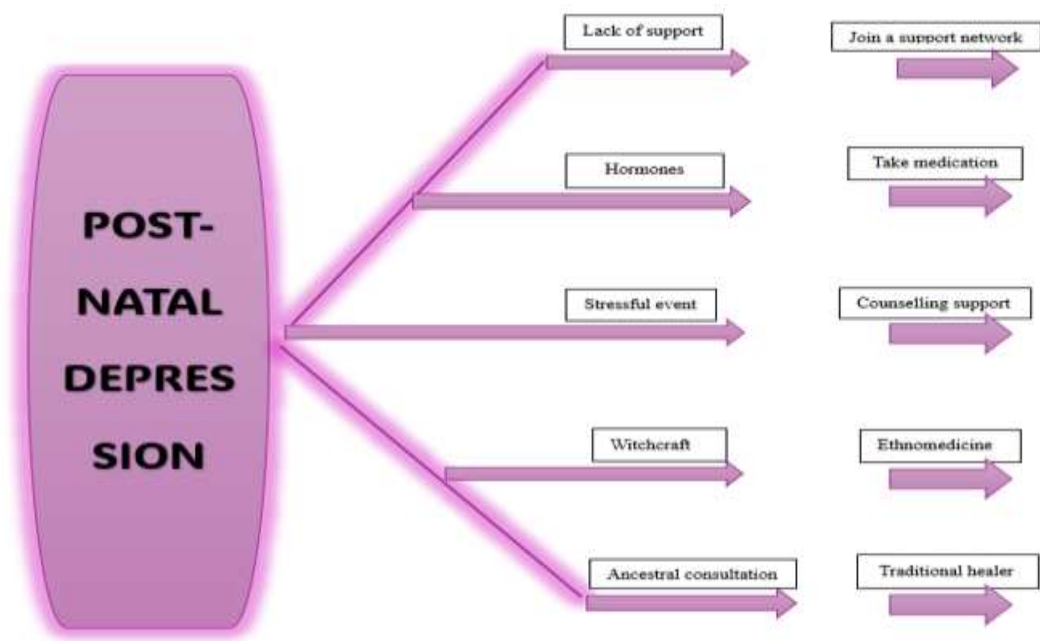

Figure 3: Framework to understand postnatal depression according to responses from the research participants

Based on the data presentation and analysis chapter, the researcher was able to put together a framework that explains postnatal depression. Through the data analysis process, it was revealed that amongst the Black African women residing in Durban KwaZulu-Natal, postnatal depression is understood in the following ways.

Postnatal depression is viewed from a medical perspective as an illness that is caused by hormones and stressful life events. From an ethnomedicine perspective, postnatal depression is caused by witchcraft, or it can be attributed to the ancestors trying to communicate a message, or the ancestors wanting a person to go on a traditional journey of becoming a traditional healer. The perspectives that shaped the belief systems of the participants were prior knowledge of postnatal depression being an illness and learning about postnatal depression through different sources of information and support groups. Furthermore, the African psyche associate's witchcraft, madness and ancestors as factors that can affect one's mental health negatively.

Based on the responses from the participants, the researcher came up with recommendations to cope with challenges around postnatal depression. For example, if a mother lacks support from family and friends, she can join a support network. Furthermore, the support network can be both virtual and physical. Secondly, if a mother is diagnosed with postnatal depression, she can be prescribed medication to help her cope with postnatal depression. Thirdly, if a mother is experiencing stressful life events, she can get counselling and be equipped with coping tools. Fourthly, if a mother believes that a spell is cast on her through witchcraft, she can consult a traditional healer or make use of traditional remedies . Lastly, if a mother believes that her ancestors are trying to communicate with her through the symptoms of postnatal depression. The mother can consult with the ancestors through a traditional healer or use traditional remedies.

7.4 Recommendations deduced from the research

- The Department of health can employ a pluralistic approach to mental health, illness and postnatal depression is suggested due to the variation of experiences of the phenomenon.
- It's suggested that the Department of Health trains their health practitioners to be culturally sensitive to symptoms outside of medicine to be able to treat the patient.

- It is recommended to communities and to the Department of Health that local councillors intervene by engaging experts, such as health practitioners and traditional healers, to educate the community about the symptoms of postnatal depression and mental health.
- It is recommended that the Department of Health should ensure that every clinic should have a programme for new mothers. In addition, mothers should be screened for signs of depression during their pregnancy and signs of postnatal depression after giving birth. It will also equip health practitioners to be able to notice the symptoms of postnatal depression. In addition, the postnatal depression measuring scale can be introduced in the relevant language. The community can also be aware of this programme, hence creating an awareness of postnatal depression at a community level.
- It is recommended the Maternity ward in conjunction with the Department of Health makes information available about postnatal depression in the form of pamphlets in health facilities. Some people might not be comfortable going to a health practitioner or joining a support group because of the fear of being labelled or ridiculed because of their mental health challenges.
- It is recommended to health policy makers that more research should be done in the Black African community about their understanding of mental health in general so that proper diagnoses are given. There are various understandings of postnatal depression depending on the belief system as well as the cultural variations.
- It is recommended all social support networks that the Black African community is taught more about postnatal depression so that family members and friends know how to support their loved ones experiencing postnatal depression.
- Lastly, it is recommended to South African households through the findings that different generations be taught about mental health both from a Western and from an African perspective to ensure that the relevant treatment avenue is sought.

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APPENDIX 1: Interview questions (English)

Data Collection Instrument

Title of the research:

Probing experiences of motherhood and postnatal depression amongst Black African women: The case study of Durban, KwaZulu-Natal.

Part A: Criteria

1. Have you been part of the Mums Support Network between 2 to 3 years?

Yes	
No	

2. Are you between the ages of 18 and 40 years old?

Yes	
No	

3. What is your exact age? ---

4. Are you a Black African female?

Yes	
No	

5. Have you been diagnosed by health practitioners either in a public or a private health facility or a traditional healer for postnatal depression? (Indicate with a cross)

Private	
Public	
Traditional	

Part B:

1. How would you define postnatal depression? (Please explain using your knowledge, examples, experiences and scenarios).
2. What was your initial response when you experienced the symptoms? (Please elaborate and draw on your experiences)
3. If any, what are the challenges that you experienced? (Please elaborate)
4. What was the reaction of your family/friends when you told them about your diagnosis? (Please describe their reactions)
5. What are the social constructions of motherhood in your culture? (Please name and explain with examples)
6. Which expectations of motherhood did you find most stressful? (Please draw on your experiences and please give examples)
7. What are the causes of postnatal depression among Black African women? (Please name and explain with examples)
8. What made you join the Mums Support Network? (Please draw from your own experiences and give reasons)
9. What do you think prevents women from joining social/support networks? (Please give reasons for your answer/s)
10. What are the benefits of being part of a Mums support group? (Please name and explain the benefits)
11. How has being part of the Mum's Support Network helped you cope with being a mother and with postnatal depression? (Please share your experience)
12. Outside of the Mums Support Network, what other treatment avenues would you recommend?
13. What were your views of mental health before you joined the Mums Support Network? (Please elaborate using examples)
14. Does culture play a role in how you interpret illnesses? (If yes, please explain)
15. Do you view postnatal depression from a cultural/biomedical? (Please explain)
16. What are your views of mental health in the Black African community now? (Please explain using examples)

17. What methods can be implemented to educate the Black African community about Postnatal Depression?

APPENDIX 2: Insimbi Yokuqoqa Idatha (isiZulu)

Itayitela loncwaningo:

Ukuhlola okuhlangenwe nakho kokuba ngumama kanye nokucindezeleka kwangemva kokubeletha phakathi kwabesifazane abamnyama base-Afrika: Ucwaningo oluyisibonelo Ethekwini, KwaZulu-Natal.

Ingxenye A: Imibandela yokuba yingxenye yocwaningo

1. Sube inxenye yeKwaZulu-Natali Mum Support Network phakathi kwiminyaka ewu 2-3?

Yebo	
Cha	

2. Ngabe uneminyaka ephakathi ka 18?

Yebo	
Cha	

3. Ingakhi iminyaka yakho ngqo? ---

4. Ngabe uyuwesifazane omnyama wase Afrika?

Yebo	
Cha	

5. Suke wahlolwa isiseebenzi sase zenhlalakahle emtholampilo womphakathi noma endaweni yomtholampilo esizimele noma inyanga mayelana nesifo sokudana ngemuva kokubeletha? (Khombisa ngo X)

Ezimele	
Eyomphakathi	
Ngokwesiko	

Ingxenye B:

1. Ungasichaze kanjani isifo sokudana ngemuva kokubeletha? (Sicela uchaze usebenzisa ulwazi lwakho, izibonelo, isipiliyoni kanye nezimo)
2. Wakuthatha kanjani khathi uqala ukuba nezimpawu zesifo se sokudana ngemuva kokubeletha? (Sicela ucacise futhi udonsele kukho ohlangabezane nakho)

3. Mazikhona, ngabe iziphi izinqinamba osuke wabekana nazo mayelana nalesifo? (Sicela ucacise)

4. Ngabe umndeni kanye naba mngani bakho bakuthatha kanjani mawubatshela ngoku hlonzwa nge sifo sokudana ngemuva kokubeletha? (Sicela uchaze ukusabela kwabo)

5. Ngabe ikuphi okwakhiwa umphakathi mayelana ukuba ngumama esikweni lakho? (Sicela usho futhi uchaze ngezibonelo)

6. Ngabe ikuphi okulindelekile mayelana ukuba umama okubona kukucindezela kakhulu? (Sicela usho futhi uchaze ngezibonelo)

7. Yini imbangela ye sifo sokudana ngemuva kokubeletha kubantu besifazane abamnyama base Afrika? (Sicela usho futhi uchaze ngezibonelo)

8. Isiphi isizathu esenza ukuba ube inxenye yeMums Support Network? (Sicela udwebe kokuhlangene nakho kwakho bese unikeza izizathu)

9. Ngabe yini evimba abantu besifazane ukube babe yinxenye yeqembu lokusekela? (Sicela unikeze izizathu zempendulo yakho)

10. Ngabe yini inzuzo yokube yinxenye leqembu lomama lokusekela? (Sicela usho futhi uchaze izinzuzo)

11. Ngabe ukuba yinxenye leqembu lomama lokusekela kukusize kanjani ukuthi ujwayele ukuba umama kanye nokuba noku cindezeleka kwangemva kokubeletha? (Sicela usiwabele ngolwazi lwakho)

12. Ngaphandle kwe Mums Support Network, iziphi ezinye indlela zokulapha ongazi ncoma?

13. Ithini imibono yakho mayelana nempilo yenqondo ngaphambi kokuthi ube inxenye ye Mums Support Network? (Sicela ucacise usebenzisa izibonelo)

14. Ingabe usiko linendima ngendela ochaza ngayo ukugula? (Uma yebo, ngicela uchaze)

15. Ingabe ubheka ukucindezeleka kwangemva kokubeletha ngokwesiko noma ngokombono wezokwelapha? (Ngicela uchaze)

16. Ithini imibono yakho mayelana nempilo yenqondo emphakathini wabantu abamnyama base Afrika? (Sicela uchaze usebenzisa izibonelo)

17. Iziphi izindlela ezingafakiwa ukuba kufundiswe abantu abamnyama base Afrika emphakathini ngesifo sokudana ngemuva kokubeletha?

APPENDIX 3: Informed consent (English)

Informed Consent Form

Dear Participant,

My name is Celuzuze Mabaso, student number 211501372, a registered PhD student in the Department of Anthropology at the University of KwaZulu-Natal at Howard College Campus. The title of my research is: *Probing experiences of motherhood and postnatal depression amongst Black African Women: the case study of KwaZulu-Natal*.
The aim of this research is to investigate Black African mothers' understanding of motherhood and postnatal depression, to probe the effectiveness of social networks in assisting mothers to cope with their role as mothers' and postnatal depression, to investigate the influence of 'cultural beliefs' in understanding postnatal depression and to probe the role of 'culture' in women's understanding of their health.
This researcher hopes that the data being collected will shine a light on postnatal depression, how its symptoms are interpreted and viewed in the Black African community. Recommendations will be made to create an awareness of postnatal depression as a mental health illness.

You are being asked to participate in this study but before you commit yourself, please take note of the following points pertaining to your participation:

- Due to the COVID-19 regulations regarding social distancing, the interview will take place on either Zoom/WhatsApp video call/phone call.
- If participants cannot sign and forward the consent form, verbal consent can be recorded or the Mums Support Network Leader can issue a formal letter with the names of the mums that will be participating.
- The information that you provide will be used for scholarly research or academic purposes only.
- Pseudonyms will be used in this study. Your names and identities will not be revealed.

- The study is voluntary, and as a participant, you can choose to withdraw at any time.

You are encouraged to ask questions at any time for clarity and indicate when you are not comfortable with any question/s being asked. The participants can contact the researcher via email/phone call using the contact details provided below.

- If a participant decides to withdraw, the data collected from them will not be incorporated in the study. They will be omitted or deleted.
- The interview with the mums will take approximately 60 minutes to 1hr 30 minutes per session.
- If permission is granted, the researcher will record the interview. At any point, the participant can ask the researcher to stop recording.
- The recordings will be handed over to the supervisor for safe keeping on a USB/computer with a password.
- If you have read, understood and asked the questions that you wanted to ask and received clarity, and you agree to participate, please sign the declaration attached to this statement (a separate sheet will be provided for signatures).

I can be contacted at the School of Social Sciences, University of KwaZulu-Natal Howard College campus, Durban. Email address: 211501372@stu.ukzn.ac.za. Cell phone number: [redacted].

My supervisor is Dr. Nokwanda Nzuza, who is located in the School of Social Sciences, Pietermaritzburg campus. Email address: nzuzan@ukzn. ac.za. Cellphone number: [redacted].

The Humanities and Social Sciences Research Ethics Committee Contact details are as follows: Ms Phumelele Ximba, University of KwaZulu-Natal, Research office, email: ximbap@ukzn.ac.za, Phone number +27312603587.

To all the participants- thank you for your contributions to this research. Your contribution is greatly appreciated.

By signing this consent form, I certify that I ______________________________ agree to
(Print full name here)
the terms of this agreement.

Signature Date

______________________________ ______________

APPENDIX 4: Informed consent (isiZulu)

Ifomu Lokuvuma Elinolwazi

Mbambiqhaza

Igama lami uCeluzuze Mabaso, umfundi onenombolo 211501372, obhalisele iziqu zePhD of Social Science e-University of KwaZulu-Natal e-Howard College Campus. Isihloko socwaningo lwami sithi: Ukuhlola okuhlangenwe nakho koMama kanye Nokucindezeleka kwangemva kokubeletha kwabesifazane abansundu base-Afrika: Ucwaningo oluyisibonelo kwaseNingizimu Afrika KwaZulu-Natal.

Inhlonso yalo cwaningo ukuloba isipiliyoni sabantu abamnyama base Afrika abayomama abayi nxenye ye South African Depression and Anxiety Group Mums Support Network aba nesifo sokudana ngemuva kokubeletha: Ngethemba lokuthi ulwazi oluzotholwa lokukhanyisa ilambu licacise mayleana nelesifo., ukuba izimpawu zokuhumusha nemibono emphakathini wabantu abamnyama base Afrika. Kanye nezincomo zokusungulu zokuqwashisa ngesifo sokudana ngemuva kokubeletha:

Uyanxuswa ukuba ube inxenye yalo cwaningo kodwa ngaphambi kokuba uzibophezele cela unfunde lama phuzo amayelana nokuba yinxenye yalocwaningo:

• Ngenxa yemigomo yeCovid 19 yokuziqhelelenisa nomphakathi ingxoxo izoba kwezoku xhumana kuZoom noma kuWhatsapps call noma ivideo call.

• Umbambiqhaza mayengakwazi ukusayini aphinde alifowade ifomi lemvuma lokuba yinxenye locwaningo, ivumo engayinika ngamazwi irekhowde noma umholi weMums Support Network engakhipha incwadi efomali enamgama omama abazoba yinxenye yocwaningo.

• Imininingwane oyinikezayo izosetshenziselwa ucwaningo lwezifundiswa noma izinjongo zezifundo kuphela.

• Imibono yakho kule ngxoxo izokwethulwa ngokungaziwa. Igama lakho noma ubuwena ngeke kudalulwe nganoma yiluphi uhlobo ocwaningweni.

• Ukubamba kwakho iqhaza kungokuzithandela ngokuphelele. Unokukhetha ukuthi ubambe iqhaza noma cha kulolu cwaningo. Kuyakhuthazwa ukuba ubuze imibuzo noma ngayisiphi isikhathi ukuze uchazeleke futhi nokuveza mawuzizwa

ungakhululekile ngombuzo obuzwe wona. Umbambiqhaza engxhumana nomcwaningi nge imeyili/ifoni imnniningwane ikhona enzansi.

• Uma kwenzeka ukhetha ukuhoxa ocwaningweni yonke imininingwane oyinikezayo (kufaka phakathi amateyipu) izokonakala futhi ishiywe ephepheni lokugcina.

• Inxoxo nomama izothatha imizuzu ksukela ku69 kuyela ku 90 umama eyedwa.

• Uma invumo bamu nikile umcwaningi inxoxo izirekhodwa. Noma nga isiphi isikhathi umbambiqhaza engacela umcwaningi ukuba ame engaqhubeki noku rekhoda.

• Yonke imininingwane eqoshiwe (uma ivunyelwe) izogcinwa iphephile. Akekho ozoba nokufinyelela kuzo ngaphandle kwabaqondisi bami. Bazoyigcina kwi-USB noma kwi khompyutha ene phasiwedi.

• Uma usufundile, futhi kuqondakala wabuza imibuza obufuna ukuyibuza wathola nokuchazeleka futhi uyavuma ukubamba iqhaza cela usayini isimemezelo esifakwe kulesi sitatimende

Ngingathintwa eSchool of Social Sciences, e-University of KwaZulu-Natal Howard College campus, eThekwini. Ikheli le-imeyili: 211501372@stu.ukzn.ac.za. Inombolo kamakhalekhukhwini: [redacted].

Umphathi wami nguDkt Nokwanda Nzuza, otholakala eSchool of Social Sciences, eMgungundlovu campus. Ikheli le-imeyili: nzuzan @ ukzn. ac.za. Inombolo kamakhalekhukhwini: [redacted].

Ikomidi le-Humanities and Social Sciences Research Ethics Ikheli lokuxhumana limi ngokulandelayo: UNks Phumelele Ximba, University of KwaZulu-Natal, Office office, email: ximbap@ukzn.ac.za, Ucingo +27312603587.

Kubo bonke ababambiqhaza ngiyabonga ngeminikelo yenu kulolu cwaningo. Umnikelo wakho ubongwa kakhulu.

Ngokusayina leli fomu lokuvuma, ngiyaqinisekisa ukuthi ______________________________ ngiyavuma imibandela yalesi sivumelwano. (Phrinta igama eligcwele lapha)

______________________________ _______________

(Isiginesha) (Usuku

APPENDIX 5: Language editor letter

CAROL JANSEN LANGUAGE EDITING SERVICES

P.O.Box 428
BRONKHORSTSPRUIT
1020
3 November 2024

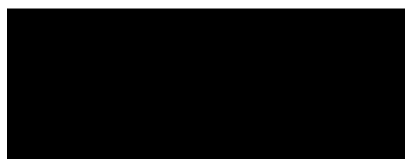
To whom it may concern

Certification of language editing done.

I hereby declare that I have edited the language, grammar, structure, table of contents, in-text referencing and referencing of the thesis entitled:

Probing experiences of motherhood and postnatal depression amongst Black African women: The case study of Durban, KwaZulu-Natal by Celuzuze Inamandla Gugulethu Mabaso.
Submitted in accordance with the requirements for the degree of Doctor of Philosophy
In Anthropology at the School of Social Sciences College Of Humanities
Howard College Campus University of Kwazulu-Natal.

I am an experienced language practitioner who has edited many theses and thesis for Unisa, the Tshwane University of Technology (TUT), and the University of Pretoria.



Carol Jansen

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HDipl(Bibl) (Unisa)

BA (Afr III & Eng III)

APPENDIX 6: Ethical Clearance