Experiences of South African Indian women screened for postpartum depression

BY

TASNEEM   KATHREE

Submitted in fulfilment of the degree of

Master of Social Science (Psychology)

At the University of KwaZulu-Natal

Howard College

DECLARATION

Submitted in fulfilment of the requirements for the degree of

Master of Social Science,

in the Graduate Programme in Psychology,

University of KwaZulu-Natal, South Africa.

I declare that this dissertation is my own unaided work. All citations, references and borrowed ideas have been duly acknowledged. I confirm that an external editor was not used. It is being submitted for the degree of Master of Social Science in the Faculty of Humanities, Development and Social Science, University of KwaZulu-Natal, South Africa. None of the present work has been submitted previously for any degree or examination in any other University.

_____

Student name

_____

Date

ACKNOWLEDGEMENTS

I would like to express my gratitude to the following persons for their support:

Professor Inge Petersen: Thank you for your encouragement and support. Your advice, your patience and your expertise was invaluable. Your availability and your patience in walking with me through this sometimes rather bumpy terrain is highly appreciated.

Naseera and Zunaid: For being there for me and for understanding.

Reyhana: For caring.

My friends for advice, suggestions, encouragement, distraction.

The participants in the study: For your invaluable contributions to the study. You made it possible.

Dr Cheryl Weaich at the Department of Health, Safety and Social services: For your cooperation in facilitating access to the research sites.

The management at the research sites.

To everyone who helped and encouraged me.

Thank you all.

ABSTRACT

BACKGROUND: Postpartum depression is a debilitating condition that has been researched in different populations. A surge in prevalence has been noted in non-western cultures and extremely high prevalence has been recorded in some South African studies. There is a dearth of literature on prevalence or experiences of postpartum depression in South African Indian women. AIMS: This study sought to understand the causes and experiences of South African Indian women potentially suffering from postpartum depression with a view to making recommendations for prevention and care of postpartum depression. METHOD: Low-income South African Indian women were screened for postpartum depression at primary health care clinics at two locations in KwaZulu-Natal. The Edinburgh Postnatal Depression Scale was used to screen women for postpartum depression. A semi-structured interview was then carried out to determine eight women's levels of coping. These included individual, interpersonal, community, societal and cultural coping mechanisms and support systems. RESULTS: In line with other studies on postpartum depression, the study revealed that interpersonal issues, abusive relationships, economic hardships and a lack of adequate social support precipitated or aggravated depressive feelings in the postpartum period. CONCLUSION: A number of recommendations for prevention and treatment of postpartum depression were identified and include Routine Screening, Psycho-education, Interpersonal Therapy, Task-shifting to Community Health Workers to aid in prevention and treatment and increased maternity and paternity leave.

Table of contents **Page**

_____

Chapter 1

A brief overview of the study 1

Chapter 3

Research design and methodology

Chapter 5

Part 1

Discussion of results

CHAPTER ONE

A brief overview of the study

Postpartum depression is experienced by women worldwide and is a debilitating illness with psycho-social and physical implications for the sufferer and her family (Chaudron, Kitzman, Szilagyi, Arcoleo & Anson, 2007). The World Health Organization (WHO-UNFPA, 2008) confirms a higher prevalence rate of postpartum depression in low and middle-income countries with an estimated rate of 10 to 34.7 %, as well as an elevated risk of severe onset of depression three times higher during pregnancy as compared to the rest of the population. The effects of maternal depression are far reaching and include impairment of cognitive and emotional development in children (Murray & Cooper, 1997) as well as impacting on a sufferer's personal relationships in the form of marital stress, isolation of the mother and adjustment difficulties (Hanlon et al., 2008, Pope, Watts, Evans, McDonald & Henderson, 1999, Roux, Anderson & Roan, 2002). This study focuses on the experiences of South African Indian women who were screened for risk of postpartum depression.

 1.1. A definition of postpartum depression

 Postpartum: The term "postpartum" refers to the period after childbirth.

Depression: Depression is a mood state that is characterised by a sense of inadequacy, despondency, pessimism and sadness. It is characterised by certain common clinical symptoms which can be organized within four psychological domains identified as affective, cognitive, behavioural and physiological (Sue, Sue & Sue, 2003). The characteristics of depression within these four states are :

1. Affective: characterized by sadness, dejection, apathy, anxiety, brooding, mourning, feelings of worthlessness and weeping.

2. Cognitive: characterized by pessimism, guilt, inability to concentrate, futility, emptiness, negative thinking, loss of interest and motivation, suicidal thoughts.

3. Behavioural: characterized by low energy, social withdrawal, lowered work productivity, crying, agitation, psychomotor retardation.

4. Physiological: characterized by poor or increased appetite, weight loss or gain, constipation, sleep disturbances, aversion to sexual activity, (Sue, Sue & Sue, 2003).

Postpartum depression is regarded as 'atypical' and differs from other forms of depression identified in the Diagnostic and Statistical Manual fourth edition (DSM-IV) and is characterised by needless concerns about the baby and the ability to be a good mother (Baker & Oswalt, 2007). Sufferers may require specific antidepressant and medical treatment since treatment prescribed for typical depression might be ineffective or unsuitable (Dalton. 1989). Postpartum or postnatal depression as it is commonly known occurs typically from four weeks up to three months following childbirth, but the time period is flexible and may extend up to a period of one year or more postpartum (Knudsen-Martin & Silverstein, 2009; Nhiwatiwa, Patel & Acuda, 1998; Pope et al., 1999). Individuals differ in intensity of experience and in duration of experience. Postpartum depression refers to non-psychotic depression which may begin in pregnancy and extend into the postpartum period (Hanlon, 2008; Heh, 2003). Questions may arise as to history of previous depressive illness and the presence of a personality disorder and whether this has precipitated or impacted on the postpartum depression. While a history of depression may be a risk factor for the development of postpartum depression in some women (Pope, Henderson, Watts, McDonald

& Evans, 2000), many women develop postpartum depression as a result of other factors and management of the condition would have to be tailored to the cause of the depression. However, it is pertinent to note that the presence of depression in the year post childbirth is in itself worrying enough to treat immediately regardless of the presence or absence of previous depressive episodes. The far-reaching physical, psychological, economic and social effects of depression as outlined in Chapter 2 necessitate timely and effective treatment in order to promote a mentally healthy society as well as being an ethical imperative to promote optimal mental health. The depression will manifest differently according to cause, and needs to be differentiated by the medical professional who has to institute appropriate treatment. Postpartum depression is a multidimensional health issue with mental and physical implications for the mother, the infant, the family unit and society in general.

1.2. Epidemiology of postpartum depression

Postpartum depression is an illness that is experienced worldwide with an estimated prevalence figure of 10 percent (Chaudron et al., 2007), but with differing figures across the world (Baker & Oswalt, 2007). It is a common disorder with serious implications for the entire family as well as the continuing development of the child or children within the family unit (Nhiwatiwa et al., 1998). Postpartum depression is estimated to be seriously under-diagnosed. Rychnovsky and Beck (2006, as cited in Baker & Oswalt, 2007) suggest that the estimated rate of postpartum depression that is undiagnosed may be almost 50% in some populations. Some studies propose that the figure is increasing in some parts of the world within specific race groups such as Indians and South East Asians (Husain et al., 2006). Research on postpartum depression in South Africa has indicated prevalence rates of 34,7 % of women in Khayelitsha in the Western Cape (Cooper et al., 1999) and 41% of women surveyed at three ante-natal HIV clinics in rural KwaZulu-Natal were found to be depressed

(Rochat, Richter, Doll & Buthelezi, 2006). These two studies were carried out on the African race group, and these findings as well as other African study findings cannot be generalised in any way due to the unique characteristics of the populations studied i.e., residents of informal housing settlements (Cooper et al., 2002), teenage mothers and HIV positive mothers (Nakku, Nakasu & Mirembe, 2006; Varga & Brookes, 2008). An estimated 25 to 60 % of cases remit within three to six months postpartum and 15 to 25 % will remit within the year. A minor percentage may persist for a longer period (Pope et al., 2000).

The popular myth of motherhood being a "naturally" joyous experience filled with love and excitement and instinctive bonding with the baby is for many women, a time of sadness and anxiety (Knudsen-Martin & Silverstein, 2009; Pope et al. 2000). A related and deeply worrying issue is the assertion that "mental disorders associated with childbirth are among the commonest illnesses to afflict women" (Nhiwatiwa et al., 1998, p. 262). This period can be experienced as a time of depression and sadness within three specific contexts. These include:

- The "baby blues: which may be experienced within the first two weeks after birth and is the result of hormonal fluctuations
- Postpartum depression
- Postpartum psychosis which is rare but extremely severe in course and in consequence (Pope, Watts, Evans, McDonald & Henderson, 1999).

These mood disorders can be differentiated based on prevalence, course and clinical presentation (Pope et al., 1999). Postnatal blues is regarded as commonly occurring and does not last longer than two weeks. Postpartum depression is more severe and may last

commonly up to six months or in severe cases for up to a year or beyond resulting in a chronic condition if untreated (Pope et.al., 1999). Puerperal psychosis is the most severe and debilitating form of depression in the postpartum period. Psychiatry has focussed on psychosis and severe depression postpartum due to the obvious danger to the sufferer's mental and physical wellbeing and the effects on the baby. Non-psychotic distress risks being overlooked due to the seemingly benign nature of the illness. Postpartum depression is cause for concern as this type of depression affects the mother-child dyad and the familial unit in multiple ways. The statistic that women are twice as likely to suffer from depression compared to men (Coon & Mitterer, 2007) could indicate that women are being labelled and treated for an illness (depression), when they are also reacting to a social system that exerts demands that women find difficult to fulfil. The cultural ideal of a perfect mother is held to place the interests of the infant above the capabilities and the interests of the mother. The role of psychiatry and psychology in treating postpartum depression can often be narrowly focussed on postpartum psychosis while overlooking postpartum depression which is less severe in presentation. This could be due to the fact that postpartum psychosis is a severe condition that can occur in women with a family history of schizophrenia or bipolar disorder and the behaviour of the affected person will include symptoms such as severe mood swings, confusion, erratic behaviour, delusions and hallucinations and requires interventions that include hospitalisation, medication and assistance with care for the infant. The psychosis is likely to recur with successive pregnancies and requires counselling for both partners to prepare for and deal with this possibility in subsequent pregnancies. Mild to moderate postpartum depression may be difficult for sufferers and/or their families to recognise (Pope et al., 2000), particularly when symptoms persist but are attributed to the "baby blues" and hormonal changes which are expected to dissipate at some point. In the context of

developing countries, primary healthcare clinics are busy and rarely diagnose or treat postpartum mental disorders (Nhiwatiwa, Patel & Acuda, 1998).

Impaired cognitive, social and emotional development in the child has been identified as a possible negative outcome of postpartum depression. The effects are potentially far-reaching and could impact on their potential for educational accomplishment and for earning potential, perpetuating poverty and its effects (Petersen, 2010). The mother could experience any number of ill-effects arising from postpartum depression including risky behaviour towards the child, marital dysfunction and social isolation (Pope et al., 2000). A mother who is abusive or neglectful towards the child faces social and possible legal censure. Poor mental health thus affects individuals, their families and the broader society. Postpartum depression can seriously compromise mental well-being and needs to be promptly and effectively treated.

1.3. The Legal implications of Postpartum Depression

There is cause for concern about postpartum depression as this has legal implications, and mothers who develop psychosis or endanger lives can be charged according to differing criteria. Some countries accept the diagnosis of postpartum depression up to a year as a valid period of time (Dalton, 1989) and will accept this as a mitigating factor for mothers who are charged with the crime of infanticide during this period. Postpartum depression could be viewed as a 'spectrum', as the common 'blues' may merge into postpartum depression or psychosis and it can be difficult to differentiate where these lines cross or blur (Dalton, 1989).

1.4. The Cultural context of Indians in South Africa

The population of Indians in South Africa who have historical roots in India, have maintained some traditional practices, but have assimilated into the local South African culture due to a long history in South Africa, as is evident in their linguistic and other practices (High Commission of India in South Africa, n.d.). The bulk of Indians settled in South Africa between 1860 and 1911, and like many immigrant groups adopted a (mainly) western ethos, although many have a "deep emotional bond with their mother culture" (High Commission of India in South Africa, n.d.). This acculturation is alluded to by Bhana (1981) and Naidoo (1977) in their studies that mention the disintegration of the joint-family structure in Indian South Africans due to economic considerations, urbanization and the popularity of nuclear families. Acculturation, urbanization and migration may have put an end to many traditional postpartum practices (Dennis et al., 2007; Husain et al., 2006). This may be true within the South African Indian cultural context of postpartum care as well.

Postpartum rituals in non-western cultures including India are viewed as beneficial, possibly due to the underlying social support provided which is the basis of postpartum care for mother and child, and may according to Heh (2003) equip the mother with informational and instrumental support. Heh (2003) suggests that social support acts as a buffer against stress in periods of transition such as motherhood. The possible protective effects against postpartum depression may prepare the new mother for future care of the child, prevent feelings of being overwhelmed due to care and pampering and enable rest and recovery (Dennis et al., 2007).

The paucity of information on postpartum depression in South African Indians does not indicate an absence of postpartum depression in this population, as research worldwide has

concluded that postpartum depression is experienced across the spectrum of race and culture (Baker & Oswalt, 2008; Chaudron, Szilagyi, Campbell, Mounts, & McInerny, 2007). Several studies have documented the prevalence of postpartum depression in Black South African women (Cooper et al., 2002 ; Nakku et al., 2006; Varga, & Brookes, 2008). The dearth of literature regarding prevalence, rituals and experiences of postpartum depression in South African Indian women represents a gap that would benefit from research. In order to optimise mental health service delivery to some of the most vulnerable members of society, it would be desirable to research postpartum depression in this population, and assess whether healthcare services are being adequately provided to deal with the problem. This is particularly important in the context of scarce resources and competition for these resources. The mental health budget allocations in LMIC's generally allocate a large proportion of funds to institutionalised care and utilise these funds mainly for psychiatric patients. In addition the public health systems are overburdened and are required to meet competing demands from other diseases such as HIV AIDS and tuberculosis (Petersen, Flisher & Bhana, 2010) which are prioritised due to the rapid spread of these diseases and the massive burdens placed on overstretched public health resources as a result of these pandemics.

1.5. Problem Statement and Motivation

Current studies in South Africa have focussed on postpartum depression in Black mothers, those infected with HIV-AIDS and teenage mothers. Women of other racial groups are excluded from these studies mostly due to considerations such as the location of the study. Further, prevalence studies dominate the research field in this area. This study sought to address this gap through researching the experiences of depression in South African Indian women in the postpartum period. South Africa is estimated to have a large population of naturalised Indians (High Commission of India in South Africa, not dated), and it would be

pertinent to investigate postpartum depression in this population group, as there is very little information available, and no records of studies on postpartum depression in Indian South Africans. Within this context, the nature, purpose and prevalence of traditional postpartum practices can provide insight into the nature and levels of social support in the community as well as indications of popular perceptions as to the benefits or harmful effects of such practices.

1.6. Aims of the Study

This study sought to increase our understanding of South African Indian women's experiences of postpartum depression. The current study should provide greater understanding of the causes and experiences of women suffering from postpartum depression which should assist in making recommendations for the prevention and care of this disorder.

CHAPTER TWO

Review of the Literature

(i). Prevalence of postpartum depression

A body of research points to increasing levels of postpartum depression in non-western countries such as India, Pakistan and in South East Asia (Husain et al., 2006). These authors recommend further research to uncover reasons for higher rates of postpartum depression in emerging economies, and suggest examining possible loss of social support as a factor. Consensus worldwide leans towards a figure between 10 and 15 % (Baker & Oswalt; Chaudron et al., 2006; Husain et al., 2006) with variations according to specific countries and specific racial and socio-economic groups. Some studies point to perinatal depression as being more common in low income countries (Hanlon, 2008; Husain et al., 2006; Stewart et al., 2008; Varga & Brookes, 2008). The prevalence of major depression in the perinatal period is estimated to be three times higher in developing countries compared to developed countries (Nakku et al., 2006). This trend has been recorded in South Africa as well where researchers have recorded prevalence rates of 34,7 % (postnatal) and 41 percent (prenatal) in different studies at two different sites (Cooper et al., 1999 and Rochat et al., 2006). Statistics from a range of studies and authors cited in Husain et al. (2006) illustrate the variation in prevalence recorded in countries such as China (13.5%), Japan (17%), India (23%) and Pakistan (28%). The prevalence of postpartum depression varies in African populations, ranging from 16 percent in Uganda and Zimbabwe (Nakku et al., 2006; Nhiwatiwa et al., 1998) to 34.7 % in Khayelitsha in South Africa (Cooper et al., 2002). The 34.7 percent

figure for postpartum prevalence in Khayelitsha should take into account poverty levels, unemployment, housing and sanitation or lack thereof as cited in the study.

(ii). From Historical to present-day Perspectives on Postpartum Depression

Postpartum disorders have been recognized and noted since the fourth century B.C. Although the cause of postpartum depression was speculated upon, there was no real understanding of the phenomenon. Present day explanations focus on physiology, psychopathology and experience based on the social ecology of the patient, and the interaction of these factors in promoting postpartum depression (Howell & Bayes, 1981). This is in keeping with the biopsychosocial model that promotes a holistic perspective of the causes and the course of illness in a patient.

The interest in postpartum depression is driven to some extent by a greater awareness of emotional disorders after childbirth (Cox & Holden, 1996). This is evidenced by the efforts of mental health professionals in developing countries who have lobbied for postpartum disorders to be included in the DSM and for specific ICD-10 codes to be included for diagnosis (Cox & Holden, 1996).

 The recognition of depression after a two-week period of postpartum "blues" as being a more serious form of postnatal depression places the sufferer in a position where diagnosis can be difficult and go undetected and there are a number of reasons for this. Depressed women often do not recognize the symptoms of depression during the postpartum period as these symptoms can easily be confused with the anticipated changes that occur during the adaptation to the experience of life with a new born infant, including fatigue and sleep disturbances (Chaudron, Szilagyi, Kitzman, Wadkins, & Conwell, 2004). At this juncture,

11

the obstetrician may no longer be treating the mother. Within the South African public health care context, the most appropriate health professional apart from the private general practitioner would be the nurse who administers the immunisations and weighs the infant at the primary healthcare clinic. This visit is generally geared towards the development and well-being of the infant and the mother may not be asked any questions about her well-being. Postnatal care is generally perfunctory (Dalton, 1989), and it is generally the responsibility of the mother to communicate any health issues that need to be addressed. The line of treatment might be psychiatric rather than medical if trends in other settings are followed (Cox & Holden, 1996). Such treatment is generally geared towards postpartum psychosis rather than depression because psychotic manifestation is more serious and alarming than depression and can be dangerous to the patient and her family.

2.1.1. Perinatal Common Mental Disorders

Perinatal common mental disorders are characterised by high levels of depression, anxiety, panic and / or somatic symptoms during pregnancy and postpartum (Hanlon et al., 2008). Prenatal depression can merge into the postpartum period and linger on to become postpartum depression. While there is comparatively more focus on postpartum depression than perinatal depression, the prevalence rates particularly in low income countries and sub-Saharan Africa range from 12.5 percent to 27 percent during pregnancy and between 10 and 34 percent postpartum (Hanlon et al., 2008), with one South African study recording a prevalence rate of 41 percent prenatally at three rural sites in KwaZulu-Natal (Rochat et al., 2006). Anxiety disorders are common and are often regarded as part of postpartum depression, resulting in lack of diagnosis. Anxiety in the postpartum period may be difficult to differentiate from the usual adjustments of parenthood, and the symptoms may not be severe enough to warrant a diagnosis of an anxiety disorder (Pope et al., 2000). Feelings of

depression, emotional disorganisation, confusion, insomnia and episodic crying are common (Howell & Bayes, 1981). Exhaustion, sleep disturbances, social isolation and work overload are also common themes identified in postpartum depression (Howell & Bayes, 1981). Sufferers may feel abnormal and feel unable to cope. Postpartum depression may be transient and non-psychotic episodes may not be considered as warranting serious attention (Howell & Bayes, 1981). Maternal health can be adversely affected due to non-adherence with medication including anti-retrovirals (Rochat et al., 2006). Some evidence suggests that the puerperium is the most vulnerable period for developing puerperal psychosis and postpartum depression.

2.1.2. The Symptoms of Postpartum Depression

Postpartum depression is characterised by feelings of irritability, anger, loss of interest and guilt (Pope et al., 2000). Fatigue is mentioned as a prevailing feeling during pregnancy and may extend into the postpartum period as a natural course. Many women are vulnerable to sleep loss during the latter stages of pregnancy. The loss of sleep may continue in the postpartum period due to the demands of a new infant, and or the combination of these demands with familial responsibilities (Howell & Bayes, 1981).

2.1.3. The Implications of maternal mental ill-health

Postpartum depression negatively affects the quality of childcare, child safety and development, and appropriate response by the mother towards the child or children (Chaudron et al., 2004), increased incidence of diarrhoea in children and infant malnutrition (Hanlon et al., 2008), impaired attachment and possible abuse and neglect (Chaudron et al., 2007; Hanlon et al., 2008). Postpartum depression is associated with having a negative impact on the cognitive, social, emotional and behavioural development in the child and

"increased rates of behavioural disturbance in school age children" (Chaudron et al., 2004, p. 551).

2.2. Theoretical Framework

The study is positioned within the biopsychosocial model. This model was introduced by Dr George Engel in 1977 and proposed that biological, psychological and social relationships are dynamically interrelated in the context of clinical medicine, and that these relationships affect the process and the outcomes of care (Borrell-Cario, Suchman & Epstein, 2004). The biopsychosocial model is a general framework rather than a specific theory and is a paradigm shift from reductionist models of healthcare to a holistic, systems-based technique (Schlebush, 1990). This perspective proposes that disease should be viewed not only in terms of pathophysiology, but also as it affects different levels of functioning simultaneously. These levels may include the cellular, organ, family and societal systems. Socio-cultural factors such as ethnicity and group processes impact on health and necessitate an understanding of culture and concomitant factors (Schlebush, 1990). Although it was developed as a criticism to biomedicine in a medical context, this model is appropriate for use in psychology as well, and is well suited to the exploration of depression offering "a powerful integrating framework for clinical psychology" (Gilbert, 2002, p13). This approach encourages "a comprehensive health care model which embodies whole-person psychological health care" (Schlebush, p3, 1990).

Human functioning is viewed taking into account the complex system that influences human disease and illness within the unique context of a particular individual. According to this model, there are three factors that need to be understood in order to understand the individual. These are:

- Biological

- Psychological

- Social

These factors are considered as systems in the body (Lakhan, 2006). Understanding the interrelatedness of these systems and how they affect human functioning is essential to treat disease and promote health. The concept of *wellness* is stressed. This state of wellness is not merely an absence of disease, but is based on a state of good health that is supplemented by a good quality of life and having strong relationships (Lakhan, 2006). This shifted the focus from pathology as the core of ill health to the recognition of psychosocial factors on the course and recuperation of illness. This idea has been articulated in disciplines such as psychobiology, behavioural medicine and psychosomatic medicine, and the biopsychosocial approach has since benefited from contributions by psychologists (Gilbert, 2000).

Some studies show that psychosocial factors can affect biological responses by predisposing patients to risk factors. This approach requires more information to be gathered at a consultation and the integration of professional multidisciplinary teams to attend to the patients needs at all three levels. The biopsychosocial approach suggests circular and structural models of causality (Borrell-Carrio et al., 2004).

The appeal of this approach is that it is a philosophical "understanding of how suffering, disease and illness are affected by multiple levels of organization from the societal to the molecular" (Borrell-Carrio et al., 2004, p576). On a practical level, it facilitates understanding of the role of the patient's subjective experiences in determining accurate diagnosis and optimum care (Borrell-Carrio et al., 2004). In the context of women's

developmental stages and biological experiences such as pregnancy and childbirth, biopsychosocial homeostasis is disturbed and holistic adjustments are required (Kok, 1990). The psychological well-being of the patient can be compromised when these factors are ignored by physicians who adopt a paternalistic attitude to female patients by discriminatory practices such as enforcing their own views and decisions on patients and who are dismissive of complaints regarding bodily changes. Paternalistic medical practices promote sex-role stereotypes as well as ignorance about women's bodies (Kok, 1990). Where pregnancy can be a period of personal growth and personality development, adverse conditions cause decline in psychological functioning and poor adjustments (Kok, 1990). The biopsychosocial modality can promote understanding about these issues and provide support regarding psychological adjustments, decision-making regarding childbirth, refer patients to appropriate health providers and ensure that interventions are prompt and effective (Kok, 1990).

2.2.1. The Bio-Psycho-Social Aspects of Postpartum Depression

Any study of postpartum depression should take into account the interrelated spectrums of biological, psychological and social systems that impact on the development and course of the depression. This biopsychosocial approach "addresses the complexity of interactions between different domains of functioning and argues that it is the interaction of domains that illuminate important processes" (Gilbert, 2002, p13). The biopsychosocial approach acknowledges the effects of social relations on physiological functions as well as the importance of distinguishing individual differences that impact on human functioning. Early social relationships significantly influence physiological systems which include cardiovascular, immune and hormonal spectrums (Gilbert, 2000). The development of these systems within a particular type of environment which could be nurturing, loving, abusive or neglectful impacts on disposition that regulates affect (Gilbert, 2000).

Genetic and personality traits may also influence the development of psychological illness such as depression at the intrapersonal level. The individual's living circumstances are influenced by the surrounding neighbourhood and community as well as the social and economic policies that govern day to day living and behaviour (Rimer & Glanz, 2005). The social environment is hugely influential on the individual and therefore on the behaviour and health of the individual.

The biopsychosocial approach embraces a holistic view of the causes of disease and therefore the treatment of disease. This model is appropriate for use in contexts where multiple factors may impact on the development and the course of disease. It is a general model and therefore serves as a guiding model rather than a specific theory.

2.3. Possible Factors that may influence the development and course of postpartum depression

2.3.1. Biological influences on postpartum depression

When considering the aetiology of postpartum depression, it is imperative to consider the possible biological factors that may precipitate or impact on postpartum depression. Factors such as hormonal changes (Cox & Holden, 1996) and the presence of disease may increase the risk for postpartum depression (Rochat et al., 2006).

Genetic vulnerability may account for some degree of risk for postpartum depression (Coon & Mitterer, 2007 ; Pope et al., 2000). Endocrine changes following childbirth are rapid and have an unmatched magnitude compared to any other biological event (Cox & Holden,

1996). Research cited in Laban, (1992) suggests that the relationship between the hypothalamic-pituitary-gonadal axes may be responsible for the fact that several mental disorders occur postpartum, premenstrually, at menopause and with use of oral contraceptives. Biological factors that could possibly impact on postpartum depression include hormonal changes that occur postpartum. Hormonal changes having significant impact postpartum include changes in prolactin, 17-b oestradiol and progesterone (Laban, 1992).

➢ Prolactin

Prolactin is related to breastfeeding and the action of suckling. Dalton (1989) suggests that elevated prolactin levels that do not normalise after cessation of breastfeeding are related to loss of libido.

➢ Progesterone

A surfeit or a lack of progesterone has been linked to susceptibility to postpartum depression (Cox and Holden, 1996).

➢ Oestrogen

Rapidly lowered levels of oestrogen postpartum have also been suggested (Dalton, 1989) as a cause of depression, but these studies are not conclusive and have deficiencies that need to be addressed. Lowered oestrogen levels are however acknowledged as impacting on mood (Coon & Mitterer, 2007).

➢ Thyroid dysfunction

Prolonged thyroid dysfunction has been linked with depression (Cox and Holden, 1996).

Childbirth is cited as increasing the risk for non-psychotic postnatal depression threefold (Cox and Holden, 1996), and some findings as indicated in Laban (1992) suggest that elevated plasma cortisol at 38 weeks is linked to severe postpartum depression. Underlying predisposition to depression may contribute to postpartum depression with monoamine oxidase activity, tryptophan metabolism and sodium excretion during pregnancy. A family history of psychopathology and history of depression may also be predisposing factors (Pope et al., 2000).

2.3.1.1. Pregnancy and the process of giving birth

Postpartum disturbances are likely to recur in subsequent pregnancies and other issues such as adjustment, longer interval between pregnancies, difficult labour, infection, blood loss and length of labour are linked to postpartum depression (Howell & Bayes, 1981). The perception of a traumatic labour or perinatal period is linked to the development of post traumatic stress disorder in the first year after giving birth. Women may differ in the amount of time required to recuperate from the birth process. This will depend on the procedures carried out and on factors such as whether a surgical procedure such as a caesarean section or an episiotomy was performed. Women who undergo these procedures do not have a uniform standard as to gauge their period of recovery, neither is the experience the same for all women as individuals differ according to pain and discomfort experienced and time taken to recover. The experience of a caesarean birth is more likely to be viewed negatively and to lead to depression as compared to vaginal deliveries. The loss of libido as explained in chapter 2 is commonly due to the biological, hormonal and physical effects of giving birth. This impacts on a woman's sexual desires and functioning and implies a negative effect on her sexual relationship.

2.3.2. Psychological factors

 Major and minor depression, anxiety disorders and adjustment disorder with depressed mood are more prevalent in the first three months after giving birth than in women of similar age without children (Pope et al., 2000). Women with a previous history of depression are more likely to experience postpartum depression, whereas women who experience postpartum depression as a first depressive episode are less likely to experience depression out of the postpartum context (Pope et al., 2000). Prenatal depression is predictive of postnatal depression (Beck, 2001).

Research indicates growing evidence that postpartum disorders are linked to psychological morbidity in the late antenatal and early postnatal period. Additional factors such as complications in delivery and psychological disorders in the eighth month of pregnancy may also increase susceptibility to postpartum depression (Nhiwatiwa et al., 2006).

Psychological causes may include personality traits that may contribute or predispose one to postpartum depression including introversion, dependency, low self-esteem, anxiety and "neuroticism" (Laban, 1992). Negative cognitive style is also a risk factor for postpartum depression. Anxiety and postpartum depression frequently co-exist, and women with anxiety disorders may develop postpartum depression. Women with postpartum depression or mood disorders may be at risk of co-morbid anxiety disorders (Pope et al., 2000).

Intrapsychic dynamics have been proposed as an important factor in postpartum distress. New mothers' conflicts over mothering may be due to unresolved identification with their own mothers (Melges, 1968, in Howell & Bayes, 1981). Where this experience between

mother and daughter has been distressing and disappointing, the daughter experiences conflict between her own frustrations with her mother and the cultural stereotypes of selfless and loving motherhood (Howell & Bayes, 1981). According to this theory, long-term individual psychotherapy exploring the client's relationship with her mother can be helpful to the client.

2.3.2.1. The impact of Loss

The concept of loss is common in all forms of depression, but particularly so when used to explain postpartum depression almost as an expected outcome of having children. The losses suffered by mothers may include:

- loss of personal identity and individuality

- loss of permanent or temporary income

- loss of freedom, loss of status associated with employment

- loss of personal independence

- loss of financial independence

- loss pf privacy, loss of social support and social networks

- loss of time to care for ones' self, including appearance and free time

These social losses lead to psychological distress. The loss of self is regarded as the most major loss for women postpartum (Littlewood & McHugh, 1997). This theme of loss is also identified by Dalton (1989) as a major contributor to postpartum depression.

Howell and Bayes (1981) suggest that the mother experiences a loss of identity which is echoed in the suggestion that postpartum depression is a manifestation of feelings of

mourning for the loss of the person that the woman used to be. The loss of status is associated with loss of income in western societies (Littlewood & McHugh, 1997).

2.3.2.2. Decision-making and Choices regarding Birth

Women who are well-read and informed about pregnancy and childbirth may hold specific or rigid views on their expectations of these experiences and may be distressed when the reality differs from their expectations. This may relate to issues of control and choice during childbirth which may result in disappointment when expectations are unmet (Littlewood & McHugh, 1997). Changing circumstances may force the decision-making process away from the woman and into the control of medical professionals. Women who perceive a loss or lack of control in the decision-making process regarding the birth are more likely to feel depressed (Kendall-Takett, 1993; Kok, 1990).

 Rather than adapting to change, the woman might feel a loss of control over her body and the welfare of her child. The issue of being educated about choices during pregnancy and childbirth can be contentious ranging from criticism of the mother for being rigid and inflexible in her thinking, to admiration for being well-informed about her body and her medical choices.

2.3.3. Social, Cultural and Economic Factors

2.3.3.1. Social Factors

The social ecology of the individual includes a number of influential factors that impact on mental health and postpartum depression in particular. These include the effects of the

nuclear family, the role of the infant, expectations of motherhood, cultural impacts, the influence of the media, adjustment issues and economic influences.

(i).The Nuclear family

Nuclear family structures do not make provision for adequate preparations and realistic expectations of childbirth, infant behaviour and parenthood due to a lack of opportunity for observation and participation in the experiences of significant others such as family, neighbours and friends. Romanticised ideals of childbirth and /or the new infant may be severely crushed by the realities of the birth experience and the behaviour of the baby, particularly when parents do not have the benefit of firsthand observation and experience of these processes within the family or peer group. The transition may be abrupt and distressing. Stressful events can reduce the body's natural defences against illness and major life changes can increase susceptibility to illness (Coon & Mitterer, 2007). Pregnancy and childbirth have been identified as possible stressful events and would qualify as major life change. Coupled with the sole responsibility of a dependant baby and possibly other dependant children, this can be overwhelming for the mother. The father faces a similar social impact with the addition of a baby to the family, and may be ill-equipped to provide the expected support to the mother. This situation may arise partly out of the expectation that all mothers have a natural instinct for motherhood and the skills involved. Mothers who do not live up to these expectations may direct the resultant anger and disappointment towards themselves and the baby (Littlewood & McHugh, 1997). Changes in family structure which include single parenthood, divorce and fewer evident support systems (Cox & Holden, 1996, Pope et al., 2000) may also impact on maternal mental health negatively. Changes in parenting are due to evolution of roles, the influence of popular media and change in work habits and lifestyles (Pope et al., 2000), and permeate across many cultures and communities

due to the pervasive influence of the media and internet, and societal expectations of gender-stereotyped roles regarding parenting duties may have evolved somewhat. However, some traditional views on motherhood may still prevail and cause distress to women who cannot identify with expected emotions and behaviours.

Nuclear family units are separated from and in many cases isolated from the extended family. This relative isolation compels the couple to rely on each other. This reliance on the partner or spouse impacts on the relationship by burdening the partners with additional demands apart from other pressures in their lives. The balance in the spousal relationship or partnership shifts immediately following the birth of the child, as the mother's dependency on her partner increases, and his emotional and possibly his physical load increases (Howell & Bayes, 1981). These authors refer to the "postpartum family" which describes the nuclear family status immediately following the birth of a child. The implication is that the entire family is part of the birth process and affects and is affected by the birth process. This ties in well with the biopsychosocial approach as the theoretical framework and illustrates the effects of the social surroundings on the individual.

Howell & Bayes (1981) point out that the clinical literature focuses on the mother alone as a "psychological entity" (p343) who is the core of her postpartum problems whereas the focus should be on the entire family. The husband who has to adjust to his wife and his newborn infant postpartum is often ignored. His added responsibilities which would have been shared in an extended family are considered less worthy of consideration (Howell & Bayes, 1981). The nuclear family thus isolates the couple and their child or children from the extended family and burdens them with emotional and physical responsibilities that cannot be shared. Work overload during this period may contribute to feelings of depression as will social

isolation. Howell & Bayes (1981) suggest that the seeming inadequacy of individual women in the postpartum period is actually a failure on the part of society to provide "institutionalised substitutes for the extended kin to assist in the care of infants and young children" (p342). This reference to 'substitutes for extended kin' could be interpreted as a criticism or shortcoming of the nuclear family system. This assertion supports the research of Heh (2003) and others who document the positive role of social support in the postpartum period.

(ii).The role of the infant

The focus of the causes of postpartum depression has mostly concentrated on the mother, but the infant is influential in the adjustment process and ease of transition of the new mother. Two aspects of the role of the infant in contributing to the mother's postpartum distress are prominent:

- The temperament of the infant
- Illness in the infant

Infants who cry frequently, do not have regular routines and are slow to accept new experiences cause feelings of distress in the mother who is fatigued as a result and may feel helpless to control the behaviour of the child and stem the crying.

Infants who are ill, premature or disabled also cause feelings of helplessness in the mother. Both infant characteristics induce feelings of helplessness and reduced self-efficacy in the mother, leading to depression (Kendall-Takett, 1993).

Infant temperament and behaviour and partner's level of depression may also impact on a woman's vulnerability to postpartum depression (Pope et al., 2000).

(iii). Expectations of Motherhood

In an analysis of qualitative studies carried out on postpartum depression between 1999 and 2005, Knudsen-Martin and Silverstein (2009) report that women across differing cultural backgrounds reported a sense of failure in living up to a cultural ideal of being a good mother. Women who experienced postpartum depression indicated apprehension at expressing their feelings for fear of being labelled as bad mothers. Women's supposed superior knowledge of motherhood and sometimes of parenthood forced fathers to step back in deference to the mother's expertise. While these expectations may vary across cultures, the net effect for the mother was feeling overwhelmed and being unable to cope, feeling anxious and not being able to confide in a close sympathetic relative, health professional or peer. Cultural expectations of parenthood also dictated the role identities that mothers and fathers expected to assume.

(iv). The role of the media

The role of the media in shaping conceptions cannot be overestimated and many couples use the popular media such as television to model their behaviours and as a basis for their expectations. Television programmes may portray idealised versions of a father's role and actual participation in the parenting process. Similarly, women may base their expectations of their partner's duties on a fictitious situation that has little bearing on reality. Women are also subject to cultural stereotypes and may perceive the behaviour of 'television mums' as the ideal which they should be able to live up to. New mothers who are portrayed as being as slim as their pre-pregnancy sizes immediately after giving birth, having supportive partners who are able to successfully juggle their career demands while being model fathers, and 'supermums' who can successfully manage a career, a household, a romantic relationship and

be a good mother all contribute to a distorted, unrealistic view of family life and demands. Many women expect the experience of pregnancy, labour and childbirth to be fulfilling. Motherhood is also expected to be a fulfilling experience, but the reality can be disappointing. While these views may seem antiquated and outdated in most modern societies, the remnants of these ideas have become embedded within our consciousness and motherhood is promoted as a natural and desired outcome of a marital or committed romantic heterosexual relationship.

(v). Cultural expectations and social support in the postpartum period

Experiences of immigrant women in the United States of America suggests that being a member of an ethnic minority group, is a risk factor, as is living in a country where your mother tongue is not dominant (Baker & Oswalt, 2007) given little or no social support and the absence of familiar and expected rituals (Kim-Godwin, 2003). Depression may also be exacerbated by the difference in cultural expectations and treatment of a woman who has recently given birth, particularly when the woman has emigrated from a culture, that practices specific customs and norms in the postpartum period, to a western culture that embraces the autonomy of the individual and where close interaction with the new mother may be viewed as interference or an imposition.

Postpartum depression may arise from the additional responsibilities and burdens related to childcare and work and relationship dynamics, or it may be exacerbated by these factors.

The protective measures of rest, seclusion, aid and change of social status in new mothers in certain cultural societies is believed to be protective against postpartum depression with lower rates of maternal distress as compared to western societies (Littlewood & McHugh, 1997). The western cultural patterning of pregnancy and childbirth medicalises these

processes. Social structuring is believed to create specific social support networks and the lack of social structuring in the pregnancy and postpartum period in western society leaves the new mother with a lack of social support. This lack of social structuring has been blamed on the medicalisation of pregnancy in the western world (Littlewood & McHugh, 1997).

Traditionally, women of Indian and Asian descent have enjoyed a social support network during pregnancy and in the first 40 days after delivery of a child (Kim-Godwin, 2003; Hussein et al., 2006). The Chinese refer to this period as 'doing the month' (Heh, 2003). The purpose of postpartum support and rituals is to avoid ill health in future years (Dennis et.al., 2007), and to provide comfort and practical aid, and ensure the physical well-being of the mother in the postpartum period. The temperaments of the child and sleep deprivation are two commonly proposed risks for postpartum depression (Knudsen-Martin & Silverstein, 2009). Traditional support structures in the postpartum period ensure that the mother has adequate sleep while other members of the family take care of the infant who is sometimes irritable or unwell.

Adequate social support has been suggested as directly affecting health and being protective against depression in times of crises and stress (Heh, 2003), and promoting mental and physical health. Heh (2003) suggests that the birth and adjustment period for new mothers is as stressful as any other transition period and that social support is an important variable in the postpartum transition period in easing the mother's "burden" and facilitating easier adjustment. Lack of social support during the postnatal period may be experienced as a sense of loss (Heh, 2003).

The multidimensional nature of social support includes tangible, emotional and informational support (Heh, 2003). Tangible support involves direct help such as material and financial aid, gifts, aiding with household tasks and physical aid to the mother and/or the infant. Emotional support involves attachment to others who provide reassurance, intimacy and who can be relied upon when needed. Informational support may involve giving advice and guidance (Heh, 2003). Historically, women of Indian origin have received many aspects of social support within the primary and extended family setting (Hussein et al., 2006; Kim-Godwin, 2003; Knudsen-Martin & Silverstein, 2009). A point of note is that the quality of relationships impacts significantly in the course and severity of postpartum depression (Knudsen-Martin & Silverstein, 2009). The concept of emotional attachment being imperative for emotional health recognises healthy relationships as being essential for support.

An interesting finding is that the level of perceived social support is a significant factor for predicting postpartum depression. Actual level of support was found to be tenuously linked with postpartum depression. The findings indicated that the cognitive perception of support and not the actual experience of postpartum support contributed to 'postpartum distress'. The implication is that faulty perception that does not reflect actual reality may influence depression (Heh, 2003). Depressed women may tend to view their husbands as unsupportive (Coon & Mitterer, 2007). Spouses or the father of the child, mothers and mothers-in-law were found to be most often blamed by the depressed mother for inadequate support (Heh, 2003; Nakku et al., 2006).

Members of ethnic minorities in the United States of America are estimated to be more at risk of suffering postpartum depression, and an analysis of qualitative interviews with women

from ethnic minorities reveals the disappointment and disillusionment of such women who immigrate to western countries where there is a total absence of social and cultural support in the postpartum period (Kim-Godwin, 2003).

Support for a woman experiencing postpartum depression may assume many forms as explained in the section above, and expectations of support may differ across cultures. A significant aspect of support for sufferers of postpartum depression may lie in publicly acknowledging the difficulties experienced by mothers. The ability to discuss the realities of motherhood and parenthood rather than dismissing postpartum depression as something that will disappear in time situates the experience in a real-life context that is acknowledged by the surrounding support structures. Dismissing the depression without actually acknowledging the crux of the reasons for the depression only serves to diminish and minimize the experience (Knudsen-Martin & Silverstein, 2009).

In studies carried out in more than 20 countries, certain common themes and practices were identified. These include prescribed periods of rest, organised support, recommended and prohibited foods, hygiene practices, guidance on infant care such as massage, bathing, breastfeeding, and general care (Dennis et.al., 2007, Kim-Godwin, 2003). Benefits to the mother include being 'mothered' herself and being relieved of her responsibilities until she is physically and mentally well enough to resume these, education regarding infant care, and a support network that is readily available. The infant benefits from having experienced and willing caregivers and has a practical support structure that takes care of the baby and mother's practical needs when a new mother may be too tired or unable to cope with the pressure. The availability of care and support is thus crucial for healthy outcomes for both mother and child (Nakku et al., 2006).

(vi). Economic factors

Economic deprivation is commonly linked with postpartum depression (Breese McCoy et al., 2006; Chaudron et al., 2006; Husain et al., 2006) as a possible risk factor although poverty in itself has not been linked as a significant factor (Husain et al.2006). Occupational instability, unemployment of the woman or her partner and low income are also cited as factors (Nakku et al., 2006; Petersen, Flisher & Bhana, 2010). Professional women who give up work tend to be vulnerable to severe postpartum distress (Howell & Bayes, 1981). Howell and Bayes (1981) mention findings that document the vulnerability of professional women who sacrifice their jobs to severe postpartum depression. This sacrifice may lead to financial difficulties and / or financial dependence of a previously independent woman on her husband. These factors on their own or in combination with stressors such as social isolation and inadequate domestic help may precipitate depression. A holistic view of the causes of depression in this study took into account the social context in which the women function and where poverty related issues such as inadequate housing, food, access to water and electricity, unemployment and low income levels were contributory factors. These issues are linked to feelings of helplessness, insecurity and shame which are associated with depression and anxiety (Petersen, 2010).

2.3.4. A summary of the aetiology of postpartum depression

The aetiology of postpartum depression may be attributed to biological, psychological and social factors. It should be noted that risk factors may increase the likelihood of developing postpartum depression but may not necessarily cause postpartum depression. However, a multitude of risk factors and possible combinations of risk factors cannot accurately predict

or explain postpartum depression in individuals. This is due to unique factors that may influence the course of postpartum depression in different individuals. Biological, social and psychological factors may be involved individually or in combination, and a thorough investigation of all these possible contributory factors should be carried out.

All mothers who have recently given birth experience a cultural transition related to the accompanying life and relationship changes and the societal and cultural expectation of "being a good mother" (Knudsen-Martin & Silverstein, 2009; Pope et al., 2000). This expectation may influence psychological well-being. This study will consider the social transition of motherhood, and the impact of this transition on the mother, cultural expectations, social changes and support structures surrounding the mother.

2.4. The Psycho-Social Implications of Postpartum Depression

Postpartum depression impacts on all aspects of a woman's functioning including her physical and emotional well-being. When a woman's physical and emotional functioning is compromised, the effects are far-reaching and may extend to significant others around her.

2.4.1. Effects of postpartum depression on the Infant:

Postpartum depression affects the mother's ability to care optimally for her baby (Nakku, et al., 2006). The negative implications of emotional distance between the mother and infant may be far-reaching and may impact on the closeness of the relationship as the child continues to grow older. The resultant behavioural problems and possible social and emotional stunting of the child (Chaudron, et al., 2007) could exacerbate the mother's frustration resulting in a negative spiral of neglect or abuse, emotional coldness from the mother and attention-seeking behaviours or impaired cognitive development in the child.

There is a significant association between maternal depression and the infant's cognitive, social and emotional development (Pope et al., 2000). The impact of postpartum depression on the newborn infant can include poor bonding with the mother, impaired social, cognitive and behavioural functioning as well as behavioural disturbances in children of school going ages (Chaudron et al., 2004) and there may be changes in the pituitary-adrenal responses to stress (Chaudron et.al., 2007). Later instances of childhood violence and lack of optimal development in term and preterm infants have also been noted (Baker & Oswalt, 2007). Brain maturation is related to the quality of attachment relationships. Furthermore, internal working models of attachment that can increase vulnerability to later disorders reflect physiological and psychological differences. Negative or abusive experiences such as parental neglect, abuse and coldness as well as maternal stress and drug taking are linked to various stress responses and vulnerabilities arising from the negative influence of the maturation of the foetal physiological system (Gilbert, 2000). The infant may be nutritionally and emotionally deprived of the experience of breastfeeding and the infant may be endangered due to risky maternal behaviour where physical safety may be compromised and health interventions such as immunisation may be neglected (Chaudron, 2004). Physical and mental well-being is recognised as being important for the development of human capital (Richter, Dawes & de Kadt, 2010) as future assets to the economy and to society. Children develop within an influential environment that requires nurturance, adequate food, stimulation and attachment (Richter et al., 2010). The mental and physical well-being of mothers as nurturers and care-givers is paramount for ensuring healthy development in children.

2.4.2. Effects of postpartum depression on the mother

The effects of postpartum depression can be debilitating for the mother as the primary caregiver and can seriously impact on all levels of principal relationships including spousal, other offspring, colleagues, family and friends (Pope et al., 2000). It impairs the mother's ability to carry out routine tasks. Fatigue has been identified as a major factor in postpartum depression. Women are vulnerable to sleep loss and particularly loss of rapid-eye-movement (REM) sleep in the last weeks of pregnancy. The REM sleep cycle is associated with dreaming and is considered of vital importance to physiological and psychological restoration (Howell & Bayes, 1981). The demands of a newborn baby also impact on the sleeping patterns of many women postpartum. This combination of sleep deprivation combined with the other domestic or work demands can cause permanent feelings of fatigue in the postpartum period.

The mother may experience marital dysfunction, stress, isolation and adjustment difficulties, anger and low energy levels (Hanlon et al., 2008 ; Pope et al., 1999; Roux, Anderson & Roan, 2002). There is a risk of chronic postpartum depression or recurrent future depressive episodes (Chaudron et al., 2004). Postpartum depression is cited by some research as a leading cause of marital breakdown and may cause loss of libido and cause feelings of revulsion towards the infant (Dalton, 1989). Loss of libido in the postpartum period is common and may be ascribed to four different causes:

- Postnatal depression
- Psychological
- Hormonal

- Structural

Loss of libido is common in all types of depression and disappears when the depression ceases, but may be the last symptom to disappear. The psychological causes of loss of libido in the postpartum are varied and range from any number of causes before, during and after the pregnancy. These may include fear of miscarriage, fear of another pregnancy and lack of trust in the partner's fidelity. Hormonal causes include raised prolactin levels (due to breastfeeding) that reduce sexual desire, abnormal oestrogen and progesterone levels or hormonal balance in the body being upset due to the hormonal influence of the contraceptive pill (Dalton, 1989). Structural changes include trauma during delivery that causes tearing of tissue, stitches, and resultant infections (Dalton, 1989) that result in painful sexual intercourse.

Women who experience postpartum depression are at risk for future depression and future postpartum depression and thoughts of harming their children. Postpartum depression can impair the mother's judgement and result in risky conduct toward the infant including the non-use of safety devices such as paediatric car seats (Chaudron et al., 2004).

2.4.3. Effects of postpartum depression on the partner

Partners who live with a depressed person are affected by the depression and may assume the role of caregivers as an extension of their role (Schmitt, 2005). Family members may notice the changes or symptoms of depression without understanding the significance if the depression has not been diagnosed, and this could lead to anxiety about the relationship. After diagnosis, the partner may experience frustration and resentment at the disruption caused. As a caregiver, the partner may feel a sense of loss and abandonment (Schmitt,

2005). Some partners report more conflict, tension, escalation in arguments and negative experiences, and deterioration in communication in studies on the impact of depression on non depressed partners (Schmitt, 2005). Some partners withdraw in response to the postpartum depression, resulting in a lack of connectivity between partners and emotional distance in the relationship (Knudsen-Martin & Silverstein, 2009). Maternal depression significantly impacts on the partner's level of depression (Pope et al., 2000).

The spouse or partner may be ill-equipped to deal with resultant marital tensions leading to resentment and deterioration in the relationship. He may have to assume extra responsibilities and may not be able to adequately shoulder these in conjunction with work responsibilities. Often, the partner is identified as the person most often blamed for providing insufficient support to the mother, and thereby associated with the depression (Heh, 2003). Marital dysfunction may be characterised by lack of support, conflict or abuse. This may be experienced as friction, sexual problems and poor communication (Roux et al., 2002). Sexual dysfunction (Dalton, 1989) and marital dysfunction may continue well after the depression ceases (Roux et al., 2002) and has severe implications for the future intimate relationship.

2.4.4. The Effects of Maternal Depression on the Family

Depressed mothers may neglect other children in the family, resulting in issues of physical and health safety regarding the children. These children may experience a loss of former closeness with the mother resulting in emotional distance. Since it has been established that postpartum neglect and lack of bonding in infants can result in cognitive and social impairment (Chaudron et al., 2004), it follows that in young siblings, cognitive and social

development may also be impaired particularly in children who are in these developmental phases.

2.5. Treatment Options for Postpartum Depression

There is a criticism of the medicalisation of postnatal depression which is based on viewing this phenomenon within a biomedical model. Postpartum depression should be viewed taking into account the value of medical diagnoses for mental illness. Postpartum depression is classified as a psychiatric disorder within the ICD 10 classification system used by medical professionals. Medical professionals now have a distinct system and category that enables diagnosis and treatment. Classification of disorders such as postpartum depression aids health professionals with diagnosis and treatment options, and affords patients the opportunity to seek medical and psychological help. The classification of postpartum depression as a psychiatric disorder legitimises the experience and enables discussion, treatment and relief. A further point to consider is the possible biological aspects that promote postpartum depression and that can therefore be treated with the correct medical interventions. Depression is a convenient term that is part of the universal lexicon. There is a danger of misuse, but this remains a question of how to differentiate postpartum depression from other categories of depression. It should not be dismissed as an illness due to lack of a specific and precise categorisation. Treatment for postpartum depression differs from treatment for other forms of depression (Dalton, 1989). This illustrates the differentiation between postpartum depression and other forms of depression.

Postpartum depression cannot be accurately predicted due to the numerous possible causes. The course and severity of the depression varies among different individuals, and this factor combined with the accurate diagnosis of the cause or causes of the depression should guide

the course of treatment. Treatment may be multidisciplinary rather than focussed on a single modality. Interventions may include individual and group therapy with multidisciplinary input, antidepressant therapy and structured psychotherapeutic treatment, and non-directive counselling (Pope et al., 2000). The practitioner who has to decide on the appropriate course of intervention for a patient diagnosed with postpartum depression, would ideally consider the characteristics of each individual case and the unique combination of possible causes for the depression. As such, it may be difficult to treat the patient without a good understanding of her individual experience of postpartum depression and the factors that precipitate it. This holistic view of the course of the illness would guide the intervention and accord with the biopsychosocial model of treatment.

While a medical diagnosis of postpartum depression is expedient for medical professionals, it can be quite limited in that this framework ignores the cultural and social dimensions of postpartum depression. This is where a biopsychosocial model is a useful lens through which the practitioner can view the causes and the course of the depression. This approach would take into account the interrelated biological, psychological and social relationships that impact on treatment outcomes. In a context of poor socio-economic circumstances for example, a multidisciplinary team comprising a psychologist, social worker and a doctor or nutritionist may be able to holistically treat a depressed mother who is experiencing multiple causes of distress. A fitting example from the current study would be an unemployed single mother who cannot access child support due to a dispute regarding the baby's paternity. She lives below the breadline and may not be able to adequately feed herself. She experiences problems breastfeeding the baby who does not seem to be satisfied. In this scenario, a social worker would be able to help the mother access child support and aid her in accessing another form of social relief for herself and her child, the nutritionist would be able to then advise the

mother on a nutritious diet according to her financial circumstances and this may help alleviate the concern with the baby not being satisfied with the breast milk. The nutritionist would also be able to advise the mother on feeding options for the baby. A psychologist would be able to diagnose the source and type of depression, and plan an appropriate intervention, and a medical doctor would ascertain whether any medical intervention might benefit the patient.

2.6. Conclusion

Postpartum depression is a widely documented illness and the literature on the prevalence, risk factors and negative effects has contributed a great deal to our understanding of the disease. The literature indicates a high level of variation in cultural practices and social support structures. In Indian culture, the traditional 40-day confinement after birth in Indian culture is regarded as essential for recuperation against a strong background of familial support (Kim-Godwin, 2003), which would aid in strength and recovery. As indicated in the introduction, Indian families in South Africa who have distant cultural roots in India have assimilated themselves into the general South African population and may have discontinued many of these postpartum support rituals. Against this backdrop, South African Indian women may be more vulnerable to postpartum depression. This research thus sought to understand the influences for as well as experiences of these women suffering from postpartum depression which should assist in making recommendations for the prevention and care of the disorder with the view to making recommendations for services to assist in the prevention and treatment of this disorder.

CHAPTER THREE

Research Design and Methodology

3.1. Introduction

This study employed a qualitative approach to data collection and analysis, and the process will be outlined in this chapter. The objective of the study was to understand and interpret the subjective experiences of women who displayed risk for postpartum depression, and to understand their perceptions of the causes of postpartum depression within a psychosocial context. To this end, the methods of design, data collection and analysis were guided within a qualitative framework, as qualitative studies are deemed most appropriate for understanding subjective experiences and social meaning (Miller & Brewer, 2003). This chapter will outline the methodology employed and the manner in which the research process unfolded.

3.2. Aim and Research Questions

(i). Aim

The aim of the study was to develop an understanding of the experiences and perceptions of the causes of feelings of depression postpartum in women of South African Indian descent with the view to making recommendations that would provide the impetus for better postpartum mental healthcare for this population.

(ii). Research Questions

A) What are the experiences of South African Indian women screened for risk of postpartum depression?

B) What are the perceptions of this group of women of the influences that promote postpartum depression?

3.3. Case study approach

A qualitative method using a multiple case study approach was used. Yin (2003) defines the case study as an "empirical inquiry that investigates a contemporary phenomenon within its real-life context" (p13), and qualifies this description as being useful when contextual conditions are believed to be pertinent to the phenomenon being studied. In this study, the contextual situations of Indian South African women experiencing postpartum depression within a western socio-cultural context were explored. The biopsychosocial model that guided the study considered the interplay of biological, psychological and social influences on the experience of postpartum depression.

Yin (2003) further elaborates on the case study method as a research strategy encompassing a predetermined design, data collection techniques and specific data analysis approaches This research strategy is comprehensive in that it covers all aspects of the study including the logic of the design, guided data collection techniques and specific approaches to data analysis (Yin, 2003). A multiple case study approach using a sample of eight participants was used. Yin (2003) asserts that multiple case studies have greater analytic benefits as compared to the single case study, since the analytic conclusions derived from multiple independent cases are more compelling than those from a single case. In the context of qualitative research where generalisation of results is not the required outcome of a study, the comparison of results

between cases in a study can add substance to specific assertions and add to a body of knowledge useful for future studies.

Using Yin's (2003) guidelines for selecting a suitable case study strategy, an explanatory approach was used. This approach is recommended when inquiring into and answering questions related to 'how' and 'why' experiences and events are construed and explained. In this study an explanatory approach details how participants experience postpartum depression, how they deal with their depression and what they perceive to be the factors that influenced the course of their illness. Particular emphasis was given to contextual conditions of the different participants and how this influenced the experience of postpartum depression.

Researchers concur that it is essential to prepare a plan before starting the data gathering in order to direct the investigation towards the research question and ensure validity and reliability (Robson, 2002; Yin, 2003). Robson (2002) suggests a plan comprising an overview of the issues being investigated, procedures to be followed, questions to be asked and reporting of the study. Yin (2003) emphasises training and skills of the interviewer, preparation including the development of a protocol, screening of participants and testing the questionnaire. This study followed these guidelines by the use of a protocol, the screening of participants using an approved questionnaire developed to measure the particular phenomenon of postnatal depression, using an interview schedule with appropriate questions and reporting the study. An independent survey was carried out by the researcher on private patients at a paediatrician's rooms where the screening instrument ie. the Edinburgh Postnatal Depression Scale (Cox, Holden & Sagovsky, 1987) was used to gauge possible participant's reactions to completing the screening instrument and to estimate willingness to participate in

a study of this phenomenon, as well as to use it as a trial for estimating the time taken by individuals to complete the instrument and anticipate possible problems at the research site.

The case study method facilitated access to the experiences of different women experiencing a similar phenomenon, and enabled the researcher to compare these experiences and to interpret them within the context of how different women perceive what the specific factors and circumstances are that influenced their postpartum experiences. This method provided limited but interesting information on postpartum rituals carried out in the Indian community and women's perceptions of these experiences. The sample size of eight women provided a suitable number of participants from two different study sites that enabled the researcher to compare eight individuals within differing personal circumstances and facilitated a thorough, in-depth exploration of the data. This use of a multiple case study approach was essential to the study in order to facilitate greater analytic benefit to the study. Their common experience of postpartum depression was interpreted and analysed using a theoretical framework that explored the psycho-social aspects of postpartum depression while keeping in mind the possible biological causes. Contextual factors vary considerably among individuals regardless of race, social and economic conditions and the comparison of cases within the study provided a rich contextual frame within which to interpret these experiences. The interpretations and conclusions made were facilitated by a biopsychosocial approach which guided the researcher's understanding.

3.4. Data Collection

(i) Study site and participants

Participants were sourced from primary healthcare clinics in Chatsworth and Phoenix respectively, that service women from low socio-economic backgrounds. These sites are

historically Indian townships that currently have large Indian populations. Purposive sampling was used to obtain 8 participants of South African Indian origin.

(ii). Procedure

Recruitment of participants involved the researcher asking each patient at the clinic who was present with an infant if she was the mother of the infant and if she replied in the affirmative, she was asked how old the baby was. If the baby was four weeks up to six months old, the mother was requested to participate in the screening process. Due to insufficient information on the exact onset of postpartum depression, all potential participants had to have given birth at least four weeks prior to the screening procedure in order to rule out the presence of postpartum "blues" which should have resolved within two weeks. The DSM IV criteria for onset of postpartum depression recognizes the period from the fourth week onwards although most studies on postpartum depression take place at the second and third months postpartum (Santos et al., 2007). It was deemed appropriate therefore to screen women from the fourth week onward. The participants were screened for risk of postpartum depression using the EPDS (Cox, Holden & Sagovsky, 1987) described below. This was administered and scored by the researcher. Women scoring 12 and above were then interviewed using the semi-structured interview schedule. The cut-off score of 12 and above was used as a reliable criterion for participation in the study for two reasons. These include studies cross-culturally and worldwide that use a cut-off score of 12 to 13 (Matthey, 2004), and the recommendations of the developers of the EPDS that a score of 9 to10 (Cox & Holden, 1996) is a reliable indication that clinical diagnosis will confirm postpartum depression. The score of 12 and above is suggestive in this study that all the participants would meet the criteria for a clinical diagnosis of postpartum depression. Women who had a history of depression not related to pregnancy were excluded from the study in order to ensure that the depressive episodes being

described could be differentiated as postpartum depression and would thus not be confused with an unrelated cause of depression.

(iii) The Instruments:

The Edinburgh Postnatal Depression Scale

This 10-item self-report screening questionnaire was developed to screen for possible depression in women postnatally, and for use in research. This is a short questionnaire comprising 10 groups of statements, which are rated on a scale of 0 to 3 with high scores (10 and above up to a maximum of 30) indicating possible depression, and an accepted cut-off score of 12-13 indicating possible major depression (Matthey, 2004). It can be completed in less than five minutes and can be administered by a person who does not possess specialist knowledge of psychiatry, and was conceived with the intention of being acceptable to women who do not consider themselves to be unwell (Cox & Holden, 1996). It is considered effective due to its reliability, is easy to score, and is predictive of a clinical diagnosis for postpartum depression (Breese McCoy et.al., 2006). An advantage is that it can be administered in a home-setting. The authors suggest a cut-off at 9/10 in order to reduce the chances of failed detection of depression to less than 10 %, particularly in the first stage of screening in a community study (Cox & Holden, 1996). The split half reliability of the 10 items is cited as 0.88 and the alpha co-efficient as 0.87. The reliability was established during a validation study of the Edinburgh Postnatal Depression Scale (EPDS) by Ruth Sagovsky, and was carried out on 84 subjects as reported in the British Journal of Psychiatry (Cox & Holden, 1996). The EPDS was developed to assess depression in recently delivered women and is used internationally.

The items are rank ordered and weighted to reflect severity of symptoms, and the last item indicates participants' thoughts about self-harm providing an indication of whether professional help is needed and the urgency of such an intervention (Baker & Oswalt, 2007).

The EPDS is considered the most widely used measure to screen for postpartum depression and is used worldwide (Pollock, Manaseki-Holland & Patel, 2006). Cox & Holden (1996) advise that since the instrument was developed for British women and using a British sample, caution should be exercised in cross-cultural settings with cognisance given to culture- bound manifestations and interpretations of depression. The EPDS has been validated in western societies and more recently in developing countries (Pollock et al., 2006). The scale is considered resilient despite the variations between the studies, and is acknowledged as possessing an inherent robustness in detecting depression. The construct validity is therefore considered high (Pollock, et al., 2006). It is considered to have good conceptual validity and avoids somatic symptoms that could distort the assessment of mental disorders perinatally (Weobong et al., 2008).

The EPDS has been validated for use in South Africa, and has been used in research on South African women experiencing depression (Rochat et al., 2006). Further, the EPDS has been validated for prenatal and postnatal screening and has a specificity and sensitivity greater than 76 %. It is used widely as a screening tool for postpartum depression. South African Indian women are generally westernised in cultural and social outlook and generally consider English as their first language. The EPDS is therefore considered a suitable instrument for use. A cut-off score of 12 was used to recruit participants. This score was used following the guideline of 12 or 13 as advised by Cox and Holden (1996) as well as taking into account the 9 to 10 cut-off advised for the first stage of screening in a community study (Cox & Holden,

1996) and the range of 8/9 and 12/13 as cut-off points for clinically significant depression (Weobong et al., 2008).

The authors emphasise that the wide use of the EPDS does not include measuring psychiatric morbidity, and that participants who score just below the cut-off (12/13) should not be assumed to be free of a psychiatric disorder. The limitations of this screening instrument include not being able to detect common psychiatric disorders such as anxiety states or severe chronic illnesses such as schizophrenia (Cox & Holden, 1996). This instrument does not indicate or make provision for a prior history of mental illness or detect chronic depression or pre-existing depression.

(iv) Semi-structured Interviews

Participants were interviewed using semi-structured interviews. The interviewer and participants had the opportunity to clarify data, and participants were given the opportunity to correct any incorrect perceptions of the interviewer regarding specific interpretations of the data. Data was recorded using a digital recorder, and observational notes were made by the interviewer as additional data, and to add to the context of the interviews. The use of audio recordings enabled the researcher to observe the participants and probe the non-verbal cues presented without the distraction of taking precise notes. The semi-structured interview was selected to provide the interviewer with a guided set of questions relating to the research question, while providing the opportunity to the participant to expand on information and add other pertinent data. This method of interviewing allows both interviewer and participant leeway to enrich the information-gathering process with specific contextual data by allowing the interviewer to encourage elaboration of issues. The participant has the opportunity to provide data that she considers relevant, where this has not been provided for in the

questions. This method added depth to the quality and quantity of data obtained. The interview schedule was developed by the researcher using the literature review as a guide to tap into questions relating to the research question and according to common themes in the literature. The questions were divided into three sections:

- Background contextual information
- Biological and psychological influences and coping
- Interpersonal, cultural and societal influences, including access to health care

In line with the aim of the study which was to understand the causes and experiences of depressive feelings in postpartum South African Indian women, universal issues of concern that were identified across different studies in the literature review were identified and formed the basis of questions in the interview schedule. Questions were then formulated using this guide as well as the biopsychosocial framework which was used to guide the study. Questions on background information were used to situate the interview within a non-threatening context for the participant and provide valuable information about the members of the household and marital status as well as employment levels, to add to the context of the feelings of stress and depression. Questions were then formulated regarding individual, interpersonal, community and socio-cultural levels of influence and coping. Access to healthcare and support systems was probed, and participants were asked about whether they had observed any traditional Indian postpartum rituals, and their views on the relevant practices. Within this context, the nature, purpose and prevalence of traditional postpartum practices were explored to provide insight into the nature and levels of social support in the community as well as indications of popular perceptions as to the benefits or harmful effects of such practices.

The interview schedule was approved by the ethical committee at the University of KwaZulu-Natal and may be viewed as Appendix 3.

Interviews were transcribed using Henning's (2007) guide for transcription, and thematic analysis (described in greater detail below) was used to interpret the data. The interviews were conducted by the female researcher who is of South African Indian origin and although this ethnic grouping is quite diverse in composition, there is a strong sense of homogeneity in the group as a whole, and this similarity was anticipated to put the participant at ease and encourage honesty and rich depth of material.

The second aspect of the study focussed on the subjective experiences of the participants and examined the social backgrounds of participants. The analysis of the data focussed on identifying dominant themes within all the participants' experiences to enable identification of common problem areas relating to the social and health service experiences of women with postpartum depression.

3.5. Description of participants

Mothers with low educational levels as well as adolescent mothers are deemed to be at higher risk of postpartum depression as well as being less likely to seek help (Baker & Oswalt, 2007). The participants were not chosen according to educational criteria or age, but most seemed to fit this profile. A description and background of each participant follows, and provides the case study context within which the experiences of each participant are analysed in Chapter 5.

Participant A: 24 October 2009

Participant A was 25 years old at the time of the interview. She was a single mother of two children. The baby was seven weeks old at the time of the interview. The pregnancy was not planned. She did not consider herself religious but defined her religious beliefs as Christian. Participant A lived in a council owned two-bedroom flat in dire poverty. She was unemployed and did not have electricity. She received the maximum 200 litres of water per day as her free water allowance, and cooked and heated her water outside on a fire. Her ex-partner who had fathered both her children had denied paternity, although she received a monthly maintenance for her older eight year old son. Participant A relied on handouts of food from neighbours and hampers of food from her child's school and charity organizations. She worked as a domestic worker prior to her pregnancy and was seeking a job. She discovered that she had been fraudulently married to a foreign national when she attempted to register her marriage. She had thus far been unable to register her three month old baby on the father's surname due to problems relating to the fraudulent marriage. She had been attempting to rectify the fraudulent marriage for three years but has been unsuccessful. This fraudulent marriage had implications for her access to a social grant and had implications for her claims for child support from the infant's father.

She had a history of abusive relationships in her family of origin as well as with her partner who had refused to assume responsibility for the baby, and who did not maintain a relationship with the children. Participant A had attempted suicide twice after her first child was born. She did not attempt to access any mental health services after her suicide attempts. This participant had twice attempted abortion previously. She subsequently miscarried the child, but was unclear about the cause of the miscarriage and seemed reluctant to attribute the miscarriage to the attempted abortion. Her family of origin was disjointed, and seemed to be

financially constrained. Participant A lived with her brother in the flat and had given shelter to a homeless, unemployed acquaintance. She did not receive any financial aid from her brother who was employed, and did not receive any financial contribution from her tenant. She detailed an abusive past during which her brother would frequently lock her out of the family home and not allow her to sleep there at night. She was then forced to sleep in a park. Her partner's family allowed her to live with them for a short while, but could not afford to let her live there. Her partner then developed a relationship with another woman when A moved out and had a child with that partner.

Her mother attempted to help her with necessities for the baby when the baby was born, but was unable to help her thereafter. Her mother cooked a meal for her brother everyday and brought it to him from her home which was situated in an adjoining town approximately twenty minutes away but was unable to provide food for Partcipant A and her children. Participant A was very calm and accepting of her circumstances. She indicated that she was advised by several people including neighbours and a teacher at her son's school that she should give her baby up for adoption, but did not consider this option seriously. Her daily life seemed to be dogged by poverty and hunger. She indicated that her older child often complained of being hungry, and that the school provided the option of a packed sandwich for indigent children, but the child was ashamed of accepting this charity and was afraid of being teased. She indicated that her baby was dissatisfied with the breast milk and as also always hungry, but that she could not afford the formula. Three days before the interview, she contacted me and requested a loan of R50-00. I refused and offered to buy her the supplies she required. She indicated that she needed diapers and was very grateful when I gave these to her, as well as being apologetic for asking me for money. Participant A said that she was not comfortable sharing her problems and feelings with family members or

others because this was part of her character, and she was reluctant to confide her financial and emotional situation to the psychiatric nurse at the clinic even though the nurse had made a concerted effort to speak to her and attempt to help.

Participant B: 04 November 2009

Participant B was 21 years old at the time of the interview. She was not married but lived with her partner. She followed the Christian faith and her baby was four months old at the interview. She was very eager to speak about her experiences and professed to being lonely during the day and not having anyone to talk to. Her partner worked six days a week. He had exacting expectations about the cleanliness of the home and about his partner and child. Participant B expressed that she felt pressurised to uphold these standards and to keep a neat home and be presentable when her partner came home from work. Her partner had offered to employ a domestic worker to ease the workload, but she had refused this offer. Participant B was a perfectionist and did not want to employ a domestic worker as she felt that the work would not be of a satisfactory standard. She expressed feeling 'tired' constantly and was resentful of the frequency of guests that she had to entertain and cater for during weekends. She also expressed frustration and anger at her partner for expecting her to take care of his needs such as ensuring that he got up on time to get to work and that all his requirements were packed into his bag and handed to him. She equated this to taking care of another child.

She had a troubled relationship with her partner's mother and resented the constant demands made by the partner's mother as well as the criticism of her mothering and housekeeping skills. She was also resentful of the fact that her partner's mother offered to help her with the baby during her pregnancy, but had since reneged on her offer. Participant B admitted that she did not expect other people to take care of her child but resented the fact that neither her

own family of origin nor her partner's family had helped her significantly with the care of her baby. She considered living within a nuclear family structure disadvantageous and expressed a preference for living within a joint family that would assist her. Her mother and her partner's mother had assisted her with the care of the baby in the first week that she had returned to her home. She intended to return to work but was concerned about leaving her baby to be cared for by a stranger.

Participant B did not plan the pregnancy, but expressed confusion about the circumstances surrounding her pregnancy. She had a termination of a previous pregnancy and felt that she was coerced into the decision by her partner and his family. She did not receive any counselling prior to or after the termination of that pregnancy, and was unsure about whether it was indeed an abortion. She seemed unwilling to use the term *abortion* and admitted that she regretted the decision to terminate the pregnancy. She expressed feelings of guilt about the act and considered herself culpable. She had kept the termination a secret from her family and friends, but felt burdened because she could not discuss it with anyone. She declined to inform the nurses who advised her subsequently about contraception and was misinformed about the effects of contraceptive usage, relying on friends and co-workers to influence her contraceptive decisions. She stopped using contraceptives after being advised by friends and her partner that it would affect her fertility, and admitted to taking a pregnancy test every month to ascertain whether she was pregnant. Her guilt and fear about the terminated pregnancy caused much stress and she admitted to being relieved at her pregnancy even though it was not planned. However, she still seemed to have unresolved issues surrounding the termination of her previous pregnancy.

Although her partner was helpful whenever he was at home, Participant B expressed dissatisfaction with these contributions and considered herself to be the principal caregiver of the baby. She wanted a greater effort at care-giving from her partner, and expressed a desire to be able to take a break from the baby and get away from her routine. She considered herself to be overprotective of her baby, and seemed conflicted about the care of the baby. She did not consider most members of her family as suitable or capable of taking care of the baby, but complained at the same time that she expected more help from them regarding the care of the baby. She considered herself to be a very private person and felt uncomfortable confiding in anyone including her partner. She considered the interview situation to be a safe space in which to confide her feelings, secrets and experiences and said that this was mainly due to the fact that as a stranger she would not have to encounter me (the interviewer) again, and would therefore not regret sharing these confidences.

Participant C: 04 November 2009

Participant C was the oldest participant interviewed. She was 35 years old and had two children. Her baby was nine weeks old at the time of the interview. Her older son was 11 years old and suffers from Down's Syndrome. The baby woke up from his sleep early into the interview and was very restless and cried. Participant C said that the baby was generally very restless and irritable. Her primary concern was the normal development of the baby, and she expressed her fear that the baby would not develop normally. Participant C said that her pregnancy was not planned although she had been hoping to fall pregnant for the past three years. She was anxious throughout her pregnancy because she feared having another child with Down's Syndrome, and says that she was very careful about her diet and exercise during the pregnancy. She did not want to test for Down's Syndrome during the pregnancy as terminating the pregnancy was not an option, and she feared confirmation of Down's

Syndrome in the baby. She felt that she would be prepared to take care of a second child with Down's Syndrome if this was confirmed at birth as she already had a son with the condition.

After the baby was born, her fears persisted, and she monitored his development vigilantly although she was reassured by the nurses that the baby was normal. She however harboured doubts about the pace of her baby's development and considered it slow for his age. Participant C was dealing with feelings of guilt related to the illness and death of her mother. She lived in cramped conditions with limited space and had to refuse to care for her ill mother as she could not accommodate her. Her mother subsequently stayed with her for a short while and then passed away. Participant C expressed the notion that the negative occurrences in her life were due to this event and that she was being punished for not caring adequately for her mother. She was at the time of the interview facing a similar situation with her brother who had asked her for accommodation as well as a mentally ill sister who was institutionalised, but with whom she had regular contact.

Participant C was afraid of mental illness being an inherent trait in her family and revealed after the interview was over that her father had been an alcoholic and had been verbally abusive and had publicly humiliated and embarrassed her family quite often.

Her husband did not provide any assistance with the care of either child, and she felt overwhelmed with the responsibilities of taking care of both children. Participant C did not have any family support structures and her one source of support had moved away to another province. This relative had helped her with the baby and the care of her family in the first week after the baby was born. She did not have any friends. She did not feel comfortable

confiding in anyone, and stated that she had always felt this way. She valued her privacy. She followed the Hindu faith.

Participant D: 11 November 2009

Participant D was one of two siblings interviewed as part of this study. The other sibling was Participant G. They were recruited at different sites and at the time of this interview, both siblings were living in the same extended family home that belonged to their parents. There were 13 people living in the home including babies. Participant D was 24 years old at the time of the interview and had three children. She expressed satisfaction with the degree of support that her parents offered her with the children and was assisted by them in their home after the birth of the baby. The baby was six weeks old and she had two other children aged three and two. The pregnancy was not planned. She had parental support in the care of the children, but felt irritated and frustrated due to having to care for three demanding children under the age of four. She expressed feelings of inadequacy at being a good mother. She was resentful of her partner's expectations of her, and felt frustrated at having to take care of his needs as well as taking care of the children. Despite her frustration and stress in taking care of her children, she also expressed joy at having children and felt that her children dissipated any negative aspects of her life.

She was reticent during the interview, but once the tape recorder was turned off, she volunteered information about her marriage and her acrimonious relationship with her husband's parents with whom they had been living previously. Participant D had moved back to her parents' home with her husband and children in an attempt to resolve issues with her husband's parents. A month later, I interviewed her sibling Participant G at the same home, and Participant D had moved back to her husband's parents' home. Participant D and

her husband were forced to live with her husband's family as they could not afford a home of their own.

Participant E: 03 December 2009

Participant E was married with two children. The baby was six weeks old and her older son was four years old. Participant E followed the Christian faith and regarded her religion as a source of solace and a guide. She had a 'Bible of marriage' on the table and said that she read it regularly as a guide to how to live her life and cope with marriage. The pregnancy was not planned. She had decided not to have any other children after the first child was born and was upset and depressed about her second pregnancy. Her relationship with her husband was unsatisfactory because she had been physically abused before the pregnancy, had obtained a restraining order against him, and still endured emotional and economic abuse. She stated that the physical abuse had stopped just before her second pregnancy, but that she had been publicly abused by him. She had never worked, and wished to do so, but was not allowed to by her husband. She did not have any funds at her disposal and stated that she could not even go to a local shop to buy her child a treat as she did not have any money. Her husband did all the shopping. She complained of being belittled by him and that his attitude was that she was of no worth except as a mother and she was not capable of improving her circumstances in any way because she was only capable of doing household chores. Her husband and children were members of a medical aid scheme, but she was not allowed to be on it. She claimed that this was at the instigation of her husband's mother.

Participant E's relationship with her husband's parents had broken down as she had lived with them when she married, and she felt disappointed that they and her husband had promised to allow her to study, but that her mother-in-law pressurised her into falling

pregnant three months after her marriage. She relates that there was much tension between them until she fell pregnant and that when the baby was born, they did not allow her to breastfeed the baby, and took him away from her, not allowing her to hold him, feed him or care for him in any way. Her husband was complicit in this and accepted the situation. This four year old child was at the time of the interview being fetched daily by his paternal grandfather and taken to spend the day with them. Participant E was afraid that they would behave in the same manner with the baby and had therefore resolved not to have another child.

She was isolated from a support system, as she did not have any friends and had lost contact with friends that she had when she was single, and she could not confide in her mother. Her mother had been abused by her father who was an alcoholic, and she did not wish to further upset her mother. She claimed that her father had been verbally and physically abusive to her family before her marriage. Her relationship with her partner seemed to be very distant apart from her keeping house for him and taking care of the baby. She indicated that he spent time after work talking to other people in the neighbourhood, ignoring her. Her relationship with her first child concerned her and made her feel inadequate as a mother. She felt depressed during and after the pregnancy, and felt unappreciated. She detested the drudgery of housework and the imbalance of power in her relationship. She was concerned that her emotional state would affect the baby's disposition. She felt uncomfortable confiding in anyone, even medical personnel and said that she would be unwilling to access any psychological healthcare. She aspired to be independent of her husband.

Participant F: 15 December 2009

Participant F was a married 28 year old mother of two children. The baby was seven weeks old at the time of the interview. The pregnancy was not planned. Her older daughter was four years old. Participant F was on maternity leave and was due back at work six weeks after the interview. She had arranged to leave her baby at the crèche that her older child attended. She had had a caesarean section and estimated that it had taken her two weeks to recover. She spent a month at her parents' home during this first month after her baby's birth, and although her mother worked, she was able to help participant F for some of that time. This recovery period was spent with her sister-in-law who had also just had a baby and was recuperating at the same home. She reported experiencing 'maternity blues' for about five days after the birth of the first child.

She had a good support system in her husband who helped with the baby and with the older child, and her mother whom she relied on for practical advice. Participant F admitted to feeling uncertain about her parenting skills and asking her mother for advice constantly. She had a busy day that started at approximately 05h00 every morning and ended typically at 23h00. She was breastfeeding the baby and would get up at between 02h00 and 03h00 to feed the baby. Her four year old daughter needed attention in the morning and she ensured that she spent quality time with her after she returned from crèche as well. Her husband spent time and played with both children as well as being of practical help with the children. Participant F reported enjoying the time that she spent with her children and was unhappy about having to leave her baby at the crèche and return to work.

She reported feeling that she was being unfair to the baby by not spending as much uninterrupted time with her as she did with her first child. She spent 18 months at home with

her first child before commencing work and would have preferred to spend the same amount of time with the baby.

She received help, practical aid and emotional support from her parents and her husband's mother. She felt able to confide in her father to some degree and confided in and relied on her mother principally for advice and support. She did not discuss her emotions at any length with her partner as he complained of "being tired". She had read about postpartum depression but did not consider herself to be suffering from it. Participant F followed the Hindu faith, and reported that she enjoyed experiencing the postpartum care rituals carried out for her benefit and that of the baby. She had continued one particular ritual called "the leg bath" and regarded it as being of great value to the comfort and well-being of the baby.

Participant F described the experience of motherhood as being similar to that of "falling in love again" and seemed to enjoy motherhood. At the time of the interview she was studying part-time towards a degree.

Participant G: 17 December 2009

Participant G was a 29 year old mother of four children. Her children ranked in age from eleven years, five years, three years to five months old. Her baby was breastfed. She had been screened almost two months previously, but had been somewhat hostile and refused to be interviewed citing her responsibilities at home and a lack of time. She recognized me at her sister Participant F's interview and reintroduced herself. She lived with her husband and four children with her parents. Her husband worked long hours, and also worked overtime since the birth of the baby, but she was aided in the home by her father. She reported feeling

60

anxious about the manner in which she was coping and felt guilty when she lost her temper with the children.

Typically, her day started at 05h30 and comprised completing chores, cooking and childcare. She did not have any domestic help apart from her father's assistance that included household chores and childminding. She reported a satisfactory level of support from her partner when he was available, and a relaxed attitude towards her without any expectations or demands. She expressed an inability to discuss her emotions and confide in her family although she felt that they would be attentive if she did attempt to do so. She had been prescribed medication to control her migraine headaches, but avoided the medication as it caused drowsiness and impaired her concentration and functioning.

She followed the Christian faith and enjoyed experiencing the postpartum care rituals associated with caring for the newborn baby and the mother. At the time of the interview, she was studying towards her matriculation qualification.

Participant H: 07 January 2010

Participant H was a 23-year-old woman. Her baby was four months old at the time of the interview. Participant H was living with her fiancé and his grandfather. She and her fiancé had planned to get married before the birth of the baby, but he had elected to postpone the wedding. The pregnancy was unplanned, but Participant H reported that she, her fiancé and their families were very happy at the news and looked forward to the arrival of the baby.

Participant H had returned to work and the baby was cared for by a domestic helper-cum nanny while she was away at work. Her fiancé also worked, but his working hours were unpredictable due to the nature of his job.

She admitted to feeling depressed and said that she had been advised about postnatal depression by a concerned family member who had noticed her changed demeanour and her distress. Her depression had begun in the final month of her pregnancy when she discovered her that her partner had been unfaithful to her during her pregnancy and that the affair was continuing at the time. She felt unsupported by her partner as he was unsympathetic about her feelings. Her partner's family advised him to be supportive and considerate of her and expressed support for her, but she indicated that her partner's support only extended to the first month after the baby's birth, and that he became distant and emotionally unavailable after the first month. Her depression resumed, and was exacerbated by unresolved issues regarding her fiancé's affair. She attempted to commit suicide approximately one month after the birth of the baby. The suicide attempt was a reaction to the physical abuse that she suffered from her partner during this period, as well as feelings of worthlessness due to her partner's infidelity and his emotional abuse.

She expressed enjoyment of motherhood and felt guilty and remorseful at her suicide attempt. Her physical scars that resulted from the attempted suicide were a constant reminder of the act, and she expressed regret at her actions. Participant H returned to work because she felt valued by the company who requested that she return, and also as a coping strategy for her depression. She reported feeling depressed whenever she was alone, and felt that the work environment would be a welcome distraction. She also valued her financial independence which had been compromised during her pregnancy.

She described her relationship with her fiancé as having changed from being focussed on their being a couple, to her being a household drudge. She felt unappreciated, and felt that her fiancé had expectations of her being a perfect housewife and a perfect mother, that he took her efforts for granted. The relationship seemed to have broken down due to their inability to deal with the infidelity. She reported feeling sad often, and considered her partner unsupportive and unsympathetic. She acknowledged his contributions towards some household chores and the care of the baby. Participant H relied on her mother and her sister for emotional support to some extent, but admitted to being uncomfortable discussing her emotions and problems. She reported that her fiancé expected her to be mentally strong and emphasised this point to her and in letters to his child, but that she felt that it was unreasonable to be strong all the time and that she needed support from him which he was unwilling to provide. She expressed fears that her fiancé would not allow her access to her baby if she left him because he had evidence of her instability as a mother, and that he had threatened her with this fact after her suicide attempt. She felt that accessing any mental health care would be counter-productive and would place her in a vulnerable position. She reported feeling embarrassed at her suicide attempt and feared being judged negatively if anyone found out about it.

3.6. Ethical issues

Permission to carry out the study was obtained from the Ethics Committee at the University of KwaZulu-Natal and from the Head of Health at the Clinical Support Department at the Department of Health, Safety and Social services. The researcher was further required to present her proposal to the management of the Health Unit at the Department of Health, Safety and Social services and motivate her reasons for proposing the study. This was done

and was well received by the management members. Permission was granted for the study by the Department of Health, Safety and Social services with the proviso that the department received a copy of the research on completion. A copy of the research proposal was handed to all the relevant stakeholders as a courtesy for allowing the research at their sites as well as for them to view the recommendations and to plan appropriate interventions.

The participants were required to provide informed consent (see Appendix 1), and were advised of all their rights and the voluntary nature of participation was emphasised. The consent form also served as an information letter and advised participants of:

- The purpose of the study

- The type of questions that they would be expected to answer

- The procedure to be followed for the interview

- The option to request help and where they would be referred

- The option to withdraw from the study without prejudice or repercussions

- Guarantee of anonymity

- Contact details for further information

- Measures to ensure avoidance of harm to participants

The participants were advised of medical and psychological services available to them, and prior support was arranged with the institutions in question. Participants' identities were protected by the use of alphabetical letters as identification and confidentiality was maintained at all times. Interviews were conducted at venues suitable for the participants and at the participants' convenience to ensure their comfort. Each participant was given a gift pack of personal pampering products that consisted of beauty and hygiene products or a photo album. This was given to participants at the end of the interviews to express the

researcher's appreciation of their cooperation and participation and was personally funded. One participant requested a loan of money which she claimed to need to buy her baby diapers. A pack of diapers was given to her as a token instead of the pamper pack.

3.7. Storage of Data

Data was recorded using a tape recorder. The transcripts of the interviews were stored with observational notes and the hardcopy of the interviews under lock and key in the department of Psychology at the University of KwaZulu-Natal. Each transcript and interview was labelled with the date of the interview and the label assigned to the participant.

Example of transcript label: Participant A , Phoenix : 21 October, 2009.

3.8. Analysis of data

After the data had been gathered and transcribed, the next step was the analysis of the data. Data analysis is the key function of research. There are several methods that can be employed to analyse data, and these methods depend on the nature of the research, the purpose of the research and the skills of the researcher. The current study employed thematic analysis to analyse the data. This method was selected because thematic analysis is encouraged as a "foundational" method of analysis in qualitative research in order to equip the researcher with the skills needed to conduct other forms of analysis (Braun & Clarke, 2006). Thematic analysis is also encouraged as a useful method of analysis for case studies by Yin (2003). The current study employed a multiple case study approach and was conducted by a researcher who was new to the field of qualitative research. It was therefore a suitable method of analysis for the proposed study providing a flexible tool to enable a detailed account of the data (Braun & Clarke, 2006).

"Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 79), organizing, describing data sets and interpreting aspects of the topic as defined in (Braun and Clarke (2006). The selection of themes was done as an active process by the researcher and was conducted within an interpretive method that acknowledged the individual's perceptions of reality while acknowledging the contextual factors that impact on the limits of this reality.

Themes reflect prevalent patterned responses within the data, and were identified by the researcher according to importance to the research question. The interviewer used Braun and Clarke's (2006) six-step guide to thematic analysis emphasising the "recursive" nature of engagement with the data and flexibility of guidelines. These steps involved:

- Familiarisation with the data
- Generating codes
- Searching for themes
- Reviewing themes
- Defining and naming themes
- Producing the report

Themes were identified and further refined using the Nvivo programme for qualitative analysis. This is a software programme developed for use in qualitative research and is a valuable, efficient and time-saving computer programme that aids in identifying themes.

Data was collected by the researcher in the form of audio recordings and was transcribed from the verbal data into written form. These transcripts were done in the form of an

electronic copy and then transferred into the NVivo 8 software programme. The process of transcription familiarised the researcher with the data. Familiarisation of data aids in the identification of common patterns. Patterns were identified from the hard copies of the transcripts. This process of pattern matching is the basic foundation that underpins the data analysis process and helped the researcher to identify patterns in the data. Patterns were identified through familiarisation with the literature as well as common themes that emerged within the different sets of data collected. Themes were thus theory-driven and data-driven.

The second phase involved the coding of data into interesting and meaningful segments that define the patterns. The NVivo 8 programme was used to code and sort the data into potential themes. Themes may be defined as recurrent or unifying ideas. Major themes and sub-themes were identified and refined. Themes were divided and identified using three different criteria:

- Psychological factors
- Social factors
- Biological factors

A process of definition and final refinement of themes was carried out. When a set of themes had been finalised, a report of the analysis including relevant and sufficient data extracts to provide evidence of themes was produced. This analytic narrative serves to "make an argument" relating to the research question (Braun & Clarke, 2006, p93).

3.9. Reliability and Validity

Reliability and validity help to establish the quality of any social research, but the terms have fallen into disfavour in terms of qualitative research. Instead, there has been a shift towards strategies that evaluate 'trustworthiness' in order to ensure rigour. However, the core ideals of validity and reliability remain integral to the research process despite the different terminologies that have gained popularity. In qualitative research, verification refers to the "mechanisms used during the process of research to incrementally contribute to ensuring validity and reliability and, thus, the reliability of the study" (Morse, Barrett, Mayan, Olson and Spiers, 2002, p. 9). These steps serve to identify and correct errors before they are built in to the budding model and before they threaten or weaken the analysis. Verification steps that ensure both reliability and validity of data include methodological coherence, sampling sufficiency, developing a dynamic relationship between data collection and analysis and thinking theoretically (Morse et al., 2002).

Methodological coherence strives to ensure that the research question is congruent with the method, the data and the process of analysis. This coherence is evident in the current research which ensured that each of these components verified the other and confirmed the methodological assumptions as a whole. The second step is ensuring that the sample is appropriate. This was ensured in the study by recruiting participants who best represented the research topic. The third requirement is collecting and analysing data concurrently. This iterative interaction between the data and the analysis was maintained throughout and ensured that focus was maintained and that data, analysis and interpretation were constantly monitored. The fourth aspect involves thinking theoretically. This aspect was adhered to in the study by constantly verifying and reconfirming ideas that emerge in order to build a solid foundation.

Some researchers prefer to use the terms validity and reliability and have provided guidelines for these concepts within a qualitative paradigm. These guidelines were also utilised in the current study and are described as follows.

3.9.1. Reliability

Reliability requires consistency in the research and implies that other researchers conducting the same case study at any other time will arrive at the same conclusions. To ensure reliability, the researcher followed a set of guidelines which included documenting the procedures followed and the course of development of the completed analysis to ensure that the case study can be repeated with the same results by other researchers in the future. The use of a case study protocol aid was the first step in this documentation as recommended by Yin (2003). The researcher endeavoured to maintain a chain of evidence that would allow any external observer to follow the data and the steps followed. Meticulous record keeping at every step of the research including the design stage was carried out in an attempt to ensure reliability. All the contact details of the relevant gatekeepers and the requirements of all stakeholders were noted to ensure that future researchers would be able to replicate the study by following the correct protocols as well as being useful for future studies in their jurisdiction. Screening procedures and interviews were noted at the end of each session. Notes were made after each interview and contact details were filed to ensure that the researcher would be able to clarify data should the need arise.

3.9.2. Validity

Validity in qualitative research is concerned with ensuring that the study is investigating what it intended to investigate. Thus, validity must be ensured from the beginning of the research

process. A sound theoretical background underpinning the research, combined with a good research design provided a solid foundation for validity. A theory incorporates concepts in a systematic way that enables understanding of events and situations and is abstract in nature. Theories are useful when used as a foundation to study situations and inform thinking on specific problems and situations although theories must be applicable to a wide range of situations (Rimer and Glanz, 2005). The selection of an appropriate theory was therefore crucial in order to describe the reasons for the problem being studied (in this case postpartum depression) and to guide the research in the appropriate direction. A biopsychosocial approach was chosen in this instance to situate the research within the constantly evolving social and cultural context and the development of the individual whilst acknowledging the biological influences of the phenomenon of giving birth. Culture and ethnicity were crucial factors considered in the choice of theory as morbidity and mortality rates, determinants of health behaviours as well as risk behaviours differ for different diseases according to race and ethnicity (Rimer & Glanz, 2005).

Ensuring appropriate interview questions and skilfully guiding the interview to provide the data required was another aspect that attempted to establishing validity. The interview questions were guided by the acknowledgement of social and cultural influences and the literature review. Other steps utilised included Yin's (2003) suggestion of establishing a chain of evidence and member-checking. The chain of evidence allows other researchers to replicate the study by providing useful information that allows the researcher to follow each step of the current study. Member-checking involves the researcher verifying the data and findings of the research with the participants. This process of member-checking was carried out after the initial results were noted. Participants were contacted telephonically. The participants and the researcher discussed the initial results and the participants verified the

researcher's interpretations in some cases and corrected the researcher on points that they did not agree with. Bearing this in mind, the findings are laid down as accurately as possible and cognisance was taken of the fact that participants may not concur with certain findings that do not accord with their own perceptions and comfort levels.

CHAPTER FOUR

Results

Introduction

This chapter will detail the themes that were identified from the data obtained during the interviews. A process of thematic analysis was used to identify the themes. These themes were primarily identified and chosen using the guidelines set out in the interview schedule. Other unprompted but common relevant themes were also identified. Themes are divided according to their psychological, social and physical impact and are detailed below. Although the themes are set out according to the guidelines used, it is important to note the overlap of issues that precipitated or influenced the course of the depression and the interrelation of the three domains listed. Issues relating to the biological domain had effects on the psychological and social functioning of the individual and in the same vein, psychological and social issues impacted on physical functioning. The results of this study imply that postpartum depressive feelings in this group were influenced by particular common factors. For the majority of participants, interpersonal issues were related to the onset of depressive feelings. The effects of these depressive feelings could be observed in compromised physical, psychological, and social well-being. These manifested as suicidal thoughts and self-harm, low self-esteem, depressed mood and social isolation.

4.1. Biological Causes of Postpartum depression

❖ **Possible undiagnosed postpartum depression due to biological causes**

From the accounts given by participants, it was possible to identify one participant who indicated a history of postpartum blues, and one possible case of undiagnosed postpartum depression. Participant F was aware of the symptoms of postpartum blues having experienced this after her first pregnancy. She had two children and indicated that she had been depressed after the birth of the first child and was currently (at the time of the interview) experiencing periods of feeling depressed. Participant H indicated that a concerned relative had alerted her to the possibility that she was experiencing postpartum depression and had advised her to seek help for this. A third participant, Participant E who had two children indicated that she had been depressed after the birth of the first child, had experienced bouts of depression during her second pregnancy and was currently (at the time of the interview) experiencing periods of depression. A fourth participant, Participant A had twice attempted suicide after the birth of her first child, and had twice attempted abortion during subsequent pregnancies, once successfully. The second attempt at abortion failed and resulted in a full-term pregnancy and the birth of a healthy child. The experiences of depression were recounted in the interviews with some participants using the actual term "depression". None of the participants received formal diagnoses so it is not possible to predict the origin or development of these experiences of depression with any certainty. The fact that all the episodes of depressive feelings had occurred in the perinatal period could be an indication of postpartum depression or postpartum blues of biological origin, but this cannot be determined with any conviction.

Participant F was 28 years old at the time of the interview. She was on maternity leave and was married with two children. She recounted her experiences of postpartum 'blues' which she had personally identified after her first pregnancy and which she experienced subsequent to giving birth the second time. This participant had a three year old daughter who she described as demanding a great deal of attention and who had missed her terribly during her stay at the hospital after the birth of the second child.

Participant H who attempted suicide approximately one month after the birth of her child was made aware of the possibility of experiencing postpartum depression by a concerned relative who recognised her symptoms as being related to depression. She was 23 years old and was living with her fiancée at the time of the interview.

"No it's just that when I was feeling the way I was feeling, and when um people used to look at me like family members and they used to see that I wasn't myself and they said to me

'H, you need to er get yourself like back into action and get yourself back into things you used to do because it seems you are falling under depression', so then she says to me, no er this was my fiancee's aunt, she says to me

'This happens to women after birth'

And then that's when I read about it, and then I realised no maybe it Is true because she says to me it's probably to do with the hormone imbalance and stuff like that"

I: Right, would you say these feelings have lasted up until now?

" Ya , I still feel the way I do sometimes." (Participant H, 06 January, 2010).

Participant E attributed her first bout of postpartum depression as being more severe due to the fact that she had been living with her husband's parents at the time. She described in detail the fact that they did not allow her access to her first child and insisted on caring for the child themselves, and that her husband colluded with them. They had maintained this contact with the child who was now four years old and fetched him every morning to spend the day with them. She was afraid that they would follow the same pattern of behaviour with the second child. Her second pregnancy was unplanned as she had decided not to have children after her first child was born. She described being depressed during her second pregnancy and related that she and her husband argued and had an acrimonious relationship throughout the pregnancy.

> *"I er was in shock. I er don't wanna tell anyone I'm pregnant. I even withdrew from my husband, and er like it was a very stressful time I used to cry all the time"*
>
> *I: right, And how did your husband react to the news?*
>
> *E:" When he received the news he was okay, then after that we used to fight all the time."* (Participant E, 03 December, 2009).

Participant A had a history of abuse and dysfunctional relationships that began in her family of origin and continued into her relationship with her estranged partner. She had struggled with accommodation for herself as a teenager and had continued to do so during her relationship with her estranged partner. She did not have a reliable source of income apart from maintenance paid towards her older child. She struggled with basic issues of survival including food and shelter and had experienced ongoing feelings of depression as a young teenager and continued to do so. It is not clear whether her perinatal feelings of depression

were due to these ongoing survival issues or if it was exacerbated by postpartum blues or postpartum depression of biological origin.

None of the participants were screened by healthcare professionals for postpartum depression, and none of the participants discussed their feelings of depression with their healthcare providers. Consequently, none of the participants received a medical or psychological diagnosis of postpartum depression or any other form of depression.

4.2. Physical factors that impact on the experience of postpartum depression

The birth of a child necessitates adjustments within a household, the family and within relationships. Babies require attention, and need to adjust themselves into suitable routines of care, feeding and sleep and these adjustments similarly have to be made by the partners and other household members. Fatigue and lack of sleep have been documented as commonly experienced physical effects on mothers postpartum. In the study, one mother compared taking care of a baby to a job, but remarked elsewhere that there was no respite or break from the baby.

4.2.1. Fatigue

Four participants mentioned feeling tired. One common reason given was having to cope with many responsibilities. This varied among individuals and included factors such as the care and demands of the infant, the care of other children in the family, caring for the husband or partner and responsibilities for household chores. Coupled with a lack of rest and sleep, this period was characterised by feeling tired and unable to cope adequately with myriad demands.

❖ **Inadequate sleep and rest**

One participant complained of not getting enough rest and sleep as she had been accustomed to during her pregnancy. Her periods of rest and sleep were now dictated by the demands of the infant as well as her husband and her household responsibilities.

> *"Because I mean before I could like go to bed at any time, wake up at any time, I mean it wasn't like you have to do certain thing certain time and I could cook at like four five o'clock in the afternoon and food would still be ready for J I mean now I can't do that because I don't know whether he's gonna be awake at that time and whether he wants to be carried at that time, so it's more tiring now, there's more work to be done . Taking care of him is a very big responsibility it's like a job."*

and

> *"there's some days that it's just so tiring , like sometimes where I don't know I just feel like I need a break", but then there's no break ((laughing)) there's nobody else.*
> (Participant B, 04 November, 2009).

Another participant described her day as being very demanding as she had to care for an older child with Down's Syndrome as well as the baby, and ensure that her husband had his meals and other requirements taken care of. She indicated that her husband did not share any childcare or household related responsibilities. Two participants described demands from their children (they each had three and four children respectively) combined with household chores as contributing to a challenging and exhausting day. The participants recounted having an early start to the day often between 05h30 and 06h00 beginning with the baby waking up and having to prepare breakfast and sandwiches for their partners and ensuring that their partners had clean, ironed clothes for work.

❖ **Temperament of the infant**

Some participants provided an indication that their stress and coping levels were influenced by the temperaments of their babies. After the birth of the second child, Participant F reported that she has good days and bad days depending on external factors such as the weather or the baby's temperament. Levels of fatigue and lack of sleep was also determined to some extent by the infants' temperaments. The following excerpts from the interviews with Participant F as well as other participants provide and indication of the impact that infant temperament has on the mother.

> *"There are days you know there are like good days and bad days when if the weather's hot she's miserable and if she's miserable then I'm miserable and er the day when I took her for immunisation that was a miserable day er cos she was in pain and that night she never slept, she had a fever. The first night I took her home from hospital as well um it was hot and it was a hot night and she refused to sleep the entire night I stayed in hospital for like a week um you know longer than I expected so I just waited to get home and when I got home then she refused to sleep and I just wanted that rest."* (Participant F, 15 December, 2009).

> *"towards the afternoon he gets up and he… by the time my husband comes he'll be screaming so I've got to be with him all the time and I'm very irritable by the time my husband comes home."* (Participant C, 04 November, 2009).

4.2.2. Pain and discomfort

At the time of the interviews, sufficient time had elapsed for the after-effects such as discomfort resulting from the birth to have dissipated. Some participants did however complain of episodic pain from either a caesarean procedure or from an episiotomy. One participant attributed her first episode of 'postpartum blues' to the trauma arising from having had a surgical procedure for the first time, staying in a hospital for the first time and the pain and discomfort related to the procedure and to breastfeeding. She attributed her second experience of depressed feelings or 'blues' postpartum, to the pain and discomfort as well as the emotional demands of her older three year-old child who had missed her during her stay at the hospital. Other participants estimated an average of between one and two weeks as the period of recovery postpartum. A related issue is that of specific postpartum rituals carried out during the period of confinement and the beneficial aspects that some participants experienced in relation to pain management and relaxation.

> *"err they say it like relaxes you and heals you, and it relieves all that pain."* (Participant G, 03 December, 2009).

And

> *"It would be nice if I had to have it again. It's really er it helps you with pain and it really, really relaxes you, and the only time they ever offer to do that is when you have a baby…"* (Participant F, 15 December, 2009).

4.3. Psychological factors that influence the onset and course of postpartum depression

4.3.1. Depressed mood

The participants who were interviewed had been identified as possibly experiencing postpartum depression because they had scored on a postpartum depression screening scale within a range that is considered a reliable indication of a clinical diagnosis for postpartum depression. As explained in chapter three, this is a screening scale developed specifically to identify postpartum depression. Five of the eight participants made some direct references to feelings of depression either during pregnancy or after giving birth. Three of the participants reported experiencing depressed mood both during pregnancy and after giving birth. The depressed moods were commonly described in terms of feelings of sadness, tearfulness and feelings of emotional pain. The reasons for the depressed moods differed for each participant and ranged from interpersonal issues, social issues, to biological factors and illustrate the crucial role of contextual factors on the course of depression and other psychological trauma. These sub-themes are described below.

❖ **History of Depression**

Participants reported feeling either "stressed", "anxious" or "depressed". Given the absence of a psychological history, and of any psychological or psychiatric diagnosis, it was not possible to classify or identify any depressive disorder in any of the participants. Some participants used the term "depressed" to describe their moods, while some preferred using the terms "stressed" and sometimes "anxious". These moods are difficult to differentiate at times, particularly for lay persons such as the participants in the study, and may be interlinked. Participants who had revealed a history of depression in the screening procedure were excluded from the study as it would not have been possible to differentiate postpartum depression from any other cause of depression in such individuals.

❖ **Unresolved issues**

A common theme was that of reflecting on past unresolved issues that had caused and that continued to cause unhappiness. Five of the participants reported feeling particularly tearful and depressed or unhappy during solitary moments of reflection when they remembered past hurts or when they struggled with unresolved issues. As detailed elsewhere in this chapter, one participant felt unhappy because she had terminated her previous pregnancy, and often felt teary and depressed when thinking about this. She had not received any counselling prior to or after the termination of pregnancy. Another participant reported feeling depressed during moments of solitude because she reflected on issues such as her partner's infidelity during her pregnancy, and she was not able to come to terms with the betrayal as well as the fact that he had physically and emotionally abused her. She did not receive any counselling regarding the issue and often brooded on it. These issues were often exacerbated by other interpersonal problems to and caused stress and tension within relationships.

> *"You won't believe it's like I'm forced to go back to work that I get my mind off things, 'cause when I'm at home I, when I'm alone, that's when the feelings come in, so I said to myself if I go back to work then I will er you know these feelings won't be so strong"* (Participant H, 06 January, 2010).

4.3.2. Guilt

Guilt as defined in The Penguin dictionary of psychology (2001, p310) is an emotional state that arises from the knowledge that one has violated moral codes and standards of society. It is a form of self-administered punishment for a perceived transgression. The reasons for guilt vary among individuals and depend on unique contextual factors. Five participants recounted

their very different reasons for feeling guilty about specific issues. The emotion of guilt was strongly evident in tone and in affect even though it was in some cases only briefly mentioned. One participant felt an enormous residue of guilt because she had chosen to terminate her previous pregnancy. Coupled with this guilt, she indicated feeling remorseful that the abortion took place at an emotionally vulnerable period for her (her father had recently passed away), and although she indicated that she followed the Christian faith, she expressed a fear that her unborn child might have been a reincarnation of her deceased father and that she had killed this child.

"So much of things play back in your mind that you can't have children and I'll be like 'was something wrong with me? Is God punishing me ?' There's so many things. If you find out you're pregnant it's gonna be a big thing, but finding out that you not pregnant is still a big thing. I'm thinking to myself 'My father just passed away'. What if it was like him coming back, me getting pregnant. I'm like 'I killed the baby', and it's not like something We did , I felt like it was Me. I didn't feel like it was me and J."(Participant B, 04 November, 2009).

Participant C, a 35 year old married woman whose eight year old child required special care because he had Down's Syndrome, and who feared that her two month old baby might also be physically or mentally challenged recounted feeling guilty about not being able to assist members of her family who asked for her help. She indicated a deep-seated sense of guilt due to her being unable to accommodate her now deceased mother who had been ill and had required full-time care. Her mother subsequently had a stroke and the participant then accommodated her for a period of time until she passed away. She followed the Hindu faith

and expressed the belief that ill-luck and unhappiness in her life was a result of her inability to help her mother and that it was 'karma'.

> *"I just tell myself that I deserve it because maybe somewhere along the line I did something to somebody and this is my karma."* (Participant C, 04 November, 2009).

This participant indicated that she was experiencing a similar quandary at the time of the interview because her brother was experiencing some difficulty with his partner and had asked her to accommodate him. She also had a younger sister who was institutionalised and who required psychiatric care. Her sister also called her often and needed her support, and she felt unable to provide accommodation and support to her siblings as she did not have adequate space and she felt emotionally drained by the demands. This participant also indicated as related in the section related to feelings of inadequacy, that she also felt guilty about being responsible for her baby's colic, and that other people blamed her for causing the colic due to her unsuitable diet. A third participant indicated a mixture of feelings ranging between feeling inadequate as a mother to feeling guilty because she had a poor relationship with her older child and spent very little time with him as he spent his days with his paternal grandparents and came home at night to sleep.

> *"So all those things all this came into play and I used to think you know what there's no use bringing a child into the world and you cannot take care of it, my first baby as well we have no relationship with him whatsoever, he's there almost all the time."* (Participant E, 03 December, 2009).

A fourth participant recounted feeling guilty for not being able to spend as much time with her second child as she did with the first, as she had to return to work and place her child in a crèche.

" Well the only thing that I don't feel so great about is you know not being able to be with them ((children)) all the time , especially that I work and um for my firstborn I was with her for 18 months and I'm dreading the day that I go back to work, you know the day that I leave her, and I'll leave her at a crèche , er I know for a fact that she (will be) getting sick more often. I would like to be at home with her and take care of her at least until she's over a year old , so I think I wouldn't be giving her enough as I gave the older one I'm forced to go to work." (Participant F, 15 December, 2009).

She indicated that she had spent a greater amount of time with the older child and that the inequality would be unfair to the younger child.

The fifth participant related that she felt guilt and regret that she had attempted to commit suicide after the birth of her child.

"I don't know, it was something I knew in my mind I would Never, ever do but even before I was pregnant I used to always like feel pity on people that used to do that. I used to always say " it's the coward's way of doing things", but at that moment you know, when you feel like you(are) absolutely nothing, and there's no purpose for you , in the back of your mind you know you have a baby , but at that moment you just, I just blanked out and I regret it more than anything, anything. I said to myself "I don't

know how and why I put myself in a position like that or put my baby in a position like

that." (Participant H, 06 January, 2010).

4.3.3. Poor self-esteem

With a single exception, participants across the sample indicated feelings related to low self-esteem, and issues of self-doubt regarding their abilities as mothers or as women. A related factor that was identified pertained to feelings of inadequacy as mothers.

❖ **Inadequacy as a mother**

Participants who expressed feelings of inadequacy regarding their parental skills cited reasons such as inadequate knowledge about child-rearing and in two cases, inability to discipline their children adequately. These participants were sisters, one of which had three children the oldest of whom was three years old. The other sister had four children of whom the oldest was 11 years old.

"Sometimes I feel I'm not worth being a mother". (Participant D, 11 November, 2009).

Participant C who was mentioned earlier admitted that she did not want others to know that she had difficulty in coping with her children, and admitted that she found it difficult to accept compliments.

"I'm not sure , but I have had compliments that is why I guess I don't want to let

people down they think that I'm failing because er like my son they all say they proud

of me the way I've brought him up and I(m) struggling with both of them.. people think oh I'm failing" (Participant C, 04 November, 2009).

One participant expressed feeling unhappy that she was not able to provide basic necessities for her children. Another wished that she could give her children anything that they asked for. One participant related feeling that her relationship with her first child was not as close as it should have been and that she was communicating her unhappiness to her baby in her demeanour and her affect.

"Sometimes I do feel inadequate that I'm not a good mother because my first child is there (in-laws) all the time, and even with this baby too as well I feel like I'm not a good mother because er like at times like I don't wanna be with her like you know? I just want to be to myself and withdraw from everything, everybody…"
(Participant E, 03 December, 2009)..

The participant who was struggling to deal with her partner's infidelity reported being belittled by him and being made to feel insignificant.

"I just blanked out and, the only option I had at the time was to kill myself because he made me feel so belittled, like there was no need for me on this earth you know?"
(Participant H, 06 January, 2010).

This participant had a job that she enjoyed and indicated that she was highly valued as an employee and that she contributed extensively to the household finances, but she reported being constantly reminded by her partner during her maternity leave that he was supporting

86

her and that she lived a very comfortable life due to his efforts. This participant indicated that the financial dependence on her partner coupled with guilt that she was not contributing to her child's financial requirements had made her feel guilty and worthless. She indicated that this need for financial independence and equality was part of the reason that she elected to return to work.

The other participant who reported feeling underrated by her husband had experienced physical and emotional abuse as had the previous participant, and in the case of the latter participant, economic abuse was also recounted. She indicated that her husband controlled all the finances. This participant indicated a strong desire for financial independence. Her financial dependence on her husband coupled with other interpersonal issues contributed to a diminished sense of self-worth.

Two participants indicated feelings of inadequacy related to uncertainty about proper care of the baby. The first participant relied heavily on her mother for advice and wondered whether she was a competent mother.

The second participant indicated receiving conflicting advice from her doctor and from family member about the cause of her child's colic. She reported feeling responsible for his discomfort and felt that people blamed her for her child's colic.

> " I feel like I've done something wrong and sometimes the child's got colic and I took him to the doctor and the doctor said it IS colic because even breastfed babies do get colic and people tell me NO it's what you Eating that's making him that way and all that guilty feelings takes over and…" (Participant C, 04 November, 2009).

87

Feelings of guilt may cause individuals to feel stressed, inadequate or unworthy and may contribute to feelings of depression. This may be compounded by the reasons for the guilt which the individual might find difficulty in discussing and which becomes a burden to be borne by the individual alone. Guilt is by nature and definition an internalised moral standard of society and is self-administered punishment, so the secret nature of the guilt contributes to the lonely burden carried by the person.

The reasons put forward by participants for feeling stressed or depressed or anxious include interpersonal issues, partner expectations, taking care of children, the demands of motherhood, feeling pressurised, financial considerations and inadequate or absent support structures. These are detailed as follows:

4.4. Social factors related to feelings of depression in the postpartum period

Each participant reported experiencing negative social influences that contributed to their current feelings of depression. The impact of unemployment, long working hours and of various economic factors was prevalent in six of the eight interviews. Social isolation and unsatisfactory relationships also emerged as prevalent themes.

4.4.1. Economic factors

The role of economic factors in contributing towards feelings of stress and depression cannot be discounted. In this sample, none of the participants belonged to medical aid groups, and only one participant had returned to work. Another was on maternity leave, but scheduled to return to work within six weeks after the interview, and a third was searching for a suitable care option for her child before returning to work. A fourth had no formal qualifications or

skills and was searching for a job which would most likely entail domestic work which is poorly remunerated. Except for this particular participant whose partner had deserted her, the other participants' partners were employed, six in the formal sector, and one was self-employed. A prevalent theme which was sometimes prominently emphasised and at other times not mentioned specifically but was evident in the background, related to finances in a household. Participant A was unemployed and destitute and lived from hand to mouth dependant on the charity of neighbours. Participant B mentioned financial difficulties related to her having stopped work and the addition of a baby in the household. Participant D mentioned that her husband's employment was unstable due to his being self-employed. This participant and her family had lived with her husband's parents for most of their marriage and were at the time of the interview living with her parents indicating an inability to afford running a home of their own.

Participant E indicated as reported elsewhere in this study that she felt economically marginalised by her husband and wanted financial independence. Participant G and her family lived with her parents in their home and indicated that her husband worked long hours including overtime from the time that the baby was born. Participant F struggled with the decision between returning to work in order to supplement her husband's income and spending enough time with her baby. Participant H had returned to work, and indicated that she valued her financial independence and that her partner would not have been able to manage coping financially without her contribution. She indicated that he had constantly reminded her during her maternity leave that he was providing a very comfortable and even a luxurious lifestyle for her and the baby and that she needed to be grateful to him. The accounts related by participants illustrate that economic factors may be exploited to create or

perpetuate dependence in some cases and may be additional sources of stress in some cases either directly or indirectly.

The correlation between financial difficulties and feelings of depression was significant for most participants, but particularly evident in the accounts of Participants A and E. Participant A as detailed above was a single unemployed mother of two children who lived in abject poverty without basic services such as electricity, with minimal water, and often little or no food. She had three unplanned pregnancies. She had one abortion; one attempted abortion and had attempted suicide twice in response to her poor financial situation and interpersonal factors. She reported feeling depressed about not being able to provide adequately for her children, and about not being able to find a job.

> *"It's hurting to see others to be very honest with you, we are poor we got no money, we got 200 litres water which we find (insufficient), and my children hardly got clothes it's like come Christmas or Diwali you see other people using new clothes and all and I feel like if I can't provide for (them). So all that"*(Participant A, 24 October, 2009).

Participant E reported feeling economically dominated by her husband. She recounted not being able to make any purchases including daily necessities such as bread and milk as all purchases were made by her husband, and she did not receive any money from him. She expressed a strong desire to be financially independent, and reported feeling distressed that she could not even buy her children an occasional treat such as a chocolate as she did not have any money.

"I would like to be independent and that's the one thing he deprives me of." (Participant E, 03 December, 2009).

4.4.2. Social withdrawal

A common feature of depressed mood is the social withdrawal of the depressed person. Conversely social isolation may precipitate or aggravate depressed mood. It was difficult to determine with certainty within a limited interview whether feelings of depression caused some of the participants to withdraw socially, or whether social isolation caused some of the women to feel depressed. In most cases feelings of depression seemed to precipitate social withdrawal. The responses indicate varied reasons for not wanting to access or accept any psychological or social help. Except for the last response which clearly indicates a fear of psychological treatment being detrimental to her legal rights as a mother, it is not clear why other respondents were unwilling to access psychological or social welfare related aid.

The following excerpt is an example of Participant E's description of her feelings. This participant was 27 years old and had a four year old child and a six week old baby at the time of the interview. She had had an unplanned pregnancy and had been experiencing, physical, emotional and economic abuse from her husband. She had decided not to have any other children after the first child, and reported being extremely depressed about the pregnancy. She was experiencing bouts of depressive feelings after the pregnancy as well.

"I get very irritable. At times I do display anger, frustration, like say things out of turn you know, cry, want to be alone, withdraw from everybody, and um just be with

the baby, you know, I don't want to talk much to anyone like how I used to." (Participant E, 03 December, 2009).

Six out of eight participants stated that they did not feel comfortable confiding in others about their lives or their concerns. A common feature of the participants' views regarding interaction with others was a desire to protect personal privacy. Another explanation that was offered was that they were by nature reserved or private people and therefore had difficulty in opening up to others. As a result, potentially supportive social networks including family and friends were discounted. This attitude also effectively shut out the option of sharing concerns with individuals such as healthcare workers and social workers who might have been able to offer appropriate advice or aid. Below are excerpts from the interviews that indicate participants' attitudes towards talking about their feelings.

(i). Unwillingness to confide in family and friends.

The first two participants quoted below had unresolved interpersonal issues that they experienced difficulty in discussing. Participant H felt that she would be judged negatively if she discussed personal issues with others.

"To be honest, I rather talk with somebody that I know I'm not going to see very often, than my family member(s) because the gonna look at me and they gonna see me and then when I feel like they gonna constantly judge me, you know, because, I don't know it's just a thing with the Indian community I feel you know?" (Participant H, 06 January, 2010).

Similarly, the following participant was afraid of negative judgement and of criticism of her actions and she had judged herself in a negative light because she had elected to have an abortion previously. This action had influenced her subsequent contraceptive choices and her next pregnancy which had resulted in the birth of her child. The participant quoted below experienced difficulty in articulating her voluntary termination of a previous pregnancy, and did not feel comfortable discussing the issue with her partner although they had ostensibly made this decision together. She was afraid that her mother would react negatively if she found out about the abortion and she did not feel able to discuss this issue with anyone. She was afraid that her mother would be extremely angry and distressed if she found out about the abortion and was at pains to withhold this information from her mother. She was afraid and ashamed about discussing this matter with anybody including her doctors and the nurses who advised her on contraception. Consequently, she was misinformed and had insufficient knowledge about her contraceptive options and choices.

"A friend of mine , she worked with me she was talking to me and like 'You going to J's house and you staying ,I'm not sure if you sleeping with him. Are you taking anything?'And then I tell her , I didn't tell her about the baby or anything because I didn't trusted her because my mother and I worked together so you must know the position I was in. I couldn't talk to anybody, I was afraid they were going to tell her, and she would totally freak out if she knew what …" (Participant B, 04 November 2009).

(ii). Unwillingness to confide in medical and psychological personnel.

Responses that indicated an inability or reluctance to confide in others regarding the feelings of depression included the following response from participant A, who described her

interview with the psychiatric nurse at the primary healthcare clinic that she had take her child to be vaccinated at.

> *"I was depressed when I took her the other day for injections and the nurse asked why am I feeling depressed and she said no I must sit and talk to her and I didn't wanted to sit and talk but she was carrying on asking me and I said no"* (Participant A, 24 October, 2009).

Other responses to whether they were willing to discuss their feelings of depression with medical or psychological personnel included:

Would you feel free to talk to your, to a nurse or a doctor about your feelings?

> *" No"*
>
> I: Why not?
>
> *er I don't know. I think because I'm quite reserved."* (Participant C, 04 November, 2009).

Some participants indicated that they did not have any desire to be helped by healthcare professionals or others. The responses to being asked whether they would like someone to help them are listed below and include replies such as:

> *"They would help me but I can't talk to them"*(Participant A, 24 October, 2009).

Participant A indicated a general reluctance to speak to health professionals at the clinic

but was unwilling to explain why. She indicated that she felt more comfortable discussing issues of concern with her cousins who would give her advice, but she also indicated that her personal concerns were her own responsibility to bear and that she would prefer to keep these to herself.

The following response was from Participant B. This participant related feeling very pressurised and not having enough time to care for her child and carry out other responsibilities. Seeking help was viewed as another time-consuming and tiring chore in an already hectic lifestyle. The reluctance to seek help should be understood within the context of accessing healthcare at a busy clinic where a great deal of time would be spent waiting in a queue to access treatment. Burdened with an already stressful, tiring and long paediatric visit, Participant B was not willing to endure another visit to the clinic where this was not essential in her view. She indicated that the paediatric visits caused her baby to be tired and restless and disrupted his routine. Coupled with the fact that she would have to take her baby with her as she did not have a suitable caregiver, seeking treatment for her feelings of depression was not an option. Her response below explains this.

> *"You mean like somebody to talk to? Ya, but I mean it depends now, like if I have to go clinic, I'll be so tired and I'll have to take baby with me , you know you can do something that will help you, I can go sit there, I can go talk to the nurse , but think about everything else, I mean then it will be so hectic for to come and I'm like you (know) I don't really need to go twice"*. (Participant B, 04 November, 2009).

Participant H indicated a fear of being labelled as an unfit mother and was afraid that her partner would use the information about her seeking psychotherapy to support his attempts to gain custody of their child. This is related in the excerpt below:

"It's very difficult to say because I, as much as I do, I want to know what will be the outcome if I'm going to talk to somebody, because I know, I know, I am a strong person but it's just that one moment of weakness that I made a big mistake, but it's just that at times you know when you don't expect things to just kick in and er if I say I want help I'm not going to have the time to go and get that help even though I want to because he will question everything that I do. And then now that I'm going to say to him that I'm going to need help he's going to say to the (court), because he did threaten me many times to say that I'm unstable. So he would want to take away the child from me if I say I'm going for psychic help and I don't want that to happen, and because even though I am getting depressed I, I'm, like I said to you I … my child, so I can get myself in a happy mood so I don't think about these things. So I'm, I'm trying to fight it on my own. If it helps, it doesn't help, I don't know how long it's gonna go on, but like I said if I have to go now and get help it's going to make my situation very difficult at home, he's gonna use it against me. Because the day that I went to the hospital, when the doctor gave him the letter saying that I… (suicide attempt) you know, he used it against me. He says to me, because we were going to split up, he says to me:'This is my proof you're an unstable mother'

And I don't want him to do that to me you know?" (Participant H, 06 January 2010).

It is a feature of depression that sufferers are often unwilling to seek help and this factor should be considered together with the reasons provided by the participants as a possible explanation for the reluctance to discuss their feelings and access aid.

4.4.3. Social Isolation

Participants recounted varied reasons for being socially isolated. An absence of close friendships was a common denominator in some accounts. Two participants indicated that they did not have any friends at all.

Participant C had a very limited circle of relatives, and her one close relative that she enjoyed contact with and who had supported her and family with practical care after her second child was born had moved away to another province.

A second participant indicated that she had friendships before her marriage, but was not allowed to have friends after her marriage.

> *"I wasn't allowed to leave the house, I wasn't allowed to go anywhere, I wasn't allowed to speak to anyone. It was just the four of us my mother-in-law, father-in-law, hubby and I. So most of the time they used to be gone out and the neighbours used to be fright to even come to see me because they knew the kind of mother-in-law I had."*
> (Participant E, 03 December, 2009).

This participant cited feeling lonely and not having anyone to talk to.

"I think loneliness, er nobody to talk to you know you can't tell anyone how you feel and stuff, and being alone the whole day" (Participant E, 03 December, 2009).

In a similar vein, a third participant also expressed feeling lonely with nobody to talk to during the day. This participant indicated that she was not able to have as much contact with her cousin who was also her close friend and confidante due to the distance between their places of residence. She indicated that that she had periodic telephonic contact with other relatives but rarely saw them due to the distance involved in travelling to visit them and not having readily available transport.

"I hardly speak the whole day, because there's nobody here and the neighbours are like everybody keeps to themselves, I mean nobody will come visit you or something, like that I don't go anywhere either, so besides talking to the baby the whole day there's nobody here unless J's sister is on school holiday or something, she normally comes here every holiday, and I don't really talk to him about er anything I mean I speak to him in general , like "How's your day" or anything but I mean towards my feelings I don't really open up to him." (Participant B, 04 November, 2009).

A fourth participant indicated that there was a limit to the interaction that she had with friends and relatives as her support structure lived away from her and she did not have the means to visit or contact them due to financial constraints. The contact was therefore at their convenience. She also indicated feeling that it was futile talking about her problems as she was the only person who might be able to resolve them.

"I don't talk to anybody about (it). If I know (it is my) responsibility, I'd rather keep it within me."(Participant A, 24 October, 2009).

Social isolation by its very nature serves to alienate possible social support structures that may help an individual by exposing her to possible aid including advice and practical help. The interaction with other members of society including family, friends and health professionals could enhance the quality of life of an individual and thus contribute towards optimum mental and physical wellness, but where an individual actively discourages such interaction, or is isolated from these social structures due to circumstances, the individual may experience detrimental social and psychological effects.

4.5. Social Support Structures

Social support structures are deemed important for optimum health and functioning in women who have recently given birth. This study revealed that social support was indeed an important aspect of psychological and physical well-being for women with newborn babies. All of the women interviewed related receiving some degree of support from either a familial or extended support network. All the women reported that they would have preferred a greater degree of support and that they regarded the support that they did receive as insufficient. Support ranged from being provided with three meals a day for one participant who was unemployed and destitute during her pregnancy (Participant A), to advice and practical help with childcare and household chores. The sources of support varied. Two participants recounted receiving support from close friends.

"I used to go when I was pregnant... I used to go to my friend. She used to give me food to eat. I used to sit the whole day with her. I used to eat breakfast, lunch and supper" (Participant A, 24 October, 2009).

Another participant recounted receiving practical aid with household chores from a friend after the birth of her child.

"She came to help to clean up the house and you know, sweep the yard, and she helped to bath the baby" (Participant G, 03 December, 2009).

4.5.1 Support from Family

Participants generally reported receiving some advice and help from their families of origin, their husband's parents and their partners. This support varied among individuals, and the expectations of support also varied among participants. One participant reported feeling overwhelmed due to an absence of an extended family structure. She expressed a preference for living within an extended family as she felt that they would have helped her with the baby and that she would have an opportunity to rest and have a responsible relative care for her baby when she needed a break.

"It's very hard when you like living alone. Every body says
'Don't go live with family' but when you living alone it's very tiring" (Participant B, 04 November, 2009).

This participant expressed disappointment that her husband's mother did not help her with caring for the baby.

"And that was like very, very tiring for me, and I mean in the beginning she said she will take care of the baby and stuff like that but then after he was born , people say stuff but then when the baby comes they totally change their minds. So then when N was born she wasn't working but she never used to come down and look after him or come down and bath him, even when I had my stitches, like he's 3 months 2 weeks and you can say she gave a bath like three times. I mean it's not about bathing him but she stays up the road." (Participant B, 04 November, 2009).

She recounted feeling overwhelmed and needing a break from her baby, but that there was nobody to help her. She regarded most people as being superficially polite in asking about how she was feeling, but that they did not want to know the extent of her feelings or difficulties in coping.

"now that I'm on my own and it's I would say like er there's no support cos I'm alone with him all the time, just the baby and me" (Participant E, 03 December, 2009).

Another participant had an acrimonious relationship with her husband's parents with whom they had previously lived and who she accused of taking her older child away from her. She did however express the view that living alone meant not having any support from others.

4.5.2. Inadequate Support from the Partner

A particularly resonant sub-theme that emerged from the participants' descriptions of their support structures related to the lack of support from their partners. Participants described a

general lack of emotional support that translated to feelings of being unloved and or unsupported. Some of these feelings could be attributed to previously dysfunctional relationships with the partner and a lack of communication that bred feelings of anger and resentment. Participant H described a change in her partnership in the ninth month of her pregnancy when she realised that her partner was unfaithful and this issue and the subsequent change in the relationship impacted negatively on the partner-relationship. Participant A had never received any emotional or practical support from her estranged partner. Participants B, F and H regarded their partners as being emotionally supportive on a superficial level that did not meet their emotional needs and Participant E was emotionally estranged from her partner. None of these women regarded the emotional support from their partners as being satisfactory. Participant H indicated that she did attempt to communicate her concerns and emotions to her partner, although she perceived him to be unconcerned. Comments included:

> *"Like he gave me a small tap , like "don't worry" and I want more out of that, I*
> *don't want just a tap on the shoulder, I want a hug now and then you know?*
> *Like I said he's there for you and everything , he's not sympathetic where he'll*
> *look at you like you talking to the (walls). Because that's how I feel."* (Participant H,

06 January, 2010).

And

> *"I don't really talk to him about er anything I mean I speak to him in general , like*
> *'How's your day' or anything but I mean towards my feelings I don't really open up*
> *to him."* (Participant B, 04 November, 2009).

This perception of a lack of partner-support also translated into the domestic domain where all the participants except Participants A and G complained about their partners' expectations

102

regarding childcare and domestic chores. Participant B had mixed comments about the level of support she received from her partner, rating his practical support as being faultless at times to rating his contributions towards caring for the baby as being unsatisfactory.

> *"Sometimes when he comes from work I'm like...Thank God you're here, I just want you to carry him, look after him, I need a break', you know and N doesn't want to stay by him, he's not used to taking care of him and he gives him back to me and I'm like 'God what's the use ?' , but on Sundays he's a big help. Like the Sunday that passed J was looking after him and he was crying and J is calling me and I'm washing the dishes... how do you expect me to carry him, don't be ridiculous and then he took him outside and then he kept quiet by the time I cleaned up he made him sleep so I had a little bit of time to myself then to lie down as well, if we come from church and N is already sleeping, he helps me clean the house, I wouldn't say he doesn't do anything, he does help, and most of the time he's not here."* (Participant B, 04 November, 2009).

Participants D, F and H reported varying degrees of contributions from their partners towards childcare and/or household chores, but Participants D and F were dissatisfied with the frequency of these efforts.

Participant G reported that her husband was helpful with childcare duties but was unable to help much as he worked overtime every working day and was therefore unavailable to help. Participants C and E did not receive any help with either childcare or domestic chores from their husbands. Comments included:

"Why do I have to be the one to be at home and do all these things when I'm not appreciated you know? Like I'm not being noticed." and

"It's supposed to be half and half. He's also supposed to help, even in doing little things you know? Showing that he's there." (Participant E, 03 December, 2009).

Participants C and E indicated a total lack of interaction from the partner with the children although they lived in the same home, and were financially supported by the husband. These feelings contributed towards participants feeling unsupported and unloved.

(i). Feeling unsupported or unloved

Five out of the eight participants reported feeling some degree of resentment towards their partner. Participant A did not have any relationship or contact with her former partner. Her former partner had fathered both her children and paid maintenance for the elder child after initially denying paternity of the child. He denied paternity of the baby and did not contribute any maintenance towards her. Participant B related feeling resentment towards her partner who had exacting standards regarding household chores and who expected her to adhere to those standards. Participant B recounted feeling very pressurised to finish her chores in time and take care of the baby while ensuring that her husband's needs were met.

"I don't know. I'm not sure. I mean what he expects is the food to be ready at a certain time, he expects N and I to be ready at a certain time… There are some days where I just feel I need to just relax and give myself a break like you know from every thing, and ya sometimes I'm very tired and some days maybe I'll just get out of bed maybe 12 o'clock or 1 o'clock. I'll be awake but I'm still in bed and N will be next to

me and the only time I will wake up is when I want to make milk for him, and I'll tell myself half an hour or one hour more, half an hour more (laughs) half of the day will get, I just (laughing). It's 2 o'clock I never bath, I never clean up the place, N never bath, I never cooked, Then you'll find me rushing, rushing and doing everything, just so everything is ready before 6 o'clock before half past six when J comes home and I'll be rushing, rushing, rushing to do everything. It becomes to tiring." (Participant B, 04 November, 2009).

Participant B also indicated that she did not feel able to broach specific subjects with her partner. This included her resentment towards him for what she perceived as his coercing her to have an abortion, and her inability to discuss the loss that she experienced and blamed him for.

Participant E indicated a seeming lack of interaction between herself and her husband. This participant had been abused by her partner.

> *"(My) husband comes from work, has supper, watch TV, he goes on the road and talk to everybody, and then ya watch a bit of TV , do whatever I have to and then retire for the night."*

And

> *"So er like (even during) my pregnancy my husband wasn't there for me, you know it was just him and his job, so er like I went through my whole pregnancy alone, and even after giving birth to him er like it doesn't mean anything you know so I can't say*

my feelings with him I can't tell him how my day went, I can't say that I'm tired, you know, that I need a break, so it's sort of getting to me, you know." (Participant E, 03 December, 2009).

The five participants presented accounts of their relationships with their partners that indicated either disinterest in their feelings and concerns or a lack of sympathy, which led to reluctance in voicing their feelings and a subsequent breakdown in communication.

This participant indicated that she felt resentment towards her partner because he expected her to cater to his needs and that she compared it to taking care of another child.

"I just woke up and I was in such a bad mood and I was like waking J up for work and he doesn't want to wake up. I feel it's so frustrating , like 'I'll wake up early in the morning for you, the least you could do is wake up when it's time for you to wake up', and then he ended up getting little bit late for work I'm thinking
'The more late you get up the more I have to do for you'
And you know? Like (he's) so late that I have to take out everything and leave it for him like, his lotion, the gel, pack his bag , make sure he takes his phone, he takes his clock-card, make sure his lunch is in his bag, make sure he has his working t-shirt I mean every single thing, like you taking care of another child I mean it's not like I don't mind doing it, but the more late he is I feel like the more responsibility I have , and I don't know maybe that's why it's so frustrating." (Participant B, 04 November, 2009).

(ii). Physical and emotional abuse

A significant factor that contributed to depression involved a history of abusive relationships with men and/or a current abusive relationship - physical, emotional or economic. Three participants indicated experiencing a history of abuse in their families of origin. Participants C and E indicated that they had abusive fathers, and Participant A had an abusive brother.

> *"And then we decided to get to know each other and then, my father is an alcoholic and like he didn't like my husband and like er my father will come from work drunk and swear, he would abuse my mother, my sister and I and then he would say 'You know what this can't go on. You need to get married and you need to get out of the house' (..) and er so that's when we decided to get married."* (Participant E, 03 December, 2009).

This participant reported a history of abuse in her family home and was forced into marriage. Her current relationship was also an abusive one. She had briefly separated from her husband and obtained a court interdict preventing him from harassing and abusing her after a public assault. She had subsequently reconciled with him and reported that the physical abuse had sporadically continued but had ceased during her second pregnancy.

Similarly, Participant A who had experienced abuse and difficulties as a teenager in accessing a basic necessity such as shelter in her familial home entered into an equally abusive relationship with her partner who denied paternity of her first child and was forced to leave his family home after her first pregnancy due to financial difficulties in that household and being accused of "eating all the food" in the home. She returned to her family home and her partner then began a relationship with another woman with whom he subsequently had a

107

child. Participant A resumed her relationship with him and after her third pregnancy, he again denied paternity of the child as he had with the first child, and refused to contribute any maintenance. Participant A reported feeling hopeless and was destitute as she and her children were often hungry and unable to afford staple food such as bread or rice. She had twice attempted suicide and this reaction is documented in research findings that recent hunger and exposure to violence were predictors of suicide (Maselko & Patel, 2008, cited in Swartz & Herman, 2010)

Participants E and H indicated that they had experienced physical abuse from their current partners. Participant E indicated that the physical abuse had ceased during her second pregnancy. Participant H indicated that the physical abuse had occurred approximately six weeks after the birth of her child and that she had attempted to commit suicide after the incident of abuse. This is supported by research that indicates that women who experience intimate partner violence are more likely to report emotional pain and self-harm (Ellsberg et al., 2008 cited in Swartz & Herman, 2010). Both women reported that although the physical abuse had ceased at the time of the interviews, they felt emotionally ill-treated by their partners and reported feeling emotionally distanced from their partners.

The act of abuse, whether physical or emotional impacts on the victim and on the relationship with the perpetrator of the abuse. Participants related feeling sad at moments when they had time to reflect on the negative experiences in their pasts. The acts of abuse in the past together with other possibly unrelated episodes of unhappiness and present dissatisfaction led to feelings of extreme unhappiness, crying and depression. While it cannot be ascertained with any certainty that these familial relationships were instrumental in affecting the choices

that these women made regarding their partnerships, these familial situations would have influenced some decision-making regarding their life choices.

(iii). Household chores

Six out of eight participants did not have any help with domestic chores.   Participant B had a domestic worker to help her once in a month, but expressed dissatisfaction with the work done and admitted that she was only satisfied if she did the work herself.   Her partner did contribute towards household chores when he was available to do so but he worked six full days a week and could not help as much as he would have liked to.   She did however complain about the volume of housework expected of her, and felt that she would benefit from more help with household chores, and that domestic help would enable her to take care of her personal grooming needs which she had neglected since the baby had been born. Participant E complained about the drudgery and unfairness of having to do household chores which her husband refused to participate in.   Participant C expressed the view that some help with domestic chores would relieve her somewhat.   Participant G who lived with her father received some help from him with the domestic chores and with caring for her children.   She admitted though that she sometimes experienced really demanding days having to care for three children and not being able to rely on her husband for help as he worked very long shifts and had consistently worked overtime since the birth of the baby.   She did not cook on some days and said that her husband was very supportive and undemanding in that respect.

4.6. The impact of Patriarchal Attitudes to Gender roles within the Partnership

A theme that played out consistently and throughout the interviews suggested a patriarchal worldview that dominated or at least influenced the gender roles that women in the study adopted. Patriarchy is a system of social organization based on the authority of male heads of

household and is commonly used as a term to denote male domination in general. Traditional patriarchal role divisions dictated clearly demarcated duties and expectations of these roles in the domestic and other social spheres. Some of the participants expressed unhappiness with these roles, but felt powerless to change their roles. Unhappiness, depression and stress were common reactions to perceived role expectations. A significant factor that influenced the gender role expectations included economic realities such as the male partner being the sole provider or the male partner contributing a significantly larger portion towards the family's financial needs. Out of a total of eight participants, two were employed at the time of the interviews. Two others had been briefly employed in the formal sector and out of these, one woman Participant D had not worked at all after her marriage.

The effects of these gender stereotyped roles could be observed in participants' mood states and in the partner relationships. The partner relationships were affected in multi-faceted ways. Unhappiness and depression in the female partner affected the relationship with the male partner who did not always understand why his partner was moody. Resentment at the partner was a common result. The underlying issues that bred resentment included a perceived lack of social support from partners and resentment of household chores. These factors are elucidated as follows and express the views of the participants as explained to the interviewer. Most male partners had an expectation that being primary breadwinners excluded them from most household chores and from sharing in childcare. Many of the male partners worked long hours and had demanding or stressful jobs. The working hours precluded many of these partners from sharing in equitably in childcare and household chores as this would be physically and logistically impossible, and those female partners who did not have work commitments were expected to cook, take care of children and clean their homes. These factors are described elsewhere in this chapter under various sections including partner

relationships, abuse and household responsibilities. The following comments illustrate participants' experiences of these roles expectations.

> *"I'm wearing the pants. I'm the one that's going to work. I'm the one who's bringing home the bread and butter"*
>
> *You know?*
>
> *"Your duty is only to be at home, do the work and just be a mother"*
>
> *It's not so simple"* (Participant E, 03 December, 2009).

And

> *"say for example he comes here at one, two o'clock in the afternoon, and he's like*
>
> *'why didn't you bath? , why isn't the house clean?' and at that time I'm getting frustrated*
>
> *and I'm like give me a break, I mean I don't have to clean the house at a certain time every day and I don't have to bath at a certain time every day. With J he comes home at like the earliest is 6 o'clock so when he's here he expects food to be cooked, he expects me and N to be ready like have a bath and, he expects the house to be clean and he doesn't expect to find washing and that's the kind of person he is."* (Participant B, 04 November, 2009).

Patriarchy is a dominant social system that is entrenched in society and has been described as a "globally shared culture", ("Traditional values", 2010) wherein "women's work, time and contributions to social reproduction are not recognised" and where "women are glorified as mothers and wives while experiencing hidden levels of violence". The terms "custom" and "tradition" are used to excuse, support or validate patriarchal practices that discriminate

against women and perpetuate oppression of women and this view of women's oppression in South Africa is attributed to South African struggle leader Oliver Tambo who expressed this view in the context of a wider backdrop of struggling to conquering oppression in South Africa ("Traditional values", 2010).   While great strides have been made in some countries to promote equality of sexes particularly in the spheres of family and childcare responsibilities through legislation and in the case of South Africa through an enlightened constitution and gender equality policies in the workplace, a paradigm shift is required in order to redress role imbalances for men and women. Some researchers into women's health behaviours conclude that women's reduced status in society can impinge on their health seeking behaviours (Pinn, 2003 in Buvinic, Medici, Fernandez and Torres, n.d.). Factors that influence women's health-seeking behaviours include restrictions on women's mobility, average lower incomes and larger time burdens than men, access to social protection such as health insurance, cultural norms and enforced hierarchical gender roles within the family. Additionally, women's underuse of health services is influenced by factors directly related to traditionally male control of health resources which affect treatment norms and previously biased medical research findings that incorrectly interpreted women's disease burdens within research results based on male subjects (Buvinic et al., n.d.). The effects of a male dominated gender hierarchy thus affects all levels of women's health.

4.7. Positive influences

4.7.1. Positive Coping mechanisms

Participants found their own strategies of coping, some finding inner strength to motivate them and others being able to rely on supportive significant others around them. Participant E used her religious faith as a means of coping, although she declined to use the formal

counselling and intervention structures in her church. She preferred to use a guide called the "Marriage Bible" and asserted that this handbook provided her with inspiration and direction. Participants F and H particularly relied on their mothers for advice about childcare and personal issues and received some practical aid in the form of help with the care of their children. Participant H drew strength from her joy in having a child and used the time spent with her child to forget about her problems with her partner.

4.7.2. The role of postpartum rituals in promoting well-being

Five of the eight participants related carrying out at least one traditional Indian postpartum ritual. Of these, three participants reported enjoying the rituals and viewed them as beneficial to their physical well-being and as an aid to faster recovery. Of these rituals, the 'leaf bath' enjoyed the most popularity with participants reporting that this ritual promoted a sense of relaxation, encouraged a sound sleep and ensured a feeling of well-being. Participants described this bath as a ritual performed by another person who pours a water solution comprising a mixture of water and three varieties of leaves over the woman. Two of the participants expressed regret that this ritual was generally performed after childbirth and not a regular occurrence as they felt that they had so thoroughly enjoyed the ritual that they would miss not experiencing it again. A fourth participant expressed disappointment that although a few individuals had offered to perform this ritual, none of them had done so and she had been looking forward to this ritual as she had previously enjoyed it

CHAPTER 5

PART 1

DISCUSSION OF RESULTS

5.1. Introduction

This chapter will discuss the experiences of the participants in this study and will endeavour to interpret these experiences in line with the aim of the study. The participants' contribution to our understanding of postpartum depression will be detailed using the literature review and the biopsychosocial theoretical framework as explained in chapters two and three. The widely accepted prevalence rate of postpartum depression at between 10 and 15 percent (Chaudron et al., 2007, WHO-UNFPA, 2008) should cause alarm as this indicates that at least one in 10 women experiences postpartum depression. This statistic is a generally accepted approximation of postpartum depression in developed countries however, and the rates for postpartum depression in low and middle income countries (LMIC's) are significantly higher according to epidemiological studies on maternal mental health and child development (WHO – UNFPA, 2008). This report ranks perinatal depression during pregnancy at between 10 and 41, 2 % in LMIC's. The study ranks puerperal depression in these countries as ranging between 14 and 50 %. Currently, no reliable estimate exists for national prevalence rates of postpartum depression in South African women as the research sites are fragmented and biased towards particular population groups. In order to understand the determinants of postpartum depression it is imperative to consider the biological domain of the patient, the psychological and the socio-cultural contexts that impact on the patient.

The psycho-social dimension of postpartum depression suggests interrelatedness with the contextual environment. Many of the potential respondents and the actual participants expressed a desire for privacy away from their families in order for the interviews to take place and expressed fear that their families would not understand their feelings. The universal expectation of motherhood to be a joyous and fulfilling experience no doubt influences this fear and expectation. Cultural stereotypes that propagate the notions of satisfaction, joy and bliss at becoming a mother downplay the stresses and upheavals that parenthood brings (Howell & Bayes, 1981). The fear of being labelled an abnormal or mentally ill mother prevents women from voicing their feelings either to family members or to health practitioners.

This chapter focuses on discussing postpartum experiences as related by participants in the study with a view to providing a better understanding of these experiences.

5.2. The role of biological factors in the experience of postpartum depression

The absence of medical testing for hormonal factors that could be attributed to postpartum depression in the sample precluded the possibility of examining the role that hormonal factors played in the current sample of postpartum depression. The time period that elapsed between the process of giving birth and the interview was a minimum of six weeks. This was sufficient time to heal physically from trauma related to childbirth, and the participants unanimously agreed that they had recovered from the procedures involved in giving birth. One participant indicated that she occasionally experienced some residual pain related to her episiotomy, which had taken place more than two months previously.

Feelings of fatigue resonated among many participants and were attributed to lack of sleep and rest, as well as increased demands on the women's time and energies due to increased responsibilities for the infant and other familial duties. The feelings of fatigue impacted on the women's daily functioning and led to difficulties in fulfilling certain duties, stress related to childcare and household chores and feelings of resentment and anger.

5.3. The role of psychological factors in the experience of postpartum depression

Depressed mood in women postpartum can be attributed to many different causes and the current study identified significant stressors arising from environmental issues such as the familial situation, lack of housing, poor economic circumstances and psychological distress. In adverse circumstances depression can be compounded by an unplanned and unwanted pregnancy. Within the current sample, none of the pregnancies were planned and of these, two women initially welcomed their pregnancies. Poor socio-economic circumstances coupled with dependency on extended family members for basic necessities such as food and shelter creates a shaky foundation fraught with desperation and anxiety about the future during a time which should herald the celebration of a new life and a union of two individuals committed to a future together. This is a stage of life when two young adults plan an autonomous life together and often children are an anticipated part of the planned family unit. When this is adversely affected by socio-economic conditions, the individual can react to the stress in psychological and physical manifestations of illness. Hopelessness often leads to feelings of helplessness, and combined with the stresses of coping with a newborn infant, many women succumb to feelings of depression. Depression is often attributed to the concept of *learned helplessness.* This is an acquired belief that a person is helpless and unable to affect the outcomes in his or her life. This feeling may be reinforced by observation that one's actions have little impact on the environment and this expectation of

helplessness may lead to passivity and depression (Sue, Sue & Sue, 2003). This approach is based on cognitive-learning theory and describes depression in terms of "belief in one's own helplessness" (Seligman, 1975 in Sue et al., 2003). Negative views of the self, the external world and the future are characteristic cognitive symptoms of depression and are epitomised by a sense of pessimism about the person's abilities, future and prospects of help from others (Sue et al., 2003). These views are linked to poor self-esteem which is regarded by some psychologists as pivotal to depressive responses. Poor self-esteem has been identified as a significant theme in the current study.

Depression has been further described by other researchers within the context of hopelessness and powerlessness (Sue et al., 2003). The depression is often exacerbated by the adjustments that the woman has to face in her personal life including in the current sample, the responsibility for another helpless person, changes within the partnership and economic difficulties. The issues that precipitated or exacerbated feelings of depression in the current study generally related to interpersonal issues. Partner relationships that were previously strained, were placed under further stress, and resulted in resentment and acrimony. The sources of strain included lack of support from the partner, infidelity, desertion and abuse. These previously unresolved issues festered and caused further strain in the relationship. Some participants experienced these issues as ongoing concerns that continued into the present. Participants B, C, E and H reported that thinking about past negative events precipitated feelings of distress and depression. This ties in with findings that indicate that depressive symptoms may be maintained as a "spillover" effect in highly depressed individuals who experience interpersonal stress, particularly on days following an interpersonal stressor. Delayed recovery from the interpersonal stressor led to negative thought and affect (Gunthert, Cohen, Butler& Beck, 2007).

Depression has been described variously in terms of "hopelessness, powerlessness and helplessness" (Sue et al., 2003, p362). These descriptions are apt regarding many of the interpersonal issues that some participants in the study face.

All the participants screened indicated that they had "never" considered harming their children in response to the question on the interview schedule. The women who were interviewed emphasised their answers as **NO** or **NEVER** in response to the question. This may be true of the sample interviewed for this study, but it is likely that no mother will ever admit to wanting to harm her child even if the thought has occurred to her. Two of the participants indicated that they had attempted to commit suicide in response to their personal situation. Both participants had a child at the time, and one suicide attempt had taken place approximately six weeks after her child was born. Neither participant received any psychiatric or psychological treatment, nor was either participant willing to receive such treatment. Participant H was wary of receiving psychological counselling due to the perceived sigma attached to mental illness as well as a fear of being labelled as an unfit mother. Most participants described themselves as not being comfortable with confiding in others regarding their feelings and problems and preferred to keep these emotions to themselves. The result seemed to be that they turned their distress inwards and became withdrawn or resentful, angry and felt helpless.

Almost all the women interviewed shied away from the term *depressed.* During the screening process, I perceived that many people are reluctant to be labelled as depressed. I explained to each participant that the instrument was merely a screening tool and a possible indication of *feeling anxious sometimes.* I used the terms *feeling anxious* and *overwhelmed* to

indicate possible feelings, as many participants immediately responded to the questionnaire by saying something to the effect "I'm not depressed" or "I am very happy" even when their responses to the questionnaire indicated otherwise. I then explained the purpose of the questionnaire as a screening tool and the need for a proper diagnosis by an appropriate professional in order to ascertain whether the high scores were of concern. During the interviews as well, I was often corrected when I used the term *feeling depressed* and was advised that the participant was not depressed. I used the term "feeling anxious" as participants seemed to be more receptive to this.

It is crucial to take into account how society as a whole views the concept of depression and whether depression is considered to be a mental illness or whether it has been normalised to some degree. The term 'depression' is commonly used to describe feelings and moods as a form of self-diagnosis. In this respect it may have been normalised to some degree as a mood state that may be transient and that although more serious forms of depression exist that require medication or psychological treatment, in lay terms it is a commonly used expression. One participant in the study indicated that she had mentioned to her partner that she had been screened for possible postpartum depression and that she was disappointed at her partner's dismissive and flippant response to her being depressed. She perceived him as treating this concept of her being depressed as a joke, although he later qualified his remark by asking her if she required extra domestic help in the home. Paradoxically although depression can be commonly and often incorrectly used in lay terms, being diagnosed or labelled as depressive can be upsetting and inspire fear. Few of the participants who were interviewed were willing to seek treatment for possible depression or related issues and this could indicate personal difficulty in accepting a diagnosis of depression. Depression and anxiety impair social

function and quality of life (Howland and Thase, 2005), and should be treated promptly in order to promote mental well-being and encourage optimal functioning.

Low self-esteem among participants was a prevalent theme evident across most of the interviews conducted. This was evident either in their doubts regarding their parenting skills or in feeling that they were not able to fulfil personal responsibilities. Low self-esteem devalues the self as being unworthy or incompetent, and is regarded by some psychologists as being pivotal to depressive reactions (Sue et al., 2003). This is common in people who experience depression. A negative self-concept that interprets the self as unworthy may lead to thinking patterns that encourage "self-blame, self-criticism and exaggerated ideas of duty and responsibility", (Sue et al., 2003, p360). Participants in the current study did exhibit this to some degree. Participant A experienced feelings of unworthiness because she could not provide adequately for her children. She also blamed herself for her pregnancies and felt that she had been "stupid" to fall into the same relationship trap over and over again where she had been hopeful that her partner would have supported her and maintained a relationship with her. Further, Participant A displayed a fatalistic attitude to her situation and when probed about her future hopes and goals she proposed that her children growing up and supporting her were her only hope. A variety of theories may exist that would explain this line of thinking. One such theory proposes that depression is an acquired belief of helplessness and inability to affect outcomes in one's personal life (Sue et al., 2003). Depression may result when this expectation is fulfilled, particularly in circumstances that are out of the person's control, and an attitude of passivity results (Sue et al., 2003).

Participant B blamed herself for being coerced into terminating her previous pregnancy and considered herself to be principally responsible for the termination of pregnancy. She felt

120

guilty and regretted the decision and blamed her partner for pressurising her to terminate the pregnancy, yet paradoxically she felt personally culpable for that decision and regarded the termination of pregnancy as an action that she was responsible for, not a joint decision with her partner.

Participant C felt responsible for not helping her family when they needed her and felt deeply distressed that she was not able to fulfil her family's requests for help. This participant was also uncertain about her parenting skills with the baby and felt distressed that she might be the cause of her baby's colic. Participant E experienced feelings of inadequacy as a mother. She related that her relationship with her elder child was not as close as it could have been and felt alienated from him because he spent every day with his paternal grandparents and returned home only to sleep at night. In addition, she felt that her acrimonious relationship with her husband impacted negatively on her children and that she could not be as good a mother as she wished to be due to this and her feelings of depression. There was an absence of joint parenting as her husband did not have any interaction with either child. She also felt inadequate because she did not have access to her husband's finances and was not allowed to work outside the home. Consequently, she felt unable to entertain her children or buy them simple treats such as chocolates or toys. Her husband had also excluded her from his medical aid cover on his mother's advice and Participant E seems to have been effectively excluded from basic rights within her marriage.

Participants D and G were unhappy with their parenting at times, particularly their disciplining skills. Participant F related having a reasonably functional marital relationship with reasonable support from her husband. However, she did express doubts about her abilities as a mother as she turned often to her own mother for advice on childcare.

121

Participant H had been abused by her partner, her partner had been unfaithful during her pregnancy, and she had been labelled as an "unfit mother" by her partner. When she attempted to break off the relationship and take her child with her, her partner had threatened to use this label of being an unfit mother to prevent her gaining access to her child.

These feelings of acquired helplessness seemed to be attached to feelings of guilt. Guilt is an emotion that often characterises postpartum depression (Pope et al., 2000). The feelings of inadequacy regarding mothering are common amongst many mothers and while not necessarily causing depression, these feelings may manifest as stress, anxiety and lack of self-confidence. In individuals who experience depression, such feelings may be exacerbated, be demotivating and may lead to exaggerated feelings of self-criticism.

Anxiety is generally defined as a vague unpleasant emotional state of apprehension. This definition implies that anxiety is concerned with possible future occurrences. Anxiety is frequently comorbid with depression or mood disorders and comorbid disorders are so frequently experienced that the diagnostic category "mixed anxiety-depressive disorder" has been included in the DSM-IV (Howland & Thase, 2005). Results from research conducted within an American survey suggest that 58% of patients with a major depressive disorder were found to have an anxiety disorder in the National Comorbidity Survey (Howland &Thase, 2005), but for many people, the symptoms of depression and anxiety are not severe enough to warrant a primary diagnosis of either condition. The researchers conclude that these patients are at increased risk of anxiety or depression symptoms being amplified into fully developed anxiety or depressive disorders. Although many participants in the current study expressed feelings of anxiety about specific issues, none of the participants had

122

received a previous diagnosis of an anxiety disorder. While it was beyond the scope of this study to identify the possible presence of anxiety disorders in participants, it is worth noting that primary anxiety disorders are associated with a family history of depression and occur more commonly in women, generally developing before the age of 30 (Howland & Thase, 2005).

In this study the term 'anxiety' was used by the interviewer and the participants sometimes as an alternative to 'depression' although the two terms differ in meaning. Many of the women who were screened denied feeling depressed even where extremely high scores indicated that this was a very likely possibility. When the words 'anxious' and 'stressed' were used however, the women seemed more willing to accept these terms as applying to them so sometimes these words were substituted.

The theme of anxiety did emerge through many of the interviews. Reasons for anxiety related to three broad issues:

- Future childcare issues related to mothers returning to work and leaving behind babies in the care of others
- Financial concerns
- Anxiety regarding the state of the partnership.

Participant A was anxious about finding a suitable job so that she could provide food for her children. Participants B and F were concerned about leaving their young babies in the care of strangers when they returned to work. Participant B was so anxious about the future care of her child that she did not plan to return to work unless a suitable caregiver could be found.

However, she was concerned about their financial situation and felt that she had to return to work at some point soon. Participant F had arranged for her baby to be placed in the same crèche as her elder child, but was concerned that her baby would be sick more often because of this (exposure to other children and germs).

Participant C was anxious about her baby's development and was afraid that the baby's development was slower than normal. She was concerned that some abnormality would be revealed in the future and felt anxious about how what it would be and how she would deal with it.

Two participants, E and H were anxious about their partner relationships. Participant E felt a sense of helplessness regarding her financial dependence on her husband and was anxious about her financial future and her marital relationship which had been dysfunctional for some time. Participant H had planned to marry her partner who had subsequently reneged on these plans and had been unfaithful to her. She felt anxious about her future with him. She was uncertain about his expectations of the relationship as she felt that he was communicating mixed signals about his intentions and his expectations of the relationship.

5.4. The role of social factors in the experience of postpartum depression

Postpartum depression has wide-ranging social consequences similar to any other form of depression. A number of participants in this study experienced a breakdown in communication with their partners as well as some degree of breakdown in the partnership itself. There was evidence of increasingly strained family relationships as well. In all the cases of strained partner and familial relationships, these relationships had been dysfunctional to some degree before the pregnancy, and the strains of the unplanned pregnancy combined

with the social and economic adjustments of parenthood had further negatively impacted on these relationships. The feelings of depression seemed to be present to some degree before the pregnancy in five out of eight women interviewed and interpersonal issues during the pregnancy and after the pregnancy exacerbated these feelings. Individuals experiencing depression often disconnect from their social network (Ravitz, 2003) so the depression seemed to precipitate the social isolation. Participants were unwilling to approach health professionals for psychological treatment and viewed such professionals with some degree of trepidation or distrust. Few participants mentioned having close friendships and some participants did not have any friendships at all. A general image of isolation was evident with most participants who seemed to have withdrawn even from avenues of likely support.

A major theme under social factors was identified as 'the social support structure' and a sub-theme would be "support from the partner". These themes explore and cluster the specific experiences of participants relating to their social support structure and in particular, their perception of their partners' support or lack thereof towards them. These sub-themes are discussed in detail chapter 4 in the section dealing with social support structures. The partner was the person most mentioned as not being supportive enough to the woman. This is in keeping with studies such as Heh (2002) that concur with this finding. The mother-in-law was also mentioned by some participants as being unsupportive and this is corroborated in findings as mentioned in Heh (2002) as well.

The individual who is guided within a collectivist cultural system such as eastern or oriental cultures or religion may value the contributions of her significant others who may include family members and the partner's family members, more than a person who subscribes to an individualistic cultural system such as is espoused by western cultures. Collectivist cultures

encourage extended familial relations and social interventions by the society itself in order to enhance the functioning of the individual. The positive effects of postpartum support within familial structures have been extensively documented as a historical and cultural reality in traditionally collectivist societies such as African and Asian societies (Heh, 2003). Many of these traditions were continued by Indians who emigrated to South Africa. With the acculturation of Indians into the multicultural societal structure in South Africa, some of these traditional practices and many of the support structures were eroded principally due to the popularity of nuclear family structures, migration and more women in employment. Many mothers and mothers-in-law as well as sisters and sisters-in-law who would traditionally be of greatest support to women postpartum are now employed and unavailable to assist. In many instances, families live too far apart to be of practical assistance, and in low income groups, inadequate transport may be a pertinent issue.

The value of rituals in any society is dependant on a positive correlation between the values of the individual and the values of that particular society. While some women in the study expressed a desire for the traditional postpartum support, others experienced conflict in wanting to simultaneously follow a medical model considering this to be in the interests of the child. Religious belief was also a significant factor that influenced whether participants felt comfortable in carrying out rituals traditionally associated with Indian culture and whether participants valued these rituals.

A common reason that was proffered for not participating in or for not recognising any value in them was a clash of religious beliefs. The participants who elected not to follow Indian postpartum rituals or who performed these rituals reluctantly followed a Christian belief system and felt that this was not compatible with the performance of rituals that were based

on Indian and Hindu culture. One participant felt conflicted between following folk remedy based rituals and medical advice. She had chosen to carry out specific rituals as opposed to all the traditional rituals as she stated that she based her choices on the dictates of her religion and of logic. This participant recounted being given a great deal of unsolicited advice from strangers and being pressurised by family members to carry out traditional and Hindu rituals because her family was composed of members of differing religious faiths. She had been reprimanded by a nurse at the primary healthcare clinic for following these rituals as one particular practice which involved applying a spice paste composed of turmeric was deemed as being possibly detrimental to infants. The spice is yellow in colour and difficult to wash off and the nurses pointed out that if an infant contracted jaundice, it would be disguised by the turmeric and would endanger the infant's health.

The almost total westernisation of this group of women also encourages a value for independence and autonomy regarding their bodies and the desire to be responsible for their infant's welfare rather than abdicating this responsibility to a family member. This worldview regards the spouse or partner as the only other significant decision maker within the family unit. The spouse or partner assumes a much greater degree of responsibility for healthcare and support issues in the postpartum period than he previously would have. The western cultural model encourages a significant contribution by the spouse that may include household chores, cooking and assuming feeding and or other care duties for the infant and other children in the home. In an eastern or oriental cultural setting, female members of the extended family, neighbours and midwives would assume these responsibilities, and the husband would benefit by having very few if any responsibilities. This situation would promote bonding with the infant and the wife in her new role as mother in cultures that permit such contact, and in other contexts, the father would also have the opportunity to

127

adjust to fatherhood. In cultures that rely totally on the spouse or partner for support, the father could be overwhelmed with these additional responsibilities while holding a full-time job to accommodate a new and possibly demanding arrival in the home. He might have to adjust his own emotional status to accommodate being a father and changing his self - concept from being a lover and or a husband to being a father.

A lack of communication between partners seemed to be prevalent. Participant B who had elected to terminate a previous pregnancy felt resentful towards her partner and blamed him for coercing her into a decision that she did not feel ready to make. These feelings were bound with other conflicting feelings of guilt that she was responsible for that decision ultimately and therefore it was her responsibility. She was not able to discuss these feelings with her partner. She described her conversations with her partner as covering superficial topics and they avoided discussing the issues that were underlying their relationship. They seemed to skirt around certain issues such as their fears about the possibility of future infertility as a result of the termination of pregnancy, and did not adequately discuss issues such as contraception or future family-planning. Participant B wavered between feeling that her partner was flippant and unsupportive regarding her emotional state and not wanting to burden him with these issues due to his demanding work schedule. She felt resentful towards him due to his expectations regarding household chores and cooking, but did not feel able to discuss these issues and reach a compromise.

Participant C did not feel able to discuss her needs and emotions with her husband as she perceived him to be intolerant of complaints. Participants D, G and F seemed to have some degree of communication with their partners regarding their concerns with childcare. Participant F however reported that her husband was not receptive to her concerns at times

citing his work responsibilities as superseding other concerns in the home to the extent that he felt that going to work absolved him from having to listen to his wife's concerns. Participant E however seemed to have experienced an almost total breakdown in communication with her husband. She described a lonely existence in which she and her husband co-existed in the same home, but with little communication. She described his interaction after work as eating his meal, watching television and then going out into the neighbourhood to chat with other people. They seemed to have little communication with each other except regarding necessities. The husband did not have any interaction with either of his children, and this was a source of distress and disappointment for his wife. They had a history of abuse before her second pregnancy and this abuse had extended to the child as well. These issues had not been satisfactorily resolved and Participant E reported feeling depressed and bitter about these and other issues. Participant H reported that she tried to initiate discussions with her partner regarding their interpersonal issues, but that he was not receptive and refused to discuss these matters. She reported that he had physically abused her in response to her questions about his infidelity during her pregnancy and that he had used her constant questioning as an excuse to hit her. He had made it clear to her that her probing had been the cause of the abuse and although her constant thoughts about these issues caused her to feel depressed she perceived him as being unsympathetic.

Leading on from the inability and unwillingness to communicate, underlying feelings of resentment towards the partner appeared to be a major factor in causing stress and in precipitating or exacerbating depression. Where emotions and issues of contention where not discussed, ill-feelings festered and became the focus of the depression.

Welburn (1980) suggests that mothers of babies must be alert for distress and danger at all times day and night creating an "on-call consciousness" (p14). She proposes that this state of constant alertness and concern is counter-productive and discourages a successful sex life. Combined with the boredom and exhaustion that characterises the chores of housekeeping and childcare, and the drudgery associated with these physical demands, the mother lacks stimulation and excitement (Welburn, 1980). This scenario suggests the inherently patriarchal design of society and in the role expectations of each parent. This patriarchal worldview is evident from the accounts of a number of participants in this sample. Quite apart from the inequality in the distribution of childcare and household chores, the lack of support experienced by some participants from their partners seems to stem directly from the view that women are responsible for specific chores which they are obliged to carry out. A proposed solution is to help women and men recreate flexible responses to gender and cultural expectations and patterning regarding these socially constructed parental and gender roles. This would go someway towards enriching the relationship and encourage men to be emotionally available and responsive to their partners and so alleviate the woman's feelings of isolation (Knudsen-Martin and Silverstein, 2009).

Psychodynamic explanations for maternal distress place the origins of such distress on the new mother's own childhood experiences and her own mother's mothering of her (Laban, 1996 ; Littlewood and McHugh, 1997). This mostly male concept effectively pathologises "women's illnesses" and effectively blames women for their depression. Motherhood and ideals of what good motherhood should be have essentially been defined by men (who do not have personal experience of motherhood). Not being able to live up to these cultural ideals and fantasies causes conflict and distress to the new mother who has internalised these ideals as the accepted and desired standard. This may result in postpartum depression.

PART 2

CONCLUSION AND RECOMMENDATIONS

This study was aimed at exploring the experiences of South African Indian women who were screened for postpartum depression in order to better understand these experiences and make recommendations for the prevention and treatment of the condition. To this end, a semi-structured interview schedule was compiled using the literature review and the biopsychosocial model as guidelines for the questions. The biopsychosocial model is based on the assumption that ill-health and disease stem from an interaction of physical or biological causes, psychological and social factors in any combination. Genetics and personality traits are recognised as being influential on the development and course of illness, and contextual situations are taken into account when studying the aetiology of illness. The model is a general, broad framework of human functioning that recognises the organic and contextual levels of influence on illness and disease. Using this theoretical model, the study sought to understand the experiences of South African Indian women's experiences of postpartum depression.

The results of the study indicated that biological, psychological and social factors were influential in the onset and course of the depression. The effects related to fatigue, sleep deprivation, inadequate rest and increased physical demands created a stressful environment that pressurised women to assume responsibilities that were sometimes overwhelming. Physical exhaustion was a common complaint with far-reaching repercussions. The effects were experienced in all spheres of the women's lives. The fatigue resulted in a compromised ability to perform household chores, difficulty with childcare, strain in the partner relationships and stress and frustration.

Negative life events, distressed personal circumstances and difficult partner relationships were major stressors that precipitated depression or exacerbated feelings of depression. These results were corroborated in other studies on postpartum depression in differing demographic populations (Cox & Holden, 1996, Howell & Bayes, 1981, Pope et al, 2000, Ravitz, 2003). Depression presented within varying personal contexts, but common themes emerged. Financial hardships, abusive relationships and low self-esteem are highlighted as common influences for depression in this study. Poor economic circumstances combined with lack of social support networks, abuse, social isolation and poor communication between partners added additional stress to mothers who were adjusting to the pressures of motherhood. Additional stressors included adjusting to changes in the partnership and negotiating financial and interpersonal issues with little social or professional support. Relationships experienced strain due to issues related to personal adjustments and social and psychological contextual factors. Some participants reported having excellent or satisfactory social support networks consisting of family, extended families and in-laws and friends, but still experienced depressive symptoms, unhappiness and anxiety, primarily in the partner relationship. Even where the partner relationship was described as being happy, supportive or loving, participants later revealed contradictions that revealed underlying resentments or anger at the partner. Partners were generally perceived as being unavailable or unsupportive, and this was a major common theme that underscored women's isolation and feelings of frustration and helplessness.

These findings support previous studies which suggest that factors such as dysfunctional or strained partner relationships, negative life events and the adjustments of parenthood are risk factors for postpartum depression (Pope et al., 1999). Absent social support structures highlighted the isolation of some participants. In support of Heh's (2003) study, women in

this study who reported having close significant relationships and supportive social networks reported less concerns and feelings of depression related to motherhood. The positive presence and contribution of at least one significant support base such as a mother or close relative provided participants with an outlet for complaints, soliciting advice and with some practical assistance. Participants who did not have such a support base were more socially isolated, withdrawn and unwilling to source help.

5.5. Implications of the study and Recommendations

Optimum health and well-being may be defined not merely as an absence of disease, but sound physical and mental health. Petersen (2010) defines mental health as a construct that encompasses multifaceted dimensions that include intellectual well-being which consists of "capacity to think, perceive and interpret adequately" (p3), psychological well-being which encompasses "belief in their own self-worth and abilities" (p3), emotional well-being which is affective state or mood and social well-being which is "their ability to interact effectively in social relationships with other people" (p3). The study was undertaken using the biopsychosocial framework which guides the exploration and explanation of ill-health using three levels that comprise the biological, psychological and social spheres of functioning. The results of this study imply that feelings of depression in the postpartum period in this group was influenced by particularly by interpersonal issues. The effects of these depressive feelings could be observed in compromised psychological, emotional and social well-being. These manifested as suicidal thoughts and self-harm, low self-esteem, depressed mood and social isolation.

Based on the findings in this study, the following five recommendations are made. These are:

(i). Provision of Interpersonal Therapy (IPT)

Given the finding that postpartum depression was often linked to poor interpersonal relationships, unstable partner relationships and inadequate support structures, one recommendation would be for psychotherapy in the form of Interpersonal therapy (IPT) to be provided. IPT recognises that biological and psychological factors may influence psychiatric problems, but focuses on current interpersonal problems and social context.

IPT is a manualised short-term flexible and integrative structured therapy with theoretical roots in attachment theory (Morris, 2002). Techniques are standardised and therapeutic goals are clearly laid out. Unsatisfactory and disruptive relationships can precipitate depression causing patients to withdraw socially and develop a sense of helplessness (Ravitz, 2003), perpetuating the cycle of isolation and passivity. The goals of IPT are to break this cycle of passivity, ease interpersonal distress, alleviate the depression and empower patients to build or make better use of social support structures (Ravitz, 2003). IPT is backed by empirical support as an effective intervention for depression and concentrates on aspects of loss, change and conflict that are resonant with most individuals (Grigoriadis & Ravitz, 2007).

IPT is generally administered by psychiatrists and psychologists but has been successfully delivered on a group basis by community health workers (CHW's) in a Ugandan trial (Verdeli et al., 2003). IPT has a high success rate and is recommended for treating postpartum depression (Morris, 2002 ; Ravitz, 2003). A focal consideration is that although pharmacologic treatment is effective in perinatal depression, neonates could be exposed to negative side effects transmitted through breast milk (Grigoriadis & Ravitz, 2007) and patients prefer options that will not compromise their infants' health. IPT in the postpartum

period is a useful and appropriate form of therapy to assist mothers to foster a positive and nurturing relationship with their children, particularly the neonatal infant who has security and attachment needs that need to be fulfilled. The therapist is in an influential position to help mothers to develop appropriate responses to their babies and to assist the mother with identifying and enlisting support structures to aid with childcare (Grigoriadis & Ravitz, 2007).

Results of the current study indicated that the participants in the study generally had a dysfunctional partner-relationship that either caused stress and depression or that could not adequately meet the needs of the participants, and that social support networks were inadequate. The participants needed short-term therapy that would be cost-effective and that would aid them in resolving the current interpersonal distress in order to strengthen social support and engage with the social environment in a more beneficial and productive manner. IPT has been proven to be effective in mild to moderate postpartum depression reducing symptoms of depression and enhancing social adjustments during a period of personal challenges and life changes (Grigoriadis & Ravitz, 2007). Group IPT and the deployment of CHW's to carry out the interventions would be cost effective measures to treat postpartum depression within context of scarce medical resources. The intervention should include the partner for a limited number of sessions of therapy if possible in order for it to be effective and benefit the relationship optimally.

(ii). Task-shifting in a scarce resource context: Using Community Health Workers (CHW's) to assist in the delivery of counselling for PPD

Community health workers (CHW's) are lay community members who are affiliated to the local health systems in rural and urban areas and who either volunteer their services or are

paid (HRSA, 2007). These workers provide a variety of services that sometimes differ according to regional and unique health and social needs of the communities they serve. CHW's serve communities worldwide and are known by a variety of names that include community health advisors, lay health advocates, outreach educators and peer health educators (HRSA, 2007). Some core functions of the CHW's include health promotion and education at household level, referrals of clients or patients to relevant departments, counselling, support, stress relief, assessment of health status of all family members and giving advice, weighing infants and recording the information and providing PMTCT support at household levels. They may be regarded as community resources that link people to healthcare, are a direct source of research and can be influential in policy evaluation (Perez and Martinez, 2006) acting as advocates for social and political issues that affect their communities.

Historically in the USA, CHW's were introduced to respond to issues related to poverty and later for health promotion (HRSA, 2007) although CHW's are recorded as being active during the early 17th century providing basic health care to Russian military personnel (Perez & Martinez, 2008) . Globally as well as in South Africa, CHW programmes have risen in popularity in the context of HIV and increased funding to address the issue as well as to facilitate the rollout of antiretroviral therapy (ART) and CHW programmes are a "significant" presence in the South African health structure (Schneider, Hlophe & van Rensburg, p180, 2008).   This presence is confined primarily within the context of HIV and ART.   Mannan et al. (2008) recommend that "counselling and hands-on support on breastfeeding techniques by trained workers within the first three days of birth should be part of community-based postpartum interventions" (p632) in their study for the Bangladesh Projahnmo Study Group. Their intervention using CHW's demonstrated that psychological

and hands-on support for breastfeeding mothers was beneficial and effective as well as necessary. Research on the efficacy of CHW's and unqualified community workers validates the presence of such workers in differing contexts and within LMIC's (Cooper et al., 2002; Patel, Goel & Desai, 2009a, Patel, Simon, Chowdary, Kaaya & Araya, 2009b). A pilot study of the effect of mother to infant intervention in an indigent community in South Africa by Cooper et al. (2002) utilised unqualified workers in home-based family interventions and found that the interventions were well received by the mothers who felt supported by the workers. The mothers also felt that the workers helped them to understand and manage their babies. This finding should be viewed within the context of a poor community in a LMIC who viewed the intervention in a positive manner as opposed to findings that home-based interventions in developed countries were perceived as an intrusion (Cooper et al. 2002). The results of the Khayelitsha trials indicated that the home-based interventions by lay workers was successful in benefiting maternal mood at six months and that these interventions encouraged mothers to interact with their infants with greater sensitivity at six and twelve moths postpartum (Cooper et al., 2009). Task shifting from specialist to non-specialist community health workers is deemed a "feasible and effective strategy for delivery of efficacious treatments" for specific mental and neurological disorders in low resource contexts where access to basic healthcare is difficult, sparse or nonexistent (Patel et al., 2009a, p37). Cultural and contextual adaptations to therapies developed in HIC's such as cognitive-behavioural therapy have successfully been implemented to be carried in the treatment of postnatal depression in Pakistan. The interventions were carried out by female community workers trained in basic health care interventions. The efficacy of nonmedical health workers in treatment of depression is further supported by trials in depression treatment in Chile where the highest recovery rates were recorded in any depression treatment research. The research is further supported by the success of home-based

interventions for postpartum depression in Trent in the UK. These two trials did not include a psychiatrist (Patel et al., 2009b).

Roman et al. (2007) found that a nurse-CHW team making home visits was more effective than standard community care in reaching pregnant women assessed for risk for depressive symptoms and for perceived stress as well as their psychosocial resources including social support and self-esteem. In support of the literature that reveals the positive effects of direct home interventions, Ciliska et al. (2001) in their evaluation of 20 studies on public health nursing support the delivery of mental health services via home visit interventions for prenatal and postnatal women with mental and social risk factors and who may not be able to access health care. Although the interventions were carried out by public health nurses, the results focussed on access to healthcare and home visits, which are the cornerstone of CHW interventions. CHW's can be a useful link between women who suffer from perinatal depression and primary health clinics and mental health centres. Beacham et al. (2008) suggest that "cultural backgrounds greatly influence the assessment and management of PPD" (p. 553) and that the home health nurse plays a central role in assessment, intervention and education regarding PPD. In this context, home health nurses are considered instrumental in influencing the quality of life for such women and their families. This role can easily be transferred to CHW's who are uniquely placed within their own communities and are able to understand the cultural barriers to treatment of PPD. Additionally, they can be trained to use relatively simple screening tools such as the EPDS and can refer at risk patients to the appropriate intervention agents and help their patients with ongoing support. A study on the role of CHW's in self-determination and self-sufficiency of low-income mothers concluded that CHW programmes are potentially the most effective method of health promotion and education for a disadvantaged community (Becker Crivelli-Kovach &

Gronseth, 2004). The CHW can be regarded as a social support network for women and CHW programmes have been found to be beneficial for women with low incomes and mothers with young children (Becker et al., 2004). These workers are in an advantageous position to listen to clients which develops client self-esteem and supports the client's dignity thereby encouraging a personal sense of control, help-seeking behaviours and behaviour modifications (Becker et al., 2004). In the context of participants' reluctance to actively seek help due to the stigma associated with accessing mental health care, home visits by CHW"s will serve a dual function. CHW's can provide an anonymous service of mental health education and referral of patients in the privacy of the home. This would also alleviate the problem of access to health care where women experience difficulties with transportation and financial burdens. Mothers who find the experience of primary healthcare taxing when having to care for their infants at the same time will also benefit from the convenience of home-visits. Women who are socially isolated and reluctant to actively seek help might also benefit from a caring CHW's advice.

Partners in Health (2006) cite barriers that preclude poor people from seeking medical care as transportation costs, social stigma, lack of information, discrimination by medical personnel and shortage of time. This should be extended to include people who need to access mental healthcare and these factors (except for discrimination by medical personnel) have emerged in the current study as being influential in whether women seek help for depression. CHW's can effectively target such patients and provide convenient home-based care and health information. CHW's could also be trained as telephone counsellors for the support of women at risk of postpartum depression as this has proved successful in a Canadian trial of the service for this at-risk group (Patel et al., 2009b).

(iii). Perinatal Psycho-education

Some participants were aware of the phenomenon of postpartum depression from reading magazines and had some knowledge of the condition. Some participants lacked basic information on postpartum depression and were not willing to read any information about it even when they were offered this material. Women who attended antenatal discussions at their primary healthcare clinics were well-informed about several issues related to their health and about the existence of postpartum "blues" and postpartum depression. This forum is therefore a suitable point at which perinatal health information can be disseminated. The implementation of psycho-educational material to women in antenatal and postnatal groups as well as discussions about postpartum depression in these forums would raise awareness of postpartum depression, extend the scope of education about postpartum depression, encourage open discussion of depression and destigmatise the depression. Women and their partners could be addressed on basic adjustment issues that occur during and post pregnancy and receive reading material or a subsidised information tool such as a DVD that would cover the relevant aspects of pregnancy, partner relationships, and adjustment issues as well as depression related to these issues. Encouraging couples to read or view the material together would facilitate better understanding and cooperation between partner and help foster closer partner relations. Statistics on access and utilisation of health care reveal that 95.1 of women in South Africa utilise antenatal care and of these women, 73.1% attended a median of 5.3 visits. 62.8% of women were recorded as attending their first antenatal visit before the sixth month of pregnancy (Penn-Kekana and Blaauw, 2002). The high attendance rates reveal that antenatal care settings are a suitable venue for education and for screening. Within a scarce resource context and taking into account a shortage of nurses within the primary health care system, psycho-education could be delivered by CHW's either as auxiliary workers or in combination with primary healthcare nurses who are based at the clinics.

Three of the women screened in the current study that had low scores, expressed a desire to talk about their experiences of motherhood and specific concerns that they had. One participant requested a copy of her completed EPDS questionnaire which she indicated she would use as a barometer to judge when her feelings were becoming overwhelming so that she could identify these and be aware of the danger of succumbing to depressive feelings. This level of educated interest in her mental health signified a positive trend that could apply to most women who are educated about the dangers of mental ill-health and supports the recommendation for education of women and their partners.

(iv). Routine screening for PPD

Routine screening for PPD using a short and speedy instrument such as the EPDS would identify women at risk of postpartum depression and would facilitate referral and treatment for such women. Administering the instrument requires little basic training and can be done by CHW's, nurses and volunteer health workers. Screening patients for postpartum depression at the six week visit to the clinic or doctor after giving birth should be mandatory as it can be a simple and quick process.

(v). Family Responsibility Leave, Maternity Benefits and Maternal Health policies

A final recommendation would be to amend existing policies on maternity benefits and family responsibility leave. Current labour legislation in South Africa entitles men to three days of "family responsibility leave" (Chavoos, 2010; Dancaster, 2008; Department of Labour, 2005; S.Williams, personal communication, May 19, 2010). This leave covers a

variety of conditions under which the leave may be taken including illness of a child and the death of close family members including the spouse, parent, grandparent, child, grandchild or sibling of the employee who must have been in employment with the employer four a period longer than four months and who must work for that employer for at least four days a week (Chavoos, 2010). Further it is not paternity leave as specified in many other countries and discriminates against men who are obliged to take their annual family responsibility leave due to illness in a child or death of one or more close family members as specified in the Basic Conditions of Employment Act 75 of 1997 (Chavoos, 2010). The family responsibility leave once utilised can not be extended and any further leave would then have to be allocated from other leave that is due.

Paternity leave is a progressive benefit that is allowed to men whose partners have given birth or who have adopted a child. It is generally taken immediately after the event and varies in duration among different countries. The purpose is to encourage bonding with the infant and to promote paternal contributions to the care and rearing of children. European countries such as Sweden, Denmark, Norway, Hungary and Slovenia lead the way with paternity and family leave entitlements that range from 90 days of paternity leave in Slovenia to 480 days of leave per child up to the age of eight years in Sweden or completion of the first year of school. This leave is reserved as sixty days per parent and the balance to be divided between the parents as they choose, and is backed by a high to moderate earnings replacement for most of the leave period (Anxo, Fagan & Smith; Letabier & Perraudin, 2007). The South African government has recognised the shortcomings inherent in the three day family responsibility leave granted to men and has called for an extension of this leave although they have referred to this leave as "paternity leave" which is not specified in the relevant legislation as referred to above. The call for this extension of leave was put forward in the

context of a presentation to the United Nations meeting of the Commission on the Status of Women in 2009 (The Presidency, 2009). The wider context of the presentation related to sharing equal responsibilities in the context of HIV and AIDS and included the proviso of care-giving. The crux of the proposed extension of leave relates to issues of health other than childbirth, childcare and child rearing, so this proposal would still be inadequate as it is not a separate proposal for paternity leave as this leave is understood in countries that recognise men's contributions to child care and rearing.

Paternity leave thus remains an issue of contention in South Africa as it is not adequately addressed or provided for. The benefits to the partner and the child would include bonding between the father and the infant and would assist the mother at a vulnerable period of adjustment. This would benefit the partner relationship as well and foster increased cooperation between partners regarding childcare and household chores. In a country such as South Africa, where concerns about productivity and loss of person power may be of concern, the option of a flexible paternity leave option of a period of 14 days could be implemented, to be utilised as required by the parent.

In order to enhance the well-being of women by promoting gender equality and encouraging paternal responsibility, the amendment of the current provisions for Unemployment Insurance (UIF) as relating to maternity benefits has been proposed as far back as 2003. The proposal by the Commission on Gender Equality to parliament suggested a de-linking of maternity benefits from the UIF structure and to raise maternity benefits which are well below the earnings rate of the woman in order to enable a woman to maintain herself and her children comfortably without drastically reducing her income (S.Williams, personal communication, May 19, 2010). Adequate financial resources similar to a woman's regular

income levels will help alleviate stress related to finance, will ensure a reasonably comfortable standard of living that a woman is accustomed to and ensure that a woman is not forced to return to formal employment before her legal entitlement of four consecutive months of maternity leave (Department of Labour, 2005; S.Williams, personal communication, May 19, 2010) unless she chooses to do so. Some of the stresses relating to inadequate finances, partner contributions to childcare responsibilities and pressures of coping with household chores and adjusting to parenthood will be reduced or alleviated, aiding the mother of a newborn infant with rest and recuperation as well as giving parents the flexibility of transferring traditional childcare roles to the father.

Fathers can be present to help with transport and care of the infant during potentially stressful occasions such as the first medical check-up of the infant and possibly a limited number of clinic visits for immunisation. Mothers with a higher earning rate than the male partner would be able to work without losing valuable income and the partner with a lower earning capacity could then utilise some of his paternity or family responsibility leave when a child is ill or requires other routine medical treatment.

 Successful detection and treatment of perinatal depression depends on early detection of patients, access to cost effective mental health care, properly trained and supervised care workers and education as well as treatment of the depression. The development and implementation of a maternal health policy that includes maternal mental health would be more beneficial to pregnant women and women with children than the present policies that target maternal and infant mortality specifically. South Africa has an unacceptably high maternal and infant mortality rate when compared to other middle-income countries that it is grouped with (Penn-Kekana and Blaauw, 2002) and needs to be urgently addressed, but

maternal mental health policies risk being compromised due to the focus on the effects on HIV AIDS and maternal mortality A report on maternal health services in South Africa indicated that out of the 8.5% of GDP allocated to healthcare, nearly 60% was spent in the private sector that caters for 23% of the population with private health insurance (Wolvardt and Palmer, 1997 in Penn-Kekana and Blaauw, 2002) stretching state health resources to accommodate health requirements of the majority of the population within a disproportionately smaller budget.

Summary

At a policy level several issues need to be addressed:

- Gender discrimination should be addressed to redress the imbalances created by patriarchal societal structures and socialisation. Advancement for the equality of sexes will encourage more equitable distribution of childcare responsibilities and divert some of the burdens associated with childcare that are expected of women due to the fact that women are the bearers of children and assume the bulk of childcare responsibilities.

- The implementation of a maternal health policy that includes maternal mental health care is essential and would place maternal mental health within the context of maternal healthcare rather than mental healthcare and would therefore destigmatise maternal depression and associated maternal mental ill-health.

- Promotion of community-based mental health interventions and education using trained and supervised CHWs

- Heightened awareness of issues promotes opportunities for policy changes and advocacy groups can be particularly effective in this regard (Petersen and Govender,

2010). The impetus for change will be enhanced by appropriate research into the issues concerned to support the policy recommendations.

5.6. Limitations of the study

The sample was skewed towards women who were willing to discuss their feelings and who were generally eager to discuss personal issues with someone other than a family member. This was a qualitative study with a limited sample of participants (eight). The study is therefore limited and cannot be used to generalise to any population of women at risk of PPD. The sample comprised Indian women from a low to medium-income urban community who utilised the public health system and who did not have medical aid. This effectively excludes women from other race groups and income levels, women in private health care, as well as women from other areas including rural areas. The study was carried out within a limited time frame and it was not always possible to screen women at later intervals in order to compare their EPDS scores and note whether their depression was reduced or elevated. None of the women consented to being referred for a formal diagnosis and it was therefore not possible to confirm the diagnoses or chart progress that might have occurred with therapeutic intervention. The study is also limited due to the use of a single screening instrument at a single screening session. There was no reliable manner in which to determine if any other depression was present or if there was a history of depression in participants that had extended into the postpartum period.

5.7. Recommendations for future research

The discussion, recommendations for intervention and the limitations of the study identify the ambit of future research. These include:

- The need for further research on the prevalence of PPD across representative samples of South African women. The samples should include women of all races, socio-economic groupings and educational levels across the healthcare spectrum. Studies should focus on women in private healthcare as well as in the public health system. Once prevalence has been established, research can then focus on possible interventions, the costs of such interventions and the feasibility of routine screening and the most cost-effective and reliable methods of routine screening for the purposes of referral.

- Research exploring resource allocation and funding for maternal health.

- The availability of mental health providers for the treatment of PPD and the capacity of the state health providers to service women who are referred for treatment of PPD. Such research should focus on the South African state health system within the context of scarce resources and how PPD can be adequately addressed within these parameters.

- Exploring cost effective options for the delivery of mental health care for PPD - including the use of CHW's for mental health information and delivery of care.

- Exploring the feasibility of using CHW's in mobile-e health as recommended by the World Health Organisation with the aim of improving service quality and delivery and building health worker capacity at primary health level. These initiatives include the accessing and managing of large quantities of health data for use in planning, resource allocation, and observation and handling of disease in India. Demographic, perinatal and immunisation data was collected in homes. The system was adapted for use by CHW's in South Africa for accessing home health and antiretroviral treatment records and the success of the programme is supported by the increase in CHW's and the number of patients reached (Iluyemi, n.d.). The concept can be adapted for

research and CHW's can be doubly effective as agents of health service delivery and as research assistants who can collect information to be used in planning interventions. This option is cost effective while reaching a large sample.

- Exploring culturally acceptable mental health interventions for the communities that are to be served.

REFERENCES

Anxo, D., Fagan, C., Smith, M.,Letablier, M.T. & Perraudin, C. (2007).*Parental leave in European countries: Establishment survey on working time 2004-2005.* Retrieved May 15 , 2010, from http://www.eurofound.europa.eu/pubdocs/2006/87/en/1.

Baker, L. & Oswalt, K. (2008). Screening for postpartum depression in a rural community. *Community Mental Health Journal, 44*, 171-180.

Beacham. T.D., May, M., Williams, P.R., Schenk, L., Askew, R., Walker, J. & Norwood, A. (2008). Assessing postpartum depression: The home health nurse perspective. *Home Healthcare Nurse, 26*, 9, 552-560. Retrieved May 21, 2010 from http://www.nursingcentre.com/prodev/ce_article.asp?tid=821490.

Beck, C.T., (2001). Predictors of postpartum depression: An update. *Nursing Research, 50 (5) 275.* Retrieved March 04, 2009 from http://www.nursingresearchonline.com/pt/re/nnr/abstract.00006199-20009000-0000

Becker, J., Crivelli-Kovach, A. & Gronseth, D.L. (2004). Individual empowerment: How community health workers operationalize self-determination, self-sufficiency, and decision-making abilities of low-income mothers. *Journal of Community Psychology, 32,* 3, 327-342.

Bhana, A. (1981). *A study of certain personality, demographic, and related variables among Indian female attempted suicides*. Unpublished masters thesis, University of Durban-Westville, KwaZulu-Natal.

Borrell-Carrio, F., Suchman, A.L. & Epstein, R.M. (2004). The biopsychosocial model 25 years later: Principles, practice and scientific inquiry. *Annals of Family Medicine, 2, 6* , 576-582.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Breese McCoy, S.J., Beal, J.M., Miller Shipman, S.B., Payton, M.E. & Watson, G.H. (2006). Risk factors for postpartum depression: A retrospective investigation at 4-weeks postnatal and a review of the literature. *JAOA, 106, (4)*, 193-197.

Buvinic, M, Medici, A., Fernandez, E & Torres, A.C. (n.d.). *Gender differentials in health.* Retrieved May 20, 2010, from http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=dcp2&part=A1059

Chaudron, L.H., Szilagyi, P.G., Kitzman, H.J., Wadkins, H.I.M. & Conwell, Y. (2004). Detection of postpartum symptoms by screening at well-child visits. *Pediatrics, 113, 3*, 551. Retrieved June 12, 2008 from www.pediatrics .org.

Chaudron,L.H., Kitzman, H.J., Szilagyi, P.G., Sidora-Arcelo, K. & Anson, E. (2006). Changes in maternal depressive symptoms across the postpartum year at well childcare visits. *Ambul Pediatrics, 6 (4)*, 221-224.

Chaudron, L.H., Szilagyi, P.G., Campbell, A.T., Mounts, K.O. & McInerny, T.K. (2007). Legal and ethical considerations: Risks and benefits of postpartum screening at well-child visits. *Pediatrics, 119,* 123-128. Retrieved at http://www.pediatrics.org/cgi/content/full/119/i/123.

Chavoos, M. (2010). *Paternity leave: what are your rights?* Retrieved May 17, 2010, from http://www.deneysreitz.co.za/index.pp/news/paternity_leave_what_are_your_rights/

Ciliska, D., Mastrili, P., Ploeg, J., Hayward, S., Brunton, G. & Underwood, J. (2001). The effectiveness of home visiting as a delivery strategy for public health nursing interventions to clients in the prenatal and postnatal period: a systematic review. *Primary Health Care Research and Development, 2*, 41-45.

Coon, D. & Mitterer, J.O. (2007). *Introduction to psychology: Gateways to mind and behaviour*. Belmont: Thomson Wadsworth.

Cooper, P.J., Landman, M., Tomlinson,M., Molteno, C., Swartz, L. & Murray, L. (2002). Impact of a mother-infant intervention in an indigent peri-urban South African context. Pilot study. *British Journal of Psychiatry, 186*, 76-81.

Cooper, P.J., Tomlinson, M., Swartz, L., Woolgar, M., Murray, L. & Molteno, C. (1999). Postpartum depression and the mother-infant relationship in a South African peri-urban settlement. *British Journal of Psychiatry, 175,* 554-558.

Cooper, P.J., Tomlinson, M., Swartz, L., Landman, M., Molteno, C., Stein, A., McPherson, K. & Murray, L. (2009). Improving quality of mother-infant relationship and infant attachment in socioeconomically depreived community in South Africa: randomised controlled trial. *British Medical Journal, 338*, b974, 1-10. Retrieved June 21, 2020 from http://www.bmj.com/cgi/content/fuul/338/apr14_2/b974

Cox, J. & Holden, J. (Eds.). (1996). *Perinatal psychiatry.Use and misuse of the Edinburgh Postnatal Depression Scale*. London: Gaskell.

Cox, J.L., Holden, J.M. & Sagovsky,R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry, 150,* 782-786.

Dalton, K. (1989). *Depression after childbirth: How to recognize and treat postnatal illness.* London: Oxford Press.

Dancaster, L. (2008). Legislative options for the combination of work and care in South Africa. Paper presented at the 5th African Regional Conference of the IIRA. Retrieved May 17, 2010 from http://www.pscbc.org.za/documents/Other /Conference%20info/5th%20IIRA%20African%20Regional%20Congress/Papers/Presentatio n%20Lisa%20Dancaster.ppt

Dennis, C.L., Fung, K., Grigiriadis, S., Robinson, G.E., Romans, S. & Ross, L. (2007). Traditional postpartum practices and rituals: a qualitative systematic review. Women's Health, 3, 4, 487-505. Retrieved May 19, 2009 from http://www.futuremedicine.com/doi/abs/10.2217/17455057.3.4.487

Department of Labour (2005). *Maternity and paternity leave.* Cape Gateway. Retrieved May 17, 2010, from http://www.capegateway.gov.za/eng/directories/services.

Gilbert, P. (2002).Understamding the biopsychosocial approach: Conceptualisation. *Clinical Psychology , 14* pp 13-17. Retrieved November 23, 2009 from http://www. criptsynet.freeuk.com/Gilbert.htm

Govender, P. (2010, Febuary 28). When 'traditional values' are a stick to beat women. Sunday Times, p11.

Grigoriadis, S. & Ravitz, P. (2007). An approach to interpersonal psychotherapy for postpartum depression: Focussing on interpersonal changes. *Can Fam Physician, 53* (9), 149-1475. Retrieved April 04, 2010 from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2234626/

Gunthert, K.C., Cohen, L.H., Butler, A.C. & Beck, J.S. (2007). Depression and next-day spillover of negative mood and depressive cognitions following interpersonal stress.

Cognitive Therapy and Research, 31, 4 , 521-532. Retrieved June 07, 2010 from http://www.springerlink.com/content/m6322j2106l60n18/

Hanlon, C., Medhin, G., Alem, A., Aroya, M., Abdulahi, A., Hughes, M., Tesfaye, M., Wondimagegn, D., Patel, V. & Prince, M. (2008). Detecting perinatal common mental disorders in Ethiopia: Validation of the Self-reporting questionnaire and the Edinburgh Postnatal Depression Scale. *Journal of Affective Disorders, 108,* 251-262.

Harkness, S. (1987). The cultural mediation of postpartum depression. *Medical Anthropology Quarterly, 1, (2)*, 194-209. Retrieved April 20, 2009 from JSTOR.

Heh, S-S. (2003). Relationship between social support and postnatal depression. *Kaohsing Journal of Medical Science, 19, 10,* 491-496.

Henning, E. (2007). *Finding your way in qualitative research.* Pretoria: Van Schaik.

High Commission of India in South Africa. (n.d.) *The Indian origin community in South Africa*. Retrieved May 20, 2009 from http://indiansouthafrica.com/india-in-south-africa/indian-community.html

Howell, E. & Bayes, M. (1981). *Women and mental health.* New York: Basic Books Inc.

Howland, R.H. & Thase, M.E. (2005). Comorbid depression and anxiety: When and how to treat. Medical Library, 329, 11, 891-1047. Retrieved April 20, 2010 from http://www.ccspublishing.com/j_psych/depression_and_anxiety.htm

HRSA (2007). *Community health workers national workforce study.* (Report). U.S. Department of Health and Human Services: Health Resources and Services Administrations. Retrieved May 20, 2010 from bphr.hrsa.gov/healthworkforce/chw

Husain, N., Bevc, I., Husain, M., Chaudhry, I.B., Atif, N. & Rahman, A. (2006). Prevalence and social correlates of postnatal depression in a low income country. *Archives of Women's Mental Health, 9,* 197-202.

Iluyemi, A. (n.d.). *Community-based health workers in developing countries and the role of m-health.* Retrieved May 17, 2010, from http://www.idrc.ca/en/ev-137420-201-1-DO_TOPIC.html

Kim-Godwin, Y.S. (2003). Postpartum beliefs and practices among non-western cultures. The American Journal of Maternal/Child Nursing, 28, 2, 74-78. Retrieved May 20, 2009 from http://www.nursingcentre.com/prodev/ce-article.asp?tid=408218.

Kendall-Tackett, K. (1993). Preventing postpartum depression: Support, information and empowerment for new mothers. The Stone Centre Link, 5-6. Retrieved September 29, 2009 from http://www.granitescientific.com/preventingpostpartumdepression.pdf.

Knudsen-Martin, C. & Silverstein, R. (2009). Suffering in silence: A qualitative meta-data-analysis of postpartum depression. *Journal of Marital and Family Therapy, 35*, 2, 145-159.

Kok, A. (1990). Applications of clinical health psychology to obstetrics and gynaecology. In L. Schlebush (Ed), *Clinical health psychology: A behavioural medicine perspective* (pp171-183) Pretoria: Southern Book Publishers.

Laban, P.R. (1992). *Psychiatric morbidity in postpartum Zulu women at King Edward VIII Hospital.* Unpublished masters thesis, University of KwaZulu-Natal.

Lakhan, S.E. (2006). The biopsychosocial model of health and illness. Retrieved November 23, 2009 from http://cnx.org/content/m13589/latest/

Lara, M.A., Navarro, C., Acevedo, M., Berenzon, S., Mondragon, L & Rubi, N.A. (2004). A psycho-educational intervention for depressed women: A qualitative analysis of the process. *Psychology and Psychotherapy, 77*, 429-447.

Littlewood, J. & McHugh, N. (1997). *Maternal distress and postnatal depression: the myth of Maddona*. Basingstoke: Macmillan

Mannan, I., Rahman, S.M., Sania, A., Seraji, H.R., Arifeen, S.E., Winch, P.J., Darmstadt, G.L. & Baqui, A. (2008). Can early postpartum home visits by trained community health workers improve breastfeeding in newborns? *Journal of Perinatology, 28*, 632-640.

Matthey, S. (2004). Calculating clinically significant change in postnatal depression studies using the Edinburgh Postnatal Depression Scale. *Journal of Affective Disorders, 78, (3)*, 269-272. Retrieved June 25, 2009 from http://wwwsciencedirect.com/scienc?_ob=ArticleURL&_udi=B6T2X-479KH2H-1

Miller, R.L. & Brewer, J.D. (Eds.). (2003). *The A-Z of social research.* London: Sage

Morris, J. (2002). Interpersonal psychotherapy: A trainee's ABC. *The Psychiatrist, 26,* 26-28. Retrieved. April 09, 2010 from http://pb.rcpsych.org/cgi/content/full/26/1/26.

Morse, J.M., Barrett, M, Mayan, M., Olson, K. & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. International Journal of Qualitative Methods, 1, (2). Retrieved December 10, 2009 from http://dosc.google.com/viewer?a=vq=cache:02fQbld_f

Murray, L. & Cooper, P.J. (1997). Effects of postnatal depression on infant development. *Archives of diseases in childhood, 77,* (2) 99. Retrieved June 07, 2010, from http://adc.bmj.com/content/77/2/99

Naidoo, L.R. (1977). *An investigation of the interrelationships between marital adjustment, personal adjustment, and role discrepancy among urban Indians*. Unpublished masters thesis, University of Durban-Westville, KwaZulu-Natal.

Nakku, J.E.M., Nakasi, G., & Mirembe, F. (2006). Postpartum major depression at six weeks in primary healthcare: Prevalence and associated factors. *African Health Sciences, 6, (4)*, 207-214.

Nhiwatiwa, S., Patel, V. & Acuda, W. (1998). Predicting postnatal mental disorder with a screening questionnaire: a prospective cohort study from Zimbabwe. *Journal of Epidemiol Community Health, 52,* 262-266.

Partners in Health (2006). *Community health workers*. Retrieved May 17, 2010, from http://www.pih.org/issues/delivery.html.

Patel, V., Goel, D.G. & Desai, R. (2009a). Scaling up services for mental and neurological disorders in low-resource settings. *International Health, 1,* (1), 37-44. Retrieved May 22 , 2010 from http://www.internationalhealthjournal.com/article/S1876-3413(09)00003

Patel, V., Simon, G., Chowdhary, N., Kaaya, S. & Araya, R. (2009b). Packages of care for depression in low-and-middle income countries. *PLOS Medicine, 6* (10). Retrieved May 22, 2010 from http://www.ncbi.nlm.nih.gov/articles/PMC2747016/

Penn-Kekana, L. & Blaauw, D. (2002). *A rapid appraisal of maternal health services in South Africa: A systems health approach.* (Final Report). Centre for Health Policy. Retrieved May 24, 2010, from http://web.wits.ac.za.

Perez, L.M. & Martinez, J. (2008).Community health workers: Social justice and policy advocates for community health and well-being. *American Journal of Public Health, 98* (1), 11-14.

Petersen, I. (2010). At the heart of development: an introduction to mental health promotion and the prevention of mental disorders in scarce-resource contexts. In I. Petersen, A. Bhana,

A.J. Flisher, L. Swartz & L. Richter (Eds), *Promoting mental health in scarce-resource contexts: Emerging evidence and practice* (pp3-20). CapeTown:HSRC Press

Petersen, I. & Govender, K. (2010). Theoretical considerations: from understanding to intervening. In I. Petersen, A. Bhana, A.J. Flisher, L. Swartz & L. Richter (Eds), *Promoting mental health in scarce-resource contexts: Emerging evidence and practice* (pp 21-48). Cape Town: HSRC Press.

Petersen, I., Flisher, A.J. & Bhana, A. (2010). Afterword: cross-cutting issues central to mental health promotion in scarce-resource contexts. In I. Petersen, A. Bhana, A.J. Flisher, L. Swartz & L. Richter (Eds), *Promoting mental health in scarce-resource contexts: Emerging evidence and practice* (pp 208-212). Cape Town: HSRC Press.

Pollock, J.I., Manaseki-Holland, S. & Patel,V. (2006). Detection of depression in women of child-bearing age in non-western cultures. A comparison of the Edinburgh Postnatal Depression Scale and the Self-Reporting Questionnaire-20 in Mongolia. *Journal of Affective Disorders*, 92, 267-271.

Pope, S., Henderson, J., Watts, J., McDonald, S & Evans, S. (1999). *Postnatal depression: Not just the baby blues.* An information paper. National Health and Medical Research

Pope, S., Watts, J., Evans, S., McDonald, S. & Henderson, J. (2000). *Postnatal Depression. A systematic review of published scientific literature to 1999.* An information paper. National Health and Medical Research Council of Australia, 1-127. http://www.nhmrc.health.gov.au.

Ravitz, P. (2003). The interpersonal fulcrum: Interpersonal therapy for treatment of depression. *CPA Bulletin, 36,* (1), pp15-19.

Reber, A.S. & Reber, E. (Eds). (2001). The Penguin dictionary of psychology (3rd ed). Rosebank: Penguin.

Richter, L., Dawes, A & de Kadt J. (2010). Early childhood. In I. Petersen, A. Bhana, A.J. Flisher, L. Swartz & L. Richter (Eds), *Promoting mental health in scarce-resource contexts: Emerging evidence and practice* (pp 99-123). Cape Town: HSRC Press.

Rimer, B. & Glanz, K. (2005). *Theory at a Glance: A guide for Health Promotion Practice.* 2nd edition. National Cancer Association. U.S. Department of Health and Human Sciences. National Institutes of Health.

Robson, C., (2002). *Real world research* (2nd ed). Oxford: Blackwell Publishing.

Rochat, T.J., Richter, L.M., Doll, H.A. & Buthelezi, N.P. (2006). Depression among pregnant rural South African women undergoing HIV testing. *JAMA, 295, (12)*, 22-29. Retrieved August 2, 2007 from www.jama.com at Human Sciences.

Roman, L.A., Lindsay, J.K., Moore, J.S., Duthie, P.A., Peck, C., Barton, L.R., Gebben, M.R. & Baer, L.J. (2007). Addressing mental health and stress in medicaid-insured pregnant women using a nurse-community health worker home visiting team. *Public Health Nursing, 24,* 3, 239-248.

Roux, G., Anderson, C. & Roan, C. (2002). Postpartum depression, marital dysfunction and infant outcome: A longitudinal study. *Journal of Perinatal Education, 11, (4)*, 24-36.

Santos, I.S., Matijasevich, A., Tavares, B.F., Lima, A.C.C., Riegel, R.E. 7 Lopes, B.C. (2007). Comparing validity of Edinburgh scale and SRQ20 in screening for postpartum depression. *Clinical Practice and Epidemiology in Mental Health, 3*, 18.

Schlebush, L. (1990). (Ed) *Clinical health psychology: A behavioural medicine perspective.* Pretoria: Southern Book Publishers.

Schmitt, C.A. (2005). The invisible casualties: The impact of living with a depressed partner. *New Voices in Psychology, 1*, 96-97.

Schneider, H., Hlophe, H., van Rensburg, D. (2008). Community health workers and the response to HIV/AIDS in South Africa: tensions and prospects. *Health Policy and Planning, 23* (3), 179-187.

Swartz, L. & Herman (2010). Adulthood. In I. Petersen, A. Bhana, A.J. Flisher, L. Swartz & L. Richter (Eds), *Promoting mental health in scarce-resource contexts: Emerging evidence and practice* (pp 167-179). Cape Town: HSRC Press.

Stewart, R.C., Kauye, F., Umar, E., Maclean, V., Bunn, J., Fitzgerald, M., Tomenson, B., Rahman, A. & Creed, F. (2008). Validation of a Chichewa version of the Self-Reporting Questionnaire (SRQ) as a brief screening measure for maternal depressive disorder in Malawi, Africa. *Journal of Affective Disorders,* doi:10.1016/j.jad.2008.04.001.

Sue, D., Sue, D.S., Sue, S. (2003). *Understanding abnormal behaviour*. Boston: Houghton Mifflin Company.

The Presidency (2009). Calls for an extension of men's three-day paternity leave to a couple of weeks paid leave. Pretoria. South African Government Information. Retrieved May 17, 2010, from http://www.info.gov.za/speeches/2009/09021612451002.htm

Varga, C. & Brookes, H. (2008). Factors influencing teen mothers' enrolment and participation in prevention of mother-to-child HIV transmission services in Limpopo Province, South Africa. *Qualitative Health Research, 18, 786*. Retrieved from http://qhr.sagepub.com/cgi/content/abstract/18/6/786.

Verdeli, H, Clougherty, K., Bolton, P., Speelman, L, Lincoln, L., Bass, J., Neugerbauer, R & Weissman, M. (2003). Adapting group interpersonal psychotherapy for a developing country: experience in rural Uganda. *World Psychiatry, 2* (2), 114-120. Retrieved May 21 from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1525093/

Welburn, V. (1980). *Postnatal depression*. London: Fontana Paperbacks:

Weobong, B., Akpalu, B., Doku, V., Owusu-Agyei, S., Hurt, L., Kirkwood, B. & Prince, M. (2008). The comparative validity of screening scales for postnatal common mental disorder in Kintampo, Ghana. *Journal of Affective Disorders*, doi:10.1016/j.jad.2008.05.009

WHO-UNFPA (2008). *Maternal mental health and child health and development in low and middle-income countries*. (Report) Retrieved March 05, 2009 from http://www.who.int/mental –health/prevention/suicidemmh-jan08-meeting-report.pdf.

Yin, R.K. (2003). *Case study research. Design and methods* (3rd ed). California : Sage

INFORMED CONSENT FORM

South African Indian women's experiences of postpartum depression.

The Research Study

We request your participation in a research study aimed at examining the personal experiences of postpartum / postnatal depression in South African Indian women. The study will be conducted by a Master's student at the University of KwaZulu-Natal (UKZN).

What information are we looking for?

This research will provide information on the manner in which postpartum depression is experienced by South African Indian women, as well as their support structures and their cultural or religious practices concerning giving birth. The study also aims to understand women's access to healthcare during postpartum depression and whether they are able to discuss their feelings with family members and with healthcare professionals.

Why is this research necessary or important?

There is almost no information available on how South African Indian women experience and deal with postpartum depression. We need to know how they cope with this illness and whether they know what treatment options are available to them.

Who will participate in this study?

South African Indian women who are attending primary healthcare clinics, and who are identified as suffering from postpartum depression will be interviewed.

What will I be expected to do if I participate in this study?

You will be asked to participate in a tape recorded interview by the researcher and asked questions regarding

- Your feelings of depression since the birth of your child

- What religious or cultural practices you have followed in relation to giving birth

- Whether you have any support from your family or community

- Whether you are able to discuss your feelings of depression with your doctor, nurse, friends and family members

- Whether you are aware of the treatment options available to you.

Are there any disadvantages to me if I participate in this study?

NO. There will not be any disadvantages to you. If you require treatment for your postpartum depression or you want to discuss your feelings with a healthcare professional, you will be referred to the doctor or mental healthcare professional to which your clinic is affiliated.

Who will see the information that we have collected?

All information is confidential. The data will only be seen by researchers and investigators. The taped interviews and transcripts will be destroyed after the data has been analysed.

What if I change my mind and no longer want to participate?

You are free to withdraw from the research at any time.

Who can I contact for more information?

If you require any information on the study and are unsure about whether you want to participate or if you decide at a later stage to participate in this study, you may contact:

Tasneem Kathree: 031 2625528 / 082 786 930

Email: 861861183@ukzn.ac.za

If you would like to obtain more information on your rights as a participant in this study please contact:

Phumele Ximba, Research Office, Universty of KwaZulu-Natal, Tel: 031 2603587

CONSENT TO PARTICIPATE

I _____, agree to participate in this study on postpartum depression.

- The aims and the requirements of the study have been explained to me, and I have understood what is required.
- The advantages and disadvantages of the study have been explained to me.
- I am aware that my interviews will be tape recorded.
- I am aware that I will be given information on treatment options available, and that I will have the choice to use or refuse the treatment services offered.
- I am aware that I can refuse to answer questions and that I can leave the study at any time without prejudice.
- I am aware that I can ask for psychological help, and that I will be referred to the appropriate mental health facilities.
- I have read and understood this document and consent to participate in this study.

Name :_____

Date :_____

Signature:_____

Witness 1:

Name :_____

Date :_____

Signature:_____

APPENDIX 2

DEMOGRAPHIC DETAILS

Name   :_____

Age   :_____

Area of residence :_____

Location of clinic :_____

Religion   :_____

Language   :_____

Date of delivery   :_____

INTERVIEW SCHEDULE

Background Information

1.Who lives with you in your home?

   Probe for number and description of people living at home.

2.Do you work?

   Probe type of job and what hours?

3.Do you have a husband or partner?

4.Does your husband/partner work?

   Probe for type of job and hours

Individual level influences and coping

5.Have you been diagnosed with postpartum depression (PPD)? If yes when?

  Is this your first baby? If not, have you been diagnosed with postpartum depression

  previously?

6.Have you ever been diagnosed with depression not related to the birth of your child?

7.When did you first experience feelings of anxiety and/or depression?

8.Describe your feelings and moods generally after the birth of your baby?

   Probe for how often she feels this way? How long do the feelings last? Get a detailed

   description of the symptoms and behaviour.

10.What do you think has caused these feelings and moods?

11.When you feel this way, what do you do?

    Probe for how she helps herself to cope with these feelings.

12.Do you ever feel that you want to harm yourself? The Baby?

13. How does the postpartum depression make you feel about your abilities / duties as a mother? As a wife?

14. What do you expect of yourself as a new mother?

15. Do you feel that these expectations are too much? Are not possible to fulfil? Unfair?

Interpersonal level

16. How does your husband/partner react to these moods/ feelings?

Probe for whether he is sympathetic and whether he helps with the baby and with chores.

17. Do you receive any sort of help or support from members of your family or friends and neighbours.?

Probe for the form of help, frequency and whether it is offered or whether she has to ask for help.

18. What does your husband/partner expect from you as a mother?

Probe for whether she thinks it is fair or that he/her family has a right to feel this way?

19. Do you feel that these expectations are too much? Are not possible to fulfil? Unfair?

20. Do you feel free to talk about your feelings and moods with family If not, Why?

Community Level

21. Where do you access healthcare?

Probe for the reason for accessing healthcare where she does, and her experience there regarding whether the health staff ask her whether she is coping or about feeling depressed.

22. Do clinic staff or doctors express any concern for your feelings of depression?

Probe for whether she has received any information on postpartum depression eg. pamphlets; talks at clinic?

23. Have you spoken to a doctor or nurse about your feelings?

169

Probe for what help she has received from the hospital / doctor / clinic?

24.Do you feel free to talk about your feelings and moods with medical personnel? If not, Why?

25. Do you take any medication for the postpartum depression? Who prescribed / recommended? Does it help?

26. Do you have any information about postpartum depression? Do you know how or where to access help?

27. Do you want somebody to help?

Probe for who they think could be helpful in this regard.

28. What does your community expect from you as a new mother?

29.Do you feel that these expectations are too much? Are not possible to fulfil? Unfair?

Cultural and Societal

30.What, if any traditional practices did you follow regarding the birth and period after the birth? Is this religious? Or cultural? who advised you about what to do?

31.Did you enjoy these practices? Yes / no ? Why? Would you carry out these rituals again if you have another child? Would you advise your own children to perform these rituals? Why / not?

32. Do you feel that any of this has helped you? or that it has complicated or made things worse?.

33.What is your view on traditional postpartum cultural practices? Would you recommend these to friends/ family? Reason?

34.Do you think that these practices help to protect you from feeling depressed or ill?

35.Are mothers supposed to have particular feelings and behaviour because they are mothers? Why? Who do you think decides this?

Edinburgh Postnatal Depression scale (EPDS)

Name:-- Address:--

Your Date of Birth:---------------------------- --

Baby's Date of Birth-------------------------- Phone: --

_____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS,** not just how you feel today.

Here is an example, already completed.

I have felt happy:

       Yes, all the time

  ×Yes, most of the time   This would mean: "I have felt happy most of the time" during the past week.

       No, not very often   Please complete the other questions in the same way.

       No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - As much as I always could
   - Not quite so much now
   - Definitely not so much now
   - Not at all

2. I have looked forward with enjoyment to things
   - As much as I ever did
   - Rather less than I used to
   - Definitely less than I used to
   - Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - Yes, most of the time
   - Yes, some of the time
   - Not very often
   - No, never

4. I have been anxious or worried for no good reason
   - No, not at all
   - Hardly ever
   - Yes, sometimes
   - Yes, very often

*5. I have felt scared or panicky for no very good reason
   - Yes, quite a lot
   - Yes, sometimes
   - No, not much
   - No, not at all

*6. Things have been getting on top of me
   - Yes, most of the time I haven't been able to cope at all
   - Yes, sometimes I haven't been coping as well as usual
   - No, most of the time I have coped quite well
   - No, I have been coping as well as ever

*7. I have been so unhappy that I have had difficulty sleeping
   - Yes, most of the time
   - Yes, sometimes
   - Not very often
   - No, not at all

*8. I have felt sad or miserable
   - Yes, most of the time
   - Yes, quite often
   - Not very often
   - No, not at all

*9. I have been so unhappy that I have been crying
   - Yes, most of the time
   - Yes, quite often
   - Only occasionally
   - No, never

*10. The thought of harming myself has occurred to me
   - Yes, quite often
   - Sometimes
   - Hardly ever
   - Never

Administered/Reviewed by_____ Date_____

Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale.   *British Journal of Psychiatry* 150:782-786

APPENDIX 5

UNIVERSITY OF
KWAZULU-NATAL

RESEARCH OFFICE (GOVAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 – 2603587
EMAIL : ximbap@ukzn.ac.za

30 SEPTEMBER 2009

MRS. T KATHREE (861861183)
PSYCHOLOGY

Dear Mrs. Kathree

ETHICAL CLEARANCE APPROVAL NUMBER: HSS/0669/09M

I wish to inform you that your application for ethical clearance has been granted full approval for the following project:

"**South African Indian Women's experiences of postpartum depression**"

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

....
PROFESSOR STEVEN COLLINGS (CHAIR)
HUMANITIES & SOCIAL SCIENCES ETHICS COMMITTEE

cc. Supervisor (Prof. I Petersen)
cc. Mrs. S van der Westhuizen

APPENDIX 6

ETHEKWINI MUNICIPALITY
Health, Safety and Social Services
Health Unit

9 Old Fort Place
Durban 4001

P O Box 2443
Durban 4000

Tel: (031) 3113679
Fax: (031) 3113710

Website: http://www.durban.org.za

Our Ref

Your Ref:

Enquiries: Dr Cheryl Weaich
                   Phone 031 3113500

14 October 2009
Tasneem Kathree

STUDENT NUMBER:

CONTACT NO. 0312625528 / 0827869330

EMAIL: kathree@telkomsa.net **or 861861183@ukzn.ac.za**

SUPERVISOR: PROF INGE PETERSEN
DEPARTMENT OF PSYCHOLOGY
UNIVERSITY OF KWAZULU-
Phone :0312697970
EMAIL:-peterseni@ukzn.ac.za

Dear Tasneem Kathree

PROTOCOL :SOUTH AFRICAN INDIAN WOMEN'S EXPERIENCE OF POSTPARTUM
DEPRESSION

Approval is granted for the short questionaire to be conducted at Ethekwini Local Clinics

We wish you all the best in your research . Please provide us with a report on completion of
your study..

Please contact Dr. Cheryl WEAICH on 031 – 311 3500 for any queries

Yours faithfully

Dr Gxagxisa
HEAD : HEALTH

174