

**SOCIAL SUPPORT AS PSYCHOLOGICAL MEDIATOR AMONG AFRICAN
BLACK WOMEN WHO HAVE RECENTLY GIVEN BIRTH**

by

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DECLARATION

I declare that “SOCIAL SUPPORT AS PSYCHOLOGICAL MEDIATOR AMONG AFRICAN BLACK WOMEN WHO HAVE RECENTLY GIVEN BIRTH” is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete referencing and that this work has not been submitted before for any other degree at any institution.

Signature

Date:

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ABSTRACT

Women's procreative capacities and the appreciation of birth experiences have always been recognised in civil society and the early days of psychology. Given that our culture is one that emphasises a woman's capacity to bear children as one of the greatest social achievements, the social responsibility to procreate and ensure collective survival becomes a potent mandate, especially so for Black African women. To fulfil this social responsibility, traditional African culture dictates a very specific process of pregnancy which involves a series of watershed moments, each of which requires that social support, of whatever form, should be available. This study explored the role that social support from significant others and health professionals play in mediating psychological issues during pregnancy, childbirth and postnatally among Black African women in Madadeni Township in KwaZulu-Natal. The study was rooted in the interpretive, qualitative paradigm and a phenomenological research design was used. Purposive sampling was used to select participants who were aged from 18 to 25 years with a baby older than two weeks but less than six months. Semi structured interviews were conducted in the mother tongue of the participants until the point of saturation where no new information arose from the six participants interviewed. Thematic content analysis was used to extract recurrent themes across participants. The results indicate that social support, especially from parents and partners, plays a defining role in helping women to cope with the stress experienced during pregnancy, childbirth and postnatally.

KEY TERMS: African indigenous knowledge, cognitive schemas, phenomenology, pregnancy, postnatal depression, postnatal period, psychological changes, social support theory; stress; support functions

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CHAPTER 1

CREATING CONTEXT

1.1. Introduction

Pregnancy is one of the most magical and defining moments any woman can experience. That this same event may also be experienced as traumatic is hardly something that is peculiar or questionable. The process of giving birth is a significant life event that may present potentially challenging moments for vulnerable women (Bashiri & Spielvogel, 1999; Bina, 2008; Cox, 1999). Although the period of pregnancy and childbirth are pleasant and magical moments, they are also typically stressful experiences characterised by substantial psychological and physical change. While pregnancy affirms womanhood and motherliness in some women, many find it difficult to deal with the psychological effects after delivering their babies as the role transitions following childbirth may potentially be overwhelming. For some women, pregnancy and childbirth can be a traumatic experience signalling the beginning of stress and depression, especially when social support is questionable or absent. Social relationships play a significant role in shaping the quality of people's lives and therefore enhance feelings of well-being, personal control and positive affect, which can help women to perceive pregnancy-related changes as less stressful. A review of the literature by Reid and Meadows-Oliver (2007) found less social support to be associated with increased rates of depressive symptoms, especially in adolescent mothers in the first year after giving birth. Support from family is deemed especially vital to ensuring the mother's adaptation to her new role (Nakku, Nakasi, & Mirembe, 2006).

People have always intuitively known that social relationships play an important role in everyday life experiences. Indigenous technologies of social inclusion that emphasise that the

upbringing of a child is the collective responsibility of the adult population in the community and not only that of the individual have been part of the consciousness of African people since time immemorial. This tacit knowledge, captured in some of the fine African literary works such as Sindiwe Magona's (1990) *"To my children's children"*, Zakes Mda's (1995) *"Ways of dying"*, Chinua Achebe's (1958) *"Things fall apart"* and Tsitsi Ndangaremba's (1988) *"Nervous Conditions"* to name a few, point to the value of friendships, interpersonal and social connectedness and sense of fit with community. As a representation of ways of being with others, this common source of knowledge, which provides important guidelines to being with the other, has, however, been taken for granted and has only recently started gaining serious attention in empirical clinical work (Brugha, 1995; Lam & Power, 1991; Leahy-Warren, McCarthy, & Corcoran, 2011; Naku, Nakasi, & Mirembe, 2006).

Women's procreative capacities and the appreciation of birth experiences have always been recognised in civil society and the early days of psychology. Given that our culture is one that emphasises a woman's capacity to bear children as one of the greatest social achievements (Ola, 2009; N'guessan, 2010), the social responsibility to procreate and ensure collective survival becomes a potent mandate, especially so for Black African women. To fulfil this social responsibility, traditional African culture dictates a very specific process of pregnancy which includes a series of watershed moments, each of which requires that social support, of whatever form, should be available. Accepting support is not problematic in its own right. First, if we accept that in the final moments of pregnancy, when a woman is in labour and about to give birth, there is precariousness in the birth process that necessitates facilitation by someone other than the pregnant woman, then accepting support at this point is critical. It can also be argued that accepting support has come to be constructed to reflect how technologies of power play out in medical discourses to produce a pregnant woman in labour as needing

containment and confinement. While this latter critical take can provide insight into how accepting support in pregnancy intersects with issues of culture and tradition, gender politics, and reproductive discourses, a full-scale critical analysis is beyond the scope of this dissertation. African wisdom as reflected in the dictum “*I am because we are*” is an instructive pronouncement about the importance of shared support in providing the lifeblood that nourishes collective survival. Appraised from within this viewpoint, accepting support during pregnancy is valorised through a philosophy that promotes connectedness of being in self and with others (Gbadegesin, 1991). Essentially, a woman who has recently given birth is supposed to be supported wholeheartedly by her family and community (Degbey, 2012; Edmonds, Paul, & Sibley, 2011; Hill, 2005; Kimmerle, 2011).

1.2. Contextualising the problem

Pregnancy and childbearing are indeed the most celebrated of human achievements in society generally. Increasingly, romantic ideas about pregnancy as resident within the institution of marriage and a privilege for mature adult women are becoming painfully contested. The fact that young unmarried women are becoming pregnant is a reality that is staring contemporary Africans in the face. The rate of pregnancy in Madadeni, a semi-urban area in which this study was conducted, is reported to be on the increase particularly among young women.

When young girls fall pregnant, questions are raised as to whether they are emotionally and cognitively ready for the pressures of motherhood. But cognitions and emotions do not (only) live inside a person, they are also influenced by how one interacts with one’s social environment such as family, friends, intimate partner and the community at large. Therefore, this study explores what social support young women have in order to adjust to pregnancy, childbirth and child rearing. Social support from the family, friends and even professionals

such as nurses and counsellors has been cited as protecting women from experiencing postnatal depression (Bashiri & Spielvogel, 1999; Bina, 2008; Chan, Levy, Chung, & Lee, 2002; Chandran, Tharyan, Muliylil, & Abraham, 2002; Cox, 1999).

Another very important question that is explored by this study is how young women experience social support. In a 1999 study, Cox showed that the institution of the family plays an important role, particularly in communities that have strong African cultural influences. Therefore this study is mainly interested in the interaction between women and their immediate family (parents, siblings, partner and friends) during pregnancy, childbirth and postnatally and how the interaction affects the latter's emotional state and cognitive schemas.

1.3. Research question

The main research question is: What role (if any) does the social support from family, friends, partner and professionals such as nurses and counsellors play in mediating negative emotions and behaviour during pregnancy, child birth and postnatally?

1.4. Objectives of the study

The main aim of the study is to explore how Black African women in a South African township experience social support or the lack thereof during pregnancy, childbirth and postnatally, and the effect it has on their cognitive schemas and emotional state. It is clear from the literature that many studies support the view that social support from partners, family, friends and professionals shield women from experiencing negative emotions after giving birth (Bashiri & Spielvogel, 1999; Bina, 2008; Chan et al., 2002; Chandran et al.,

2002; Cox, 1999; Oates et al., 2004). These studies have been conducted in non-African and mainly middle class settings, and it is therefore important to conduct a study among African women who reside in a township.

The objective of this study is to explore the role that family and friends can play in helping women who have given birth and who may be susceptible to postnatal depression.

Another objective of this study is to explore the formal structural support provided by health care professionals and how it mediates negative symptoms experienced by pregnant women. Informal structural support provided by a partner, parents and significant others is also explored, especially the emotional and financial component, during pregnancy, childbirth and postnatally. Interaction patterns between the woman and her partner, parents and healthcare professionals during the three phases are also be explored.

It is hoped that with this study, a helping model will be developed that will help women to deal effectively with negative symptoms after giving birth. This model will be structured in such a way that they will form their own support groups in order to share with other women who have gone through similar experiences.

1.5. Background to the research context

Madadeni is a semi urban township situated on the outskirts of Newcastle, KwaZulu-Natal. It falls under the Amajuba District Municipality (see Figure 1). According to 2012 census figures, the estimated population of Amajuba stands at 577 634 people, with a large proportion living in Madadeni and Osizweni Township (Wikipedia, 2013).

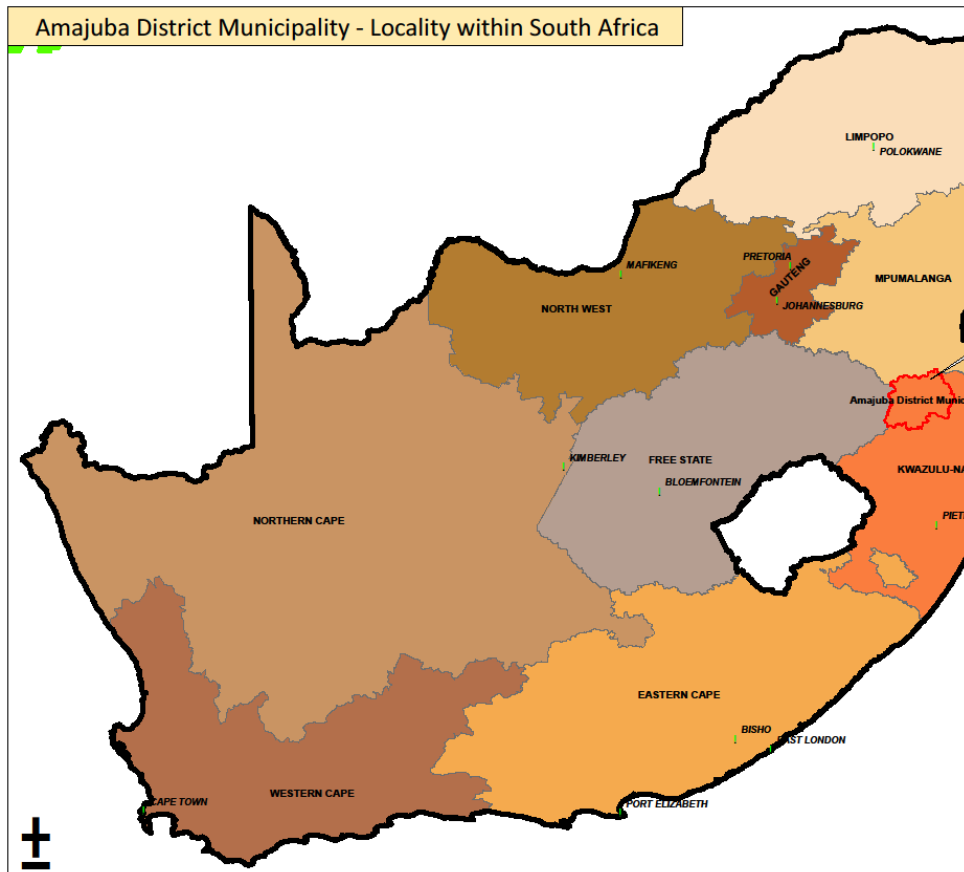


Figure 1: Location of Amajuba (Source: Amajuba District Municipality)

The basic infrastructure, such as running water, pre-paid electricity, tarred roads and proper sanitation, is in place (Amajuba District Municipality, 2010; Statistics South Africa, 2011). Newcastle has three hospitals (Wikipedia, 2013), with one located in Madadeni township, and 16 government clinics located in Osizweni and Madadeni (Wikipedia, 2013), specifically four clinics in Madadeni. A large proportion of the population (37%) is between age 15 and 34 years (Amajuba District Municipality, 2010). The rate of pregnancy in Madadeni is high (Nkonyeni, 2008; Draft concept document for social ills conference, 2013) with many households (47, 5%) headed by women (Statistics South Africa, 2011) because men look for greener pastures in the city in order to support their families. Many people (33, 1%) have matric and post-matric qualifications (Amajuba District Municipality, 2010; Statistics South

Africa, 2011), hence they have pursued their careers elsewhere and migrated to the cities because there are not enough job opportunities in the district. Historically, Newcastle's economy has had a strong dependency on coal mining, but unfortunately many collieries are now closing (Department of Co-operative Governance and Traditional Affairs, Province of KwaZulu-Natal, 2014). The region also has a strong manufacturing sector and the textile industry is very visible, with some 65% of the country's textile companies headquartered around Newcastle (Department of Co-operative Governance and Traditional Affairs, Province of KwaZulu-Natal, 2014). This narrow focus on technical jobs has forced people with other "soft" and specialised qualifications such as human and social sciences, commerce, law, medicine, health-related qualifications and engineering qualifications to ply their trade elsewhere – especially in bigger cities such as Johannesburg, Durban and Cape Town. This 'migration' has led to the disintegration of the 'original family' and as a result, the partial collapse of social and family values. This collapse could in part be the reason why there is lack of social support especially after pregnancy. The grandparents have played an important role for millennia in African communities with regard to taking care of the grandchildren (Cunningham, Elo, & Hosegood, 2010; Kilimanjaro Foods blogger, 2012; Newman & Grauerholz, 2002) but now things have changed; for example, grandchildren no longer stay in the extended family because the parents work in the city and they themselves study in city schools (Kilimanjaro Foods blogger, 2012).

1.6. Mental health and indigenous cultures

Psychological disorders in African and other indigenous cultures have been observed with suspicion, stigma and taboo (Abdulah & Brown, 2011; Gureje & Alem, 2000; Kabir, Iliyasu, Abubakar, & Aliyu, 2004). The lack of understanding of the influence of culture from the

medical personnel on how women conceptualise what constitutes mental disorders could be a hindrance to detecting women who may be susceptible to postnatal depression. Then again, the very same woman who is susceptible to depression could hide her negative emotions and feelings because of the fear of rejection. It is vitally important for the health professionals to be sensitive and aware of these situations. Most patients who present with mental health problems consult traditional healers (Okasha, 2002) who offer them traditional medicines. In a study by Kabir et al., (2004) it was found that 34% of the respondents sought spiritual treatment for their mental health problems and a further 18% consulted traditional herbal medicine. This clearly shows that a large number of people still consult traditional healers when presenting with mental health problems. What role (if any) does psychology and Western ways of looking at mental health play in the lives of Africans? At times, a woman who suffers from depression may project her emotions as originating from some unexplained metaphysical systems (Bound, 2004; Parle, 2003). Cox (1979) used the phenomenon 'Amakiro' to investigate Ugandan postpartum depression and he found that 28 out of 31 women (90%) knew of the illness, but the most interesting finding is that 70% of the women believed that taking traditional medicine during pregnancy could prevent Amakiro, which clearly shows that traditional healing is still preferred in certain regions.

According to an article by Bashiri and Spielvogel (1999), culture plays an important role in the diagnosis and understanding of postnatal depression. They are of the opinion that the distress that is often characterised by sadness and feelings of guilt in Western countries is expressed in somatic complaints in non-Western countries. The predominant Western way of establishing the causes, understanding and treatment of mental health problems must be sensitive enough and understanding of the different culturally specific ways of addressing

mental health issues (Ally & Laher, 2008; Babatunde & Moreno-Leguizamon, 2012; Cox, 1979; Laungani, 1992).

The simple definition of postnatal depression is that it is a kind of depression that occurs after the woman has given birth. According to ICD 10 diagnostic criteria, at least two of the following symptoms must be present for a period of two weeks: A depressed mood for most of the day, loss of interest or pleasure in activities that are pleasurable including playing with the baby, tiredness, and decreased energy and fatigue. Additionally, any four of the following should be present: Loss of confidence and self-esteem, feelings of guilt and blaming oneself, recurrent thoughts of suicide and the death of the child, difficulty in concentration, agitation or lethargy, sleep disturbance, and appetite disturbance.

Growing up in the township has motivated me to pursue this topic. I have observed that many women who have given birth do not get enough support from the public health system with regard to professional counselling services and social support from their families. In our African culture, pregnancy out of wedlock is perceived as a taboo and the situation is aggravated if one's family is poor and the father of the child neglects the mother (Cox, 1999).

The failure of both institutions (the family and the public health system) to support the mother may lead to tragic consequences such as infanticide and suicide. There have been instances in Madadeni township where, tragically, mothers have killed their babies barely a few days after giving birth. There are two true stories that happened in my township that I will quote which motivated me to choose this topic. I believe that stories are powerful tools to convey a message.

On the 18th of April 2009, a three-day-old baby was found wrapped in a plastic bag used for solid waste, dumped in the sewerage. He was found by municipal workers; unfortunately, he

had died. On the 4th of September 2009, a woman threw her seven-day day-old from the 6th floor of a building and committed suicide in the same way; unfortunately nobody will ever know the true reason why she decided to end her own, and the baby's, life.

Other incidents that occurred in KwaZulu Natal were reported as follows:

“On the 1st of June 2007 a new born baby was miraculously rescued from the bottom of a pit toilet in Pietermaritzburg; he was found suffering from hypothermia and ant bites. He had survived 12 hours in the two metre toilet pit in freezing temperatures. His 23 year old mother was later arrested for attempted murder. Two weeks later another baby was found dumped in garbage in Pietermaritzburg; unfortunately the infant did not survive. The body was found with a plastic bag over his head, indicating that he was suffocated before being placed in the bin.” (Oxley, 2010, n.p.)

These are chilling stories which leave people with questions such as: Why this cruelty? Who could do such a thing? Could these mothers not have opted for abortion if they did not want the babies or, better still, given the babies to adoption agencies? Some of the reasons mentioned in the literature why mothers sometimes commit suicide and kill their children include extreme stress created by the transition to motherhood, especially in the case of first time mothers (Glavin & Warren, 2013; Nicolson, 1998; Rasmussen, Dunning, Hendrieckx, Botti, & Speight, 2013), lack of social support (Babatunde, 2010; Eastwood, Jalaludin, Kemp, Phung, & Barnett, 2012; Glavin & Warren, 2013; Inandi, Elci, Ozturk, Egri, Polat, & Sahin, 2002) and lack of, or hesitancy in, offering professional help, specifically counselling (Oates, Cox, Neema, Asten, Glangeaud- Freudenthal, Figueiredo, Gorman, Hacking, Hirst, Kammerer, Klier, Seneviratne, Smith, Sutter-Dallay, Valoriani, Wickberg, & Yoshida, 2004).

1.7. Rationale for the study

This study will hopefully be of benefit to healthcare providers because they will understand how African women experience pregnancy, childbirth and the postnatal period.

Black African women do not necessarily use the same concepts as women elsewhere to explain how they feel. Articles by Cox (1996) and Bashiri and Spielvogel (1999) indicate the role that culture plays in diagnosing postnatal depression. They are of the opinion that different cultures display different symptoms when reporting on postnatal depression. Complaints of sadness and guilt are more characteristic of depression in Western countries, whereas in non-Western countries women characterise their symptoms of depression through somatic complaints. This may not be in line with ICD10 criteria, and hence postnatal depression may not be diagnosed when it is in fact present. African women will hopefully also benefit from this study because it provides a platform for them to describe and explain their experiences during pregnancy, child birth and postnatally and, more importantly, the role that can be played by people who are close to them and by professionals.

Currently the rate of referrals from the maternity wards to clinical psychologists is very low-almost non-existent (Z, Mchunu, personal communication, September, 2010). The reason for this could be that nurses do not have specific psychological knowledge that could be useful in identifying those who are in psychological distress and susceptible to postnatal depression. The short stay of women (usually a day or two if both the mother and a child are healthy) in hospital after they have given birth does not help either. According to Mchunu, personal communication, September, 2010, these women are quickly discharged and are not followed up. They may be all alone and deal in their own way with psychological distress and postnatal depression.

African communities are often described as having a collectivist orientation (Kimmerle, 2011; Ramose, 2005; Triandis, 1993; Wafula, 2003). The community or family has traditionally been of paramount importance (Degbey, 2011), but this is slowly fading because many Africans have become more acculturated to the Western way of living (Naidoo & Mahabeer, 2006) that puts the individual first (Kimmerle, 2011). The helping professions may benefit by understanding how Africans relate to one another, which may be useful in intervention strategies for women who have been diagnosed with postnatal depression. The helping professions in the public health system may develop a model that is in line with support, such as outpatient support groups that comprise of women who suffer from postnatal depression.

1.8. Chapter outline

This dissertation consists of six chapters. The current chapter, **Chapter one**, sets the scene for the rest of the dissertation.

Chapter two explores literature on pregnancy and the importance of birth experiences. The exploration of literature is grounded in psychological frameworks that explain pregnancy as a process and the implications of maturation and support on optimal adaptation to the role of motherhood.

The theoretical framework of the study is discussed in **Chapter three**. In particular, the social support theory of Leahy-Warren (2011) is described and linkages are made to pregnancy and the process of motherhood, as well as the potential role it plays in buffering psychological ill-health in African Black women who have just given birth.

In **Chapter four**, the methodology of this inquiry is discussed. The basic tenets of the interpretive qualitative approach and the implications for the paradigmatic positioning of the researcher are presented. Furthermore, the research methods employed in the study are discussed, focusing on Smith's Interpretative Phenomenological Analysis (IPA). A stepwise presentation of how the data were collected and analysed, ethical considerations and practical issues related to gatekeeping is provided.

The results are presented and discussed in **Chapter five**. The analysis of themes that are extrapolated from the conversations with participants is grounded within the theoretical ideas about social support and literature on pregnancy and social support.

Chapter six provides a synthesis and critical evaluation of the study. The strengths and limitations and the implications these have for the study are briefly discussed. Finally, recommendations for further research are provided.

CHAPTER 2

LITERATURE REVIEW

2.1. Introduction

The previous chapter briefly introduced the reader to this research report. The foundation of the study was laid through the research question, rationale, aims and objectives. The significance of the study was indicated and finally an outline of chapters was presented.

This chapter begins with a brief discussion on the psychology of pregnancy, particularly the psychoanalytic orientation. The discussion of whether pregnancy and motherhood is a crisis or a maturational process will be further explored. The multifaceted perspective on pregnancy, and the processes related to pregnancy, is adopted for purposes of this enquiry. Hormonal and metabolic changes and the effects they have on a pregnant woman will be briefly explored. Two main important hormones are highlighted here; these are relaxin and progesterone. Catabolism and anabolism are briefly discussed and the role they play in the health outcome of a new-born child. The discussion of arguably two of the most important constructs in abnormal psychology, which are anxiety and depression, are briefly explored - how they affect the pregnant women and their effects on pregnancy and the postnatal period. The need for support for pregnant women is again emphasised.

One of the psychological distresses experienced by women after giving birth is postnatal depression. The clinical definition of postnatal depression according to the Diagnostic and Statistical Manual of Mental Disorders-IV-TR (2000) and the International Classification of Diseases (1992) is briefly highlighted, and the prevalence rate of depression and risk factors for developing postnatal depression are discussed.

Expectant fathers have received little research attention and yet when things go wrong they are often blamed. A section of the chapter is accordingly devoted to the role expectant fathers could play in helping women adapt to their new role. Reasons why expectant fathers sometimes find it difficult to offer support are briefly explored. The chapter concludes by considering contemporary realities affecting depression.

2.2. The psychology of pregnancy: An exploration of theoretical orientations

2.2.1. The psychoanalytic orientation

The psychoanalytic perspective views pregnancy as a traumatic experience which is deeply influenced by unconscious processes (Leon, 2008). Earlier we saw that in the literature, pregnancy is indeed perceived as a traumatic transitional experience (Bashiri & Spielvogel, 1999; Bina, 2008; Cox, 1996) during which support is deemed vital to counteract emotional distress (Chan et al., 2002; Chandran et al., 2002; Cox, 1999). In order to understand the psychological distress that may be encountered by a woman who is not supported during pregnancy and post-natally, it is vital to more closely examine the development crisis during pregnancy.

2.2.2. Development crisis during pregnancy

The earlier work by Bibring, Dwyer, Huntington et al., (1961) and by Tudiver and Tudiver (1982) identified three phases or tasks that pregnant women have to successfully negotiate in order to adapt to their new roles as mothers. These are the acceptance of the foetus, concentrating on the foetus and letting go of the foetus.

The first task is *acceptance of the foetus as part of herself*. The pregnant woman has to first accept the pregnancy and the potential change of roles this may entail. For example, there may be adjustments in one's school routine, work routine and leisure. Some women may opt to 'put brakes' on their habits such as going out with friends, drinking alcohol and so forth. It could be more difficult for those who did not plan their pregnancies (Tudiver & Tudiver, 1982). This is usually met with feelings of ambivalence (Tudiver & Tudiver, 1982) causing a pregnant woman to begin to question whether this is really what she wants. Physiological changes such as nausea and morning sickness may exacerbate doubt, which subsides as a foetus begins to move inside (Tudiver & Tudiver, 1982).

The second task involves *concentrating on the foetus* (Tudiver & Tudiver, 1982). The physiological changes that pregnant women experience force them to begin shifting attention to a growing belly (foetus inside). It is not uncommon to hear pregnant women talking about their unborn foetus, how the foetus moves, their feelings towards the foetus and in some cases they even allow others to touch and 'feel the foetus moving'. During this phase, women who have accepted their pregnancy have integrated a foetus as part of themselves, and begin to prepare for the arrival of the baby. This is evidenced in practical actions such as buying baby's clothes and baby supplies.

This is a critical stage in a sense that a woman begins to bond with her child. However, it should be borne in mind that the bonding may manifest differently in different cultures. In some cultures (Zulu and Tswana, for instance), a woman is not allowed to start preparing for the unborn child. Buying clothes and baby supplies for the unborn child could lead to bad luck (miscarriage) and therefore buying necessities for one's unborn child is not a benchmark to measure whether a pregnant woman will successfully negotiate this phase. The nature of

relationships and how a woman relates with significant others, especially the partner, could also play a role in how the woman actually feels towards her unborn child.

The final task entails *the woman preparing to let go* and this is accelerated by the physical discomfort most women feel (Tudiver & Tudiver, 1982). This implies that pregnant women are looking forward to the birth process so as to alleviate themselves of discomfort and reach the end of a demanding period in their lives. According to Tudiver and Tudiver (1982) successful resolution of each phase prepares the pregnant woman for her new role.

Viewing these phases as linear and cast in stone could be problematic and cannot fully uncover the process or developmental crisis during pregnancy. For example, what about women who have unplanned pregnancies or, worse, those who have been raped? The importance of context and how culture sometimes dictates what women should do during pregnancy cannot be overly emphasised.

2.3. Pregnancy as a maturational crisis

Leon (2008) explains psychoanalytic perspectives that view pregnancy from the lens of unconscious processes and past relations. These are: An early drive model and relational models. The early drive model developed by Freud focused on psychic expression of sexuality and aggression (Leon, 2008). Stages of pregnancy (first trimester, second trimester and third trimester) are seen as similar to Freud's psychosexual stages of development (Barlow & Durand, 2005), particularly the oral, anal and phallic phase (Leon, 2008). The first trimester is likened to the oral phase in that nausea and food cravings dominate. The second trimester is a recapitulation of the anal stage in that anal trends become important. The third trimester is likened to the phallic stage in that a mother prepares for delivery and all the

negative and aggressive thoughts come to mind, such as fear of the baby dying and fear of losing control (Lyon, 2008).

The relational model of psychoanalysis views pregnancy as an important period during which an expectant mother reflects on the relationship that she had with her mother (Lyon, 2008; Pines, 1990). According to this model, the course of pregnancy depends on how a woman interprets the relationship with her own mother (Lyon, 2008). If a woman had a negative relationship with her mother, chances are that she will project this onto her own foetus (Pines, 1990). Whether pregnancy becomes a crisis or not depends on whether the expectant mother deals effectively with her own issues towards her mother, and if not, regression takes place (Leon, 2008; Pines, 1990).

Other authors reiterate that pregnancy is a period of emotional upheaval (Dalfra, Nicolucci, Bisson, Bonsembiante, Lapolla, & Quality of life Italian Study Group, 2012; Rich-Edwards, Kleinman, Abrams, Harlow, McLaughlin, Joffe, & Gillman, 2006; Tudiver & Tudiver, 1982) with many mood swings (Smith, Refuerzo, & Ramin, 2014) and coupled with the presence of many stressors (Schetter, 2011). Importantly, however, despite these upheavals pregnancy is a normal maturational process (Tudiver & Tudiver, 1982) and is not a pathological condition (Negrato, Mattar, & Gomes, 2012).

2.4. Motherhood as a maturational process

Crises are necessary for development because they are seen as turning points which could result in personal maturation and growth (Bibring et al., 1961). Two schools of thought (psychoanalytic researchers and family researchers) have engaged in a debate on whether motherhood is a crisis or simply a period of transition (Leon, 2008). The psychoanalytic view

sees motherhood as a crisis (especially taking the regression theory, ego psychology, internal and psychic orientation into account). The family orientation views motherhood (albeit in a conventional family set-up) as a transition where new roles are defined and reconciled in new familial arrangements (Lyon, 2008). Some researchers see motherhood as a transition (Glavin & Leahy-Warren, 2013; Peterson, Paulitsch, Guethlin, Gensichen, & Jahn, 2009; Rasmussen, Dunning, Hendrieckx, Botti, & Speight, 2013) and others see it as a crisis, albeit normal (Pines, 1990; Tudiver & Tudiver, 1982). For purposes of this study, motherhood will be considered as both a crisis and a transition.

2.5. Psychosocial processes in pregnancy

A more integrated view of pregnancy is vital for the understanding of this phenomenon (Schetter, 2011). This may include *individual factors* such as medical, genetic, neuroendocrine, behavioural and so forth; *relationship factors* such as social networks, social support, partner, family relationship, among others; *sociocultural factors* such as race/ethnicity, socioeconomic status, acculturation and so forth; and *community-level factors* such as physical environment, characteristics of neighbourhood, access to health-care and so forth (Schetter, 2011).

Women who have had a history of miscarriage find it difficult to adjust and accept their current pregnancy (Bergner, Beyer, Klapp, Rauchfuss, 2008; Fertl, Bergner, Beyer, Klapp, & Rauchfuss, 2009; Gong, Hao, Tao, Zhang, Wang, & Xu, 2013; Peterson et al., 2009; Woods-Giscombe, Lobel, & Crandell, 2010). They are anxious as to whether the current pregnancy will be successful. Genes are also implicated in anxiety. Ryan (2013) postulates that certain individuals are more susceptible to anxiety than others due to genetic factors.

Rich-Edwards et al., (2006) found that women from low socioeconomic backgrounds, who are going through financial hardship, have a higher prevalence rate of depressive symptoms compared to their counterparts. Other authors have also found similar results (Seguin, Potvin, St-Denis, & Loiselle, 1999; Stein, Malmberg, Sylva, Barnes, Leach & the FCCC team, 2007).

Pregnant women who have poor social networks and low levels of social support (Glavin & Leahy-Warren, 2013; Jackson, 1998; Rasmussen et al., 2013) find it difficult to cope during pregnancy and this could also have negative implications during a postnatal period.

A partner and family play a pivotal role for a pregnant woman and lack of support during this period complicates the pregnancy. Access to proper medical services is also implicated in depression (Inandi, Elci, Ozturk, Egri, Polat, & Sahin, 2002) and the physical environment such as a neighbourhood where crime is rife could be detrimental to a pregnant woman (Schetter, 2011).

2.6. Somatopsychic and psychogenic factors in pregnancy

According to Bashiri and Spielvogel (1999) the identification of postnatal depression is more complex for Western-trained professionals when working with women from other cultures, such as African women. They are of the opinion that the issue of somatisation and acculturation complicates the understanding of depression among women from non-Western cultures. They further state that in non-Western cultures, women often report somatic complaints when reporting signs and symptoms of postnatal depression and psychological distress.

2.6.1. Hormonal changes

Hormones are significant chemicals, particularly for pregnant women, and during this period there are massive hormonal fluctuations (Nauert, 2011) implying that for one moment a pregnant woman may be happy and then suddenly become irritable and sad. Physically, two particular hormones called relaxin and progesterone enable the muscles of the uterus to relax so that the foetus can have enough room to grow (Kristiansson & Wang, 2001; National Childbirth Trust, 2012; Omar, Ramez, & Gibson, 1995). Psychologically, hormones also play a role in how one experiences feelings (National Childbirth Trust, 2012). Kinsley and Franssen (2010) argue that during pregnancy women's threat-sensitivity level is heightened and this is beneficial in the sense that it prepares a woman to be extra careful in order to protect her offspring-to-be from harm. During the first trimester, pregnant women are usually tearful, and feel irritable and out of control. Understanding that hormones play a significant role in the emotional state of pregnant women during the first trimester is vital for significant others, a partner, family and health professionals.

2.6.2. Metabolic changes

Metabolism is defined as chemical processes involved in maintaining the living state of the cells and organism (Mandal, 2013; Wikipedia, 2014). Pregnancy affects metabolism substantially (Lain & Catalano, 2007; King, 2000). Two broad categories of metabolism are found in the literature, namely catabolism and anabolism (Mandal, 2013; Martinez-Outschoorn, Sotgia, & Lisanti, 2014; McCarthy & Esser, 2011). Catabolism is the breakdown of molecules to obtain energy and anabolism is defined as the synthesis of all compounds needed by the cells (Mandal, 2013). Anabolism is a constructing element and catabolism is the breaking down element. King (2000) found a correlation between metabolism and the

socioeconomic status of pregnant women in the sense that women from developed countries had better metabolism because of their access to proper nutrition, which often lead to the birth of healthy babies. On the other hand, poor women do not have much of a choice when it comes to choosing what to eat, which affects foetal growth and development.

2.7. Emotional manifestations and implications of pregnancy

Stocky and Lynch (2000) emphasise that childbirth is a time of significant physical and emotional upheaval, with postnatal mood disorders representing the most frequent form of maternal morbidity following childbirth. Cox (1996) indicates that during this period most women depend on social support from family and friends in order to help them adapt to the new role of being a mother. These aforementioned studies show that there is a need to learn more about postnatal depression, especially the role of social support in shielding women from psychological distress and postnatal depression.

2.8. Development of a relationship with a baby

Attitudes regarding conception and pregnancy can predict the outcome of pregnancy and how the pregnant woman interacts with her baby-to-be (Leon, 2008). As seen earlier, the relationship between the baby and the mother begins developing during pregnancy (Tudiver & Tudiver, 1982). According to psychoanalysis, how well a pregnant woman bonds with her child depends on the perception that she has of the relationship between her and her mother (Leon, 2008; Pines, 1990).

Nakku et al., (2006) have found the prevalence rate of major depression at six weeks to be 6.1% for their sample from Kampala in Uganda, which is far below the 34.7% found by

Tomlinson, Cooper, Stein, Swartz and Molteno (2006) in Khayelitsha, South Africa. Patel, Rodrigues and De Souza (2002) have done many studies in Asia that tackle postnatal depression. One study (Patel et al., 2002) considered the effects of postnatal depression on infants and found that women who suffer from postnatal depression put their children at risk of impairment in their growth. This study is important because it addresses the importance of managing postnatal depression so that children will not be harmed in some way. The identification of postnatal depression and psychological distress among African women could save countless children from impaired growth as being identified by Patel et al. (2002).

2.9. Anxiety and depression during pregnancy: Psychological aspects

Anxiety seems to be more common than previously thought during pregnancy, for example, pregnant women worry about the wellbeing of their children, the process of giving birth and giving birth to a healthy child (Ali, Azam, Ali, Tabbusum & Moin, 2012; Ryan, 2013; Tartakovsky, 2012).

Pregnant women who experience anxiety are at increased risk of postnatal depression (Grant, McMahon & Austin, 2008; Heron, O'Connor, Evans, Golding, Glover & ALSPAC Study Team, 2004). The exploration of the causes of anxiety and depression during pregnancy may shed light and help in understanding what pregnant women go through in this period, and suggest steps that could be taken by significant others in their lives to support them.

2.9.1. Causes of anxiety

External stress such as a lack of resources (Schetter, 2011) causes anxiety in some women because they keep thinking and stressing about how they will care for their unborn children

after birth. This is usually the case for women who are unemployed and those from low socioeconomic backgrounds (Schetter, 2011).

Domestic violence, particularly sexual, physical and verbal abuse (Ali et al., 2012), has been found to play a role in the development of anxiety. Emotional abuse can have more far-reaching effects as compared to other forms of abuse (Ali et al., 2012).

Lack of social support (Kleinman, Abrams, Harlow, McLaughlin, Joffe, & Gilman, 2006; Milgrom, Gemmill, Bilszta, Hayes, Barnett, Brooks, Ericksen, Ellwood, & Buist, 2008; Richardson et al., 2006; Robertson, Grace, Wallington, & Stewart, 2004) is also cited as a cause of anxiety among pregnant women. There is a strong body of literature that sheds some light on how social support mediates the negative psychological effects during pregnancy, childbirth and during the postnatal period (Bashiri & Spielvogel, 1999; Bina, 2008; Cox, 1996; Cohen & Lakey, 2000; Nakku et al., 2006; Reid & Meadows-Oliver, 2007; Wandersman et al., 1980). In a nutshell, lack of social support from family, a partner and significant others could perpetuate anxiety from the perspective of a pregnant woman. Unfortunately severe anxiety could be distressing and disabling to the point that a pregnant woman struggles to function on a daily basis (Tartakovsky, 2012).

2.9.2. Causes of depression

Causes of depression are usually broken down into three main areas: Physical, emotional and social.

Physical changes: Cardiovascular changes such as heart rate and blood pressure are usual during pregnancy (Campbell, 2000; Carlin & Alfirevic, 2008) and a deficiency in these important bodily functions could be a catalyst for depression in a pregnant woman. Weight

gain, swollen feet and antenatal low back pains are normal during pregnancy, and are reported by 80% of pregnant women (Campbell, 2000). Some women find this to be frustrating because it disturbs their daily routine. For example, a woman who usually jogs in the morning could find it difficult to keep fit because she has to stop exercising for the sake of her unborn child.

Body image issues such as a change in pigmentation (Muallem & Rubeiz, 2006; Nussbaum & Benedetto, 2006) could be seen in a negative light by a pregnant woman. Some pregnant women find this distressing (Elling & Powell, 1997), but do not complain about it and choose to keep it to themselves, which in effect becomes 'bottled up' (Maya et al., 2006). Gaining weight and swollen body parts such as feet could negatively impact on one's self-esteem and self-image, especially if one has low self-esteem and a negative self-image before pregnancy. Changes in body image and size occur rapidly during pregnancy and for some women it causes concern, anxiety and depression (Tudiver & Tudiver, 1982).

Hormonal changes in pregnant women are dramatic and could occur suddenly (Nussbaum & Benedetto, 2006). Mood swings are also common during this period and this is caused by the rapid rise of progesterone and estrogen. When the placenta does not produce sufficient progesterone, feelings of depression could occur (Pre and Postnatal Depression Advice and Support, 2014). Hormone imbalance could lead to nausea (Pre and Postnatal Depression Advice and Support, 2014; Smith et al., 2014).

Emotional changes: The literature provides ample evidence that pregnancy is a challenging period accompanied by emotional turmoil, particularly for first-time mothers (Bashiri & Spielvogel, 1999; Bina, 2008; Cox, 1996). Pregnancy is also perceived as a transitional period (Leon, 2008) during which proper negotiation is necessary for adjustment to the new

role of being a mother (Nakku et al., 2006). This implies that failure to adjust properly during pregnancy could precipitate depression postnatally.

Another factor that pregnant women have to contend with is the reality that friendship dynamics could change. They could be required to change their lifestyles because of the demands of pregnancy.

Fear of the unknown could also cause pregnant women to feel agitated and anxious. Questions such as ‘Will my baby be alright?’ ‘Will I make a good mother?’ (Pre and Postnatal Depression Advice and Support, 2014) often lead to unnecessary anxiety.

Social changes: Adjusting to pregnancy and changing daily routines could be challenging and frustrating to a pregnant woman. Striking a balance between family and a job can be difficult (Pre and Postnatal Depression Advice and Support, 2014) and it becomes more challenging when the woman is a single parent, without a partner. This is when social support from friends and family (Jackson, 1998) becomes of paramount importance in order to help a pregnant woman shed some of the responsibilities.

2.10. Need for support of the expectant mother

One of the latent psychological distresses often experienced by women after giving birth is postnatal depression. Different authors have indicated that social support from family, friends and partners may protect women from the adverse effects of postnatal depression (Chan et al., 2002; Holopainen, 2002; Leung, Kung, Lam, Leung, & Ho, 2002). Nakku et al. (2006) also found that lack of social support, especially from the partner and mother, put women at risk of developing postnatal depression. A South African study by Cooper, Tomlinson, Swartz, Woolgar, Murray and Molteno (1999) found that among women who had delivered eight

weeks previously postnatal depression was associated with poor emotional and practical support from their partners. The aim of this inquiry is to explore whether supportive structures play a pivotal role in shielding women from psychological distress, including postnatal depression. Girls and women usually have closer ties with their mothers and they depend on them for support especially emotional support, beginning from a young age. It is not surprising that young pregnant women turn to their mothers for support and advice on how to deal with pregnancy and childbirth, and on how to care for the baby post-natally, since their mothers have the know-how and experience of how to deal with different phases of pregnancy. When the partner decides to neglect his responsibilities, the family becomes the main source of support during this period.

According to the psychoanalytic theory, pregnancy is the period when a pregnant woman projects the image of her own mother onto her foetus and that could play a role in how she feels towards her foetus. If the projection is largely negative then that means chances of displaying negative feelings and rejection towards her foetus are high (Pines, 1990).

2.11. Different risk factors for developing postnatal depression

People are unique and respond differently to situations, but researchers have identified some uniform risk factors for developing postnatal depression. These are discussed below.

Life stress during pregnancy has been cited as playing a role in pregnancy. Life stressors could include a fragile relationship between a pregnant woman and her partner (Tudiver & Tudiver, 1982). Parents could also play a role by not supporting the pregnant woman. This could be financial or emotional support. Other life stressors include worrying about how the pregnant woman will support her child, especially when she is not working and the partner

neglects his responsibilities. Dropping out of school because of the ridicule and shame accompanying pregnancy could frustrate some pregnant women especially when they have low self-esteem. It should be noted that the Department of Basic Education in South Africa allows pregnant women to attend school for as long as they can; however, physical changes accompanying pregnancy can force a pregnant woman to stop attending school and at times learners in schools can be cruel, in effect driving a pregnant woman away from school.

Morning sickness, which takes the form of nausea and vomiting, usually develops by five to six weeks of pregnancy (Smith et al., 2014). It can be an irritation for some pregnant women and this could lead to lethargy and hopelessness. In extreme cases, the nausea could be severe, last longer and lead to weight loss and dehydration (Smith et al., 2014).

Relationships, particularly from the partner, have been cited in the literature as playing a role in how women cope with pregnancy and the postnatal period. Negative relationships may be a risk factor in the development of postnatal depression. For example, a woman who is often subjected to emotional abuse and is not supported by her partner could have a bleak perception of her future and that of her unborn baby. Lack of support postnatally could exacerbate those negative perceptions and precipitate the development of postnatal depression.

Rich-Edwards et al., (2006) found that *unwanted pregnancy* is associated with antenatal and postpartum depressive symptoms. Researchers have also focused on the *gender of the child* as one of the risk factors for developing postnatal depression. The study that was conducted by Templeton, Lorna, Velleman, Richards, Persaud, Albert, Milner and Philip (2003) found that Black women preferred a son. Patel et al. (2002) and Saravanan (2002) have also found that theme in their studies. Nahas et al. (1999) reported that Lebanese women perform rituals such

as prayer asking for a son. In Africa this is also the case. The study conducted by Hanlon, Whitley, Wondimagegn, Alem and Prince (2004) in Ethiopia reported that women's partners prefer a boy and celebrations are held when the baby boy is born. According to these women, boys are conferred higher status than girls as well as inheriting the family's property and wealth.

For African men, having a son affirms that a family legacy will live on. When a woman has given birth to a girl, this may be a threat to her happiness in the postnatal period (Hanlon et al., 2004). One woman in the aforementioned study reported thus: *"boys are preferred. I myself was expecting it (my baby) to be a boy and when I saw the baby I said 'she must be a boy'. The traditional birth attendant said 'she is a boy'. But when the baby cried, I knew that she was a girl and I was disappointed"* (p. 1214). This extract shows the importance of giving birth to a boy within an African culture. This may have negative consequences for women who give birth to girls.

One grandmother had an informal chat with her grand-daughters-in-law who had recently given birth to baby girls. She made it clear that they have to try harder to give birth to boys because according the family tradition they will never be afforded the respect that is due to them unless they give birth to boys (Gogo Zulu, personal communication, December 2013). This clearly shows that in this day and age, women who could not bear a boy are still discriminated against.

2.12. Describing postnatal depression

Postnatal depression is the kind of depression that is experienced by mothers who have recently given birth (International Classification of Diseases [ICD10], 1992). According to

ICD 10, a woman is diagnosed with postnatal depression if the following features have been present for two weeks: A depressed mood for most of the day, loss of interest or pleasure in activities that are normally pleasurable such as playing with the baby, tiredness, decreased energy and fatigue. Additionally, any four of the following should be present: Loss of self-confidence and self-esteem, feelings of guilt and blaming oneself, recurrent thoughts of suicide or death including that of the baby, difficulty in concentration, agitation or lethargy, sleep disturbance and appetite disturbance. This description is congruent with the Diagnostic and Statistical Manual of Mental Disorders-IV-TR (2000) for postnatal depression. Looking at these symptoms, it becomes clear that this disorder is disabling to both the mother and the infant.

2.12.1. Postnatal depression in South Africa

The dearth in literature on the topic of postnatal literature in South Africa is troubling, particularly taking into account that this disorder is prevalent across the world. One study by Tomlinson et al. (2006) estimates the prevalence of depression to be 34.7% at two months postpartum. The authors of this study also postulate that the disorder occurs three times more in developing countries than in developed countries. These statistics are alarming and clearly indicate that postnatal depression is a more common disorder than previously thought, but there has been limited research among African women on the nature of postnatal depression, risk factors for developing postnatal depression and the prevalence rate of postnatal depression. Ramchandani, Ritches, Stein and Norris (2009) conducted a study in Soweto, Johannesburg, and estimated the rate of postnatal depression for their participants to be at 16, 4%. This is lower than the 34.7% estimate given by Tomlinson et al. (2006), but is still alarmingly high

2.12.2. Prevalence rate of postnatal depression

Many studies that investigate the prevalence of postnatal depression have been conducted and the rate seems to be consistent in different countries (Oates et al., 2004; Ramchandani et al., 2009; Reid & Meadows-Oliver, 2007). Cooper and Murray (1998) estimate prevalence to be 10%. O'Hara and Swain (1996) indicate a 13% prevalence of postnatal depression in different countries. In some Asian countries the rate is between 11% and 19% (Patel et al., 2002). Gold (2002) and Miller (2002) estimate it to be between 8% and 15% respectively. Quantitative methods have taken precedence over the more qualitative studies, and often only the prevalence of postnatal depression and the validity of postnatal depression scales are investigated, with little attention to how the depression actually manifests. However, there are signs of a paradigm shift in terms of which women's experiences of postnatal depression and risk factors are beginning to be explored.

Thus, although many studies of postnatal depression have been conducted, a central limitation of many studies is that the study designs have been informed by existing research and by researchers' own beliefs, experiences and assumptions rather than by research participants' own account of their experiences and perceptions.

2.13. Expectant fathers

Expectant fathers have received little attention from researchers (Gage & Kirk, 2002; Tudiver & Tudiver, 1982); however some studies on expectant fathers (Deave, Johnson, & Ingram, 2008; Widarsson, Kerstis, Sundquist, Engstrom, & Sarkadi, 2012) have begun to shed some light on their perception of pregnancy (Lyon, 2008). Pregnant women attend ante-natal

classes where they are equipped with tools on how to transit successfully to motherhood, how to care for the baby (Deave & Johnsson, 2008; Deave et al., 2008; Widarsson et al., 2012) and how to deal with strenuous conditions during pregnancy, childbirth and postnatally. By contrast, some expectant fathers feel ‘invisible’ and left out of the pregnancy, including attending ante-natal appointments (Deave et al., 2008) or other measures to prepare them for the transition to fatherhood (Deave & Johnson, 2008).

2.13.1. Fatherhood as a crisis

Research indicates that expectant fathers turn to negative coping behaviours when frustrated during their partners’ pregnancy (Curtis, Blume, & Blume, 1997). Some researchers have found an increase in fathers’ outside activities such as cheating and job changes (Colman & Colman, 1971).

Rossi (1968, in Curtis, Blume, & Blume, 1997) cites a number of reasons why transition to fatherhood is difficult: (a) It is not always a voluntary decision. The woman can decide to keep the child and the man will often have no say in whether to do abortion. (b) The termination of pregnancy is not socially accepted. Interestingly this finding still applies, even though abortion has been legalized in many countries. (c) Becoming a parent is irreversible. One becomes a parent until one’s child dies. (d) Men do not get an opportunity to be prepared for or to be sensitized to becoming a father (Deave & Johnson, 2008; Deave et al., 2008). (e) Finally, there are no clear roles and responsibilities for a father. Traditionally, fathers were expected to provide financially for their children; however, in the contemporary world they are required to be hands-on involved in child rearing. This could include bathing the baby, feeding the baby and changing nappies.

An interesting concept that has developed and brought new debate on male symptomology during pregnancy is Couvade syndrome, informally known as sympathetic pregnancy (Laplante, 1991; Kazmierczak, Kielbratowska, Pastwa-Wojciechowska, & Preis, 2013). This is a condition where a partner of the pregnant woman experiences some of the symptoms and behavior of the expectant mother. This includes minor weight gain, altered hormone levels, morning nausea, and disturbed sleep pattern. In extreme cases a partner may experience labour pains (sympathy pain), and postpartum depression (Laplante, 1991; Wikipedia, 2013). Couvade syndrome may also include social customs and rituals such as bed rest and mimicking of labour (Laplante, 1991).

Kazmierczak et al. (2013) found the existence of couvade symptoms among some expectant fathers, particularly those related to weight (weight gain and changes in appetite) and empathy, especially the tendency to take on the negative emotions of others. Couvade syndrome need not be negative – the empathy and support that a pregnant woman experiences from the expectant father who has the syndrome could help the woman deal with pregnancy symptoms because she has someone who is sympathetic and ‘understands’ what she goes through.

2.14. Contemporary realities affecting depression

Researchers have also shown that, like other forms of depression, the risk of postnatal depression tends to be higher among women of colour, immigrant women and women of lower socio economic status (Abrams & Curran, 2007; Benoit, Westfall, Treloar, Philips, & Jansson, 2007; Templeton, Velleman, & Persaud, 2003). The context where this study was conducted is characterised by some similar factors, such as women of colour and low socioeconomic status. As seen earlier, social support, which entails emotional support,

informational support and structural support, is important and could play a vital role in mediating negative emotion during a stressful period. In moving forward, it may be time to revert back to basics where friendships and support from the family was a cornerstone and a pillar during stressful times.

2.15. Conclusion

Having briefly looked at some studies on postnatal depression, it has become clear that this disorder is prevalent. The aim of this study is to explore the role that social support plays in mediating psychological effects during pregnancy, childbirth and postnatally. Pregnancy is a magical moment for some women, even though it presents with challenges because, by its nature, it is a transitional moment and a crisis requiring support for adaptation to a new role. Physiological changes, psychological adaptation and societal expectation all seem to have an effect on how well this transition is negotiated. Research seems to suggest that psychological distress is common during pregnancy and postnatally, particularly depression; however, little has been done to understand this phenomenon. Fathers as significant role players; could benefit from being offered support during the ante-natal period, during pregnancy and postnatally because they also experience difficulties in adapting to their new roles.

CHAPTER 3

THEORETICAL FRAMEWORK

3.1 Introduction

Brugha (1995) argues that "the concept of social support has no identifiable beginning in the sense that, rather like parenthood, it has always been there and its importance has always been taken for granted" (p. 2). This chapter will begin by tracing the history of social support, particularly in the fields of psychiatry, biology and ethological studies. One common theme across these fields is the impact of early life experiences, especially attachment, in adaptation (or maladaptation) later in life. The types of social support as postulated by different theorists and authors will be discussed, including the work of Lakey and Cohen (2000); Jacobson (1986); Wandersman, Wandersman and Kahn (1980); Schaefer, Coyne and Lazarus (1981); Brugha (1995); and Leahy-Warren, McCarthy and Corcoran (2011). Social support theory (Lakey & Cohen, 2000) is based on the triadic perspective which comprises of: The stress and coping perspective, the social constructionist perspective and the relationship perspective. Social support theory is incomplete without exploring and linking three vital dimensions, which are: *Support type*, *sources of support* and *support functions* (discussed later in this chapter).

Psychosocial theories that help in clarifying the importance and impact of social support are mentioned, followed by a brief discussion of measurement issues to be taken into account when one uses social support theory. Finally, the determinants of social support will be discussed, paying particular attention to developmental influences, individual and social influences and the influence of symptoms. The chapter concludes with the appreciation and rationale of using social support theory in this study.

The African proverb “It takes a village to raise a child” (Healey & Sybertz, 1997) emphasises that upbringing is not only the responsibility of parents and immediate family but is a responsibility of the community, and this community, which includes neighbours and friends, provides support for people to enjoy a long-lasting feeling of happiness. When one scrutinises social support perspectives, there seems to be consensus among authors that a health component is vital (Brugha, 1995; Jacobson, 1986; Lakey & Cohen, 2000; Wandersman et al., 1980).

3.2. A brief history of support

A song by an American singer Dionne Warwick and friends (1982) titled *That’s what friends are for* sums up the importance of friends. One line goes like this: “For good times, and bad times, I’ll be on your side forever more, that’s what friends are for.” Friendship as part of one’s social relationships is vital for human survival, especially in times of need and distress. The intuitive importance of social relationships to people’s life goals has been confirmed by recent empirical work (Lam & Power, 1991). Mda’s (1995) *Ways of Dying* points to the value of the attention of friends. For millennia friends have always been a central part of one’s social relationships and positive friendships correlate with high self-esteem (Bagwell, Bender, Andreassi, Kinoshita, Montarello & Muller, 2005; Felton & Berry, 1992; Walen & Lachman, 2000). In essence a person’s sociability is measured by the quality of friends he or she has (Hartup & Stevens, 1997). A person who has no friends, lacks intimate social contacts, and is often lonely, is perceived to be anti-social (Chen & Feeley, 2013). It is not surprising that people mention friends as one source of support in times of need, of course in addition to family members.

The concept of social support has developed within a number of different disciplines and different theoretical frameworks.

Psychiatry: Early ideas were rooted on attachment theory as seen in the writings of Bowlby (1969) and Brewin and Champion (in Brugha, 1995). Bowlby (1969) defines attachment as a deep and long-lasting emotional bond that connects one person to another across time and space. These authors placed an emphasis on the importance of early social relationships, particularly with one parent. This implies that parents, particularly mothers, play an important role in nurturing an infant to develop the secure attachment behaviour and ultimately the ability to develop social relationships. According to attachment theory, those who display secure attachment behaviour are thought not to struggle with developing friendships, are cooperative, develop healthy intimate relationships, and are respectful, trustworthy and loving. Again this is problematic in a sense that it implies a 'negative prognosis' of the developmental path for those who did not grow up with their parents hence did not develop a secure attachment behaviour.

Biological field: Harlow's (1960) work, which was mainly in the biological field, confirmed that secure attachment behaviour could be damaged experimentally by extreme separation experiences in the early weeks of life (Brugha, 1995), which had a profound effect in adulthood. According to this theory, one's chances of healthy adaptation in adulthood are severely compromised if one experienced painful separation in infancy. Harlow's (1958) work must be viewed with caution because not all individuals who experienced separation in infancy develop depression, loneliness and lack social skills. In addition, Harlow & Zimmerman (1958) based most of their theories on research with monkeys that they isolated, which may have had the negative effect on animals behaviour, rather than purely the fact that they separated them from their parents.

Ethological studies, as seen especially in the work of Goodall (1973), also had an influence on the development of academic thinking about social support (Brugha, 1995). Goodall's (1973) studies found a pattern of clinical depression due to separation in non-human primates. Goodall (1973) makes an important contribution in that she acknowledges individual differences in her studies – i.e., not all individuals are equally affected by absent or inadequate social support.

3.2.1. Social support as a public health concept

In America the public health system has for a long time provided some social support via a network of community-based sources of medical, social and welfare assistance, and organised around community mental health centres (Brugha, 1995).

One can also argue that in South Africa the public health system has indeed been a backbone of social support, albeit informally, especially in the case of chronic diseases such as cancer and HIV and Aids. Community health workers are now recognised by the department of Health. Historically, public health workers were treated mainly as volunteers who, in line with the principles of Ubuntu, offered help to those in need without asking for or expecting anything tangible in return. This movement was started by concerned locals, churches and stokvels (social savings clubs); and later, hospices and non-governmental organisations. The idea was that willing local members should help those who cannot help themselves, especially the elderly, with day-to day basic things such as bathing, cooking and cleaning the house. It later grew to include those who were suffering from chronic diseases such as cancer and HIV and Aids. The department of health adopted this vision and embraced it by officially creating formal posts for community health workers. One of the criteria for one to be considered for the position is that one must be a local community member with the hope that

those who are sick would be receptive to the person they know or to the person they supposedly share a common goal with. This raises certain questions: Do people prefer to be helped by someone they know or by a stranger? The argument is that a known person could easily gossip to other community members and a stranger is just that, a stranger. He or she will do his or her job and leave, go back to where he or she came from. It must be kept in mind that in the olden days, a community used to share the joys, the pains, food, shelter and so forth. There was no 'outsider' in the community. It was common that a sick person would be known, and there would be means by the community, as a collective, to help him or her. Generally, the Department of Health hires a community member to become a community health worker. Even with home-based care, community members are preferred, but then again, the issue of stigma is common. Some people prefer to be helped by a stranger.

Social support has been embraced by the South African public health system in as far as employing people from the community is concerned, those who will help with instrumental support, informational support and also emotional support. Ideally, this study would want to see social support being formally introduced to help women who encounter difficulties during pregnancy, child-birth and postnatally.

3.3. Types of social support

Early research focused almost exclusively on the emotional and more subtle qualitative aspects of personal social support, particularly in relation to depressive disorders (Brugha, Bebbington, MacCarthy, Sturt, Wykes, & Potter, 1990). Two other aspects of social support have begun to dominate empirical writing, namely instrumental or tangible support and emotional or esteem-enhancing support (Cobb, 1976 and Cassel, 1976 in Brugha, 1995; Lin & Dean, 1984; Schaefer, Coyne & Lazarus, 1981; Tolsdorf, 1976).

There seems to be some consensus among social support authors that emotional, esteem, appraisal, tangible (material or instrumental), informational (cognitive) and companionship (network) components are all central in understanding the social support concept (Jacobson, 1986; Lakey & Cohen, 2000; Leahy-Warren et al., 2011; Schaefer et al., 1981; Wandersman et al., 1980).

Wandersman et al. (1980) distinguish three types of social support: emotional support, esteem support and instrumental support. Emotional support entails feelings by the recipient that they are loved and cared for.

Esteem support entails public confirmation that one is valued. Pregnancy, as seen earlier, is a period of emotional turmoil (Bashiri & Spielvogel, 1999; Bina, 2008; Cox, 1996; Jacobson, 1986) and chances are that if a pregnant woman feels devalued and taken-for-granted, she may develop negative emotional coping mechanisms. When a woman is blamed for the pregnancy, perceived as promiscuous and a threat of 'moral degeneration' (Macleod, 2011), she may internalise those opinions and begin blaming herself.

Emotional support and esteem support are indeed vital for a woman to adapt during those periods, but without instrumental support, which entails provision of tangible support such as goods and services, the woman is likely to also develop negative coping mechanisms. Such women are susceptible to opting for an abortion or to dumping their babies after giving birth. One interesting example of instrumental support in action is documented in the discussion chapter whereby the nurses (with the assistance of the KwaZulu-Natal department of health) provide nappies and milk formula to women who have recently given birth. According to the women I interviewed, it went a long way in helping them adjust to motherhood, especially bearing in mind that some of them had to deal with rejection from their partners and parents.

Jacobson (1986) also uses a triadic typology to explain types of social support. He reiterates the emotional and material support components as postulated by Wandersman et al. (1980). In addition, he interestingly adds a cognitive component of support which entails “information, knowledge and advice that helps the individual to understand his/her world and to adjust to his or her world” (p. 252). This is usually the case in the South African public health system where pregnant women attend ante-natal classes to discuss, with the healthcare professionals, physical and hormonal challenges they encounter during pregnancy and how to effectively deal with those challenges. All my participants had attended ante-natal classes before giving birth.

The Prevention of Mother-To-Child Transmission (PMTCT) programme is also an example of how cognitive support operates. In this case, women who have tested positive for HIV anti-bodies are not only given antiretroviral treatment to prevent the HI virus from being transferred to the child, they are also provided with information and knowledge on how to live positively and care for their unborn child. This extends to the post-natal period when women attend post-natal classes to be equipped with information and knowledge on how to take care of their newborns.

Shaefer et al. (1981) also mention the emotional, esteem, tangible and informational functions of social support. In addition, they discuss the network component of social support. They postulate that a person looks to his or her network for support in times of need. The Michael Jackson song (1995), ‘*You are not alone, I am here with you*’, reminds one that networks, friendships and a need to belong are vital for human survival. Even many animals live in groups and support each other through this kind of network.

Leahy-Warren et al.'s (2011) framework involves two broad categories of social support: functional support and structural support. The former consists of informational, instrumental, emotional and appraisal components. This is in line with Jacobson (1986), Scheifer et al. (1981) and Wandersman et al. (1980) who also found these functional components (informational, instrumental, emotional, appraisal) to be useful in the conceptualisation of social support. Leahy-Warren's (2011) second category (structural support) consists of formal and informal components. Formal structural support is provided by healthcare professionals and informal structural support by partners, parents, family members and significant others. In the present study both functional and structural components of social support will be considered.

3.4. Social support theory

The framework that informs this study is social support theory. This theory tries to explain how a relationship, be it good or bad, may influence the way we think, feel and behave (Lakey & Cohen, 2000). According to these authors, there are three theoretical perspectives on social support theory: the stress and coping perspective, the social constructionist perspective and the relationship perspective (see Figure 2).

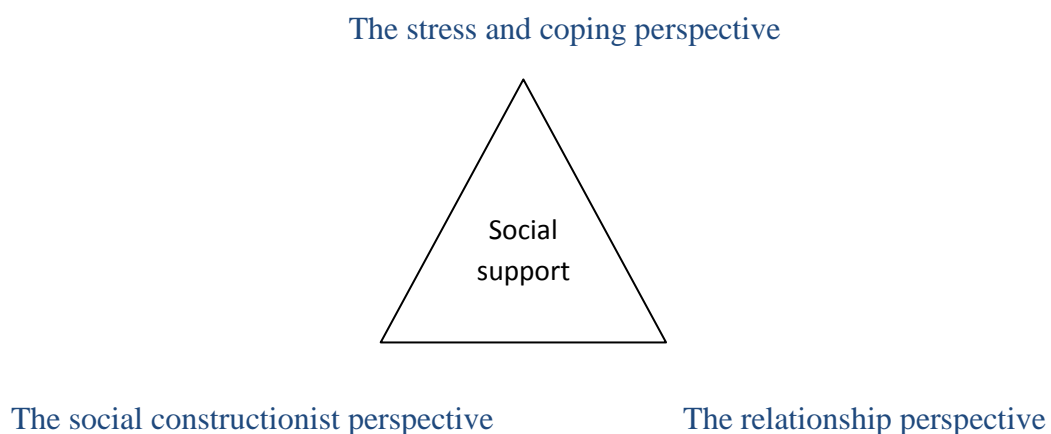


Figure 2: Three theoretical perspectives on social support

The stress and coping perspective postulates that support contributes to health by protecting people from the adverse effects of stress. The social constructionist perspective postulates that support influences health by promoting self-esteem and self-regulation, even in the presence of stress (Lakey & Cohen, 2000). The relationship perspective postulates that health the effects of social support influence relationships. In other words, if people have low levels of conflict, good companionship and positive intimacy amongst themselves, their health will be promoted. The opposite is also true.

3.4.1. The stress and coping perspective

According to Lakey and Cohen (2000) , the most influential theoretical perspective on social support postulates that support acts as a buffer; in other words, it reduces the effects of stressful life events on health through "either *supportive actions* of others or the *belief* that support is available" (p. 30). The supportive actions a person receives from others, especially significant others such as family, friends and a partner, enhance coping performance. This means that even if one experiences stressful life events, the supportive actions may *reduce the stress effects* on health. In the context of this study, this may translate to parents giving advice on how to care for a new-born, providing financial support to take care of the new-born, information on what one should avoid during pregnancy and so forth. Most importantly, the supportive actions must be appropriate to a specific context and situation. For example, a pregnant woman who feels stressed because she does not have resources to look after her child may benefit more by being offered a job than by being given advice and emotional support.

This perspective further states that the perception (belief) that support is available does indeed reduce the threat of a stressful situation (Lakey & Cohen, 2000), even if it is potentially harmful. In other words, how one interprets a situation has a bearing on how one deals with it. The more one perceives a situation in a negative light, the more stressed one becomes. Conversely, the more one perceives (and sees) a situation in a positive light, the less stressed one becomes.

Lakey and Cohen (2000) further point out two types of appraisals: primary appraisal which entails one's "judgement of whether the event is a threat" (p. 34) and secondary appraisals which entail "the evaluation of personal and social resources available to cope with the event" (p. 34). When one makes a judgement that a particular event is a threat and thinks that one does not have proper structures and resources to deal with the event, it may lead one to start negatively appraising the event as stressful and to allow negative emotions to creep in. An example would be an unemployed woman who has recently given birth who does not receive any financial support from her parents, and whose partner refuses to take responsibility for the baby. She makes a judgement that this situation is a threat, that she is all alone (primary appraisal) and decides to dump a child because she will not be able to take care of her child (secondary appraisal). How people appraise situations has a profound effect on coping. Therefore, changing a negative appraisal to a positive appraisal is deemed necessary and useful in coping with a stressful event (Lakey & Cohen, 2000).

This theory supports the view that support by family, friends, partners and professionals may act as a buffer to protect them from stressful negative emotions (Jacobson, 1986; Nakku et al., 2006; Wandersman et al., 1980). This theory further postulates that perceived support is as useful as actual support; and may help in reducing the effects of a stressful event on one's health by allowing one to interpret stressful situations less negatively.

3.4.2. The social constructionist perspective

The social constructionist perspective postulates that there is no ultimate reality. Reality is socially constructed and since people are diverse and often do not reach consensus; perceptions and interpretations of reality differ, including social support (Lakey & Cohen, 2000). Two concepts of this perspective are vital in understanding social support; these are *social cognition* and *symbolic interactionism* (Lakey & Cohen, 2000). The social cognitive view of social support is closely related to the perception of support described above in the stress and coping paradigm. The stress and coping paradigm makes clear that how one perceives a situation has a bearing on how one deals with it and the effect of the situation on one's health. Negative perceptions are a fertile ground for negative emotions and ultimately stress. The social cognitive view of social support echoes this and further states that once a person develops strong beliefs about supportiveness of others, he or she integrates this with pre-existing beliefs about social support (Lakey & Cohen, 2000), which ultimately leads to a higher level of perceived support. This is closely related to the relationship (network) component of social support postulated by Shaefer et al. (1981) in terms of which the relationships and networks that one has with significant others have a bearing on how one perceives social support. Negative relationships or poor networking with significant others may deprive one of social support (actual or perceived) in times of need.

The self plays a central role in the social cognitive perspective in the sense that whatever perception one has of the world (social relations), overlaps with and stimulates thoughts and perceptions about oneself, which in turn overlap with and have a profound effect on one's health. An example would be a person who constantly has negative thoughts about the world, which reflects in poor self-esteem, "which, in turn overlap with and stimulate emotional distress" (Lakey & Cohen, 2000, p. 37; see also Lakey & Cassady, 1990).

The premise of social cognitions is that negative thoughts about social relations stimulate negative thoughts about self, which often leads to negative emotions.

On the other hand, identity and self-esteem is the cornerstone of symbolic interactionism (Lakey & Cohen, 2000). From a symbolic interactionist perspective "social roles promote well-being through building and sustaining identity and self-esteem" (Lakey & Cohen, 2000, p. 41). In other words, when a person identifies a social role that makes sense and is fulfilling to him or her, a positive identity and self-esteem is developed which ultimately leads to positive health.

The social constructionist perspective by its very nature postulates that relations and roles are socially constructed which then, according to this perspective, means that whichever role one adopts, society prescribes how one is to behave. The role that one adopts is intricately linked with society. There are 'unwritten' rules and expectations regarding the role of father, mother, child, teacher, pastor and so forth. These roles play a very important part in identity formation (Lakey & Cohen, 2000). Negative self-identity is essentially negative social identity (Mead, 1934, in Lakey & Cohen, 2000) which translates to mean that an individual's poor health is a reflection of society's poor health.

3.4.3. The relationship perspective

This perspective may in a way be viewed as 'a stand-alone', leaning neither towards actual support nor towards perceived support or beliefs. It is in fact a constellation of hypotheses that attribute social support to relationship qualities such as low conflicts, companionship and social skills (Lakey & Cohen, 2000). When individuals have a low level of conflicts with one another, there is closeness and positive regard for one another. Companionship implies

positive relations among individuals, closeness and enjoyment of each other's company. This implies that if one has strong companionship with one's fellows, one's chances of receiving social support in times of need are high. Social skills have the potential of helping an individual develop friendships and this may in turn be useful when one needs support during stressful events. In summary, this means that relationships are important to an individual's health as Jacobson (1986) has indicated.

Brown & Harris (1978, in Brugha, 1995) emphasise the importance of a single dyadic relationship. This kind of relationship will normally be with a sexual partner and involves closeness and confiding, in which there is trust and free expression of feelings. Others have emphasised the importance of a much wider network of close relationships (Bagwell et al., 2005; Felton & Berry, 1992; Lam & Power, 1991; Walen & Lachman, 2000).

3.5. Social support concepts

Empirical research supports three distinct dimensions of social support. These are *support type* (Newcomb & Chon, 1989; Sarason, Sarason, Potter, & Antoni, 1985); *sources of support* (Brugha, Sturt, MacCarthy, Potter, Wykes, & Bebbington, 1987; Leahy-Warren et al., 2011) and *support functions* (Kirke, in Brugha, 1995; Leahy-Warren et al., 2011).

Support type refers to the amount of support received and one's satisfaction with it. This component is subjective because it depends on how the person perceives the support from others. One can give as much support as possible, but if the person supported is not satisfied, it will not be useful. The second dimension taps into sources of support. Leahy-Warren et al. (2011) distinguish between formal structural support and informal structural support, with the

latter meaning the support given by family and friends and a partner whereas the former incorporates support from healthcare professionals such as providing knowledge and advice.

The third dimension seems to be more researched than others. Many authors are interested in the function trait of social support, which includes emotional support, informational support, instrumental support, esteem support and appraisal support (Jacobson, 1986; Leahy-Warren et al., 2011; Schaefer et al., 1981; Wandersman et al., 1980).

3.6. Psychosocial theory

Brugha (1995) mentions important psychosocial theories that are interlinked with social support. These are cognitive aspects, interpersonal aspects, social skills, including assertiveness and attachment theory, social comparison, exchange and rank theory, social learning theory, coping and self-esteem and social development.

3.7. Measurement of support

Assessment of the reliability and validity with which specific concepts can be measured is vital in research. This is also the case with regard to social support concepts. The distinction between actual behaviour and perceived support must be clearly covered and articulated in measuring support (Brugha, 1995). Tangible support and emotional support must also be covered and measured. Sources of support such as who provides it (friends, a partner, family, healthcare professionals, significant others and so forth) and the quality of support must also be covered (Brugha, 1995). This will in turn tap into social relationships that are important to the respondent.

3.8. Determinants of social support

The literature clearly shows that social support plays an important role in mediating negative psychological effects that may be experienced during a stressful period, in this context during pregnancy, child-birth and postnatally (Bashiri & Spielvogel, 1999; Bina, 2008; Cox, 1996; Nakku et al., 2006; Lakey & Cohen, 2000; Reid & Meadows-Oliver, 2007; Wandersman et al., 1980). If deficits in social support play a role in the onset of psychological distress and in extreme cases psychiatric disorder, measures must be taken to correct such deficits and that requires knowledge and understanding of the determinants of social support (Brugha, 1995). Brugha (1995) identifies three determinants of social support that will be discussed below.

3.8.1. Developmental influences

It was mentioned previously that early childhood experiences, such as attachment issues (Bowlby, 1969; Goodall, 1973; Harlow, 1958, 1960; Harlow & Zimmerman, 1958) play a profound role in how one copes with stressful life events during adulthood; with the assumption that individuals who had negative childhood experiences such as separation anxiety and negative attachment styles, are susceptible to psychological distress as they become adults. These individuals fail to establish social relationships and strong social networks which may help them during times of distress. Brugha (1995) postulated that perceived support may be strongly influenced by heredity as compared with available support.

3.8.2. Individual and social influences

Authors such as Monroe and Steiner (1986) have reviewed studies showing the effects of personality factors on social support (Brugha, 1995). Some of these factors are locus of control, self-esteem and sociability. Life events, whether positive or negative, also have an effect on social support (Lloyd, in Brugha, 1995).

Individuals with internal locus of control take active steps to initiate and maintain social relationships in times of distress as compared to individuals with an external locus of control who tend to be passive (Fusilier & Ganster, 1987; Krause, 1987; Lefcourt, Martin, & Saleh, 1984). In addition, individuals with internal locus of control deal with stressful situations head-on as compared to those with an external locus of control who attribute stress to external events (Fusilier & Ganster, 1987).

Various studies (e.g., Brown, Andrews, Harris, Adler, & Bridge, 1986; Budd, Buschman, & Esch, 2009; Savi Cakar, & Karatas, 2012; Tajbakhsh & Roustafar, 2012) have attempted to find a link and correlation between social support, self-esteem and psychological distress, particularly depression; the results indicate that individuals with low self-esteem struggle to form and maintain social relations and are reluctant to seek support in times of distress. Lack of support and negative self-evaluation were also found to increase the risk of depression after the stressor has occurred (Brown et al., 1986). Budd et al. (2009) did a study with university students that specifically focussed on perceived support; their study confirmed the role of self-esteem in that they found a positive correlation between perceived social support and self-esteem. This means that individuals who perceive that support is available in times of distress tend to report higher self-esteem (and, conversely, that individuals with higher self-esteem tend to perceive that support is available).

Riggio, Watring and Throckmorton (1993) found evidence that possession of social skills was positively correlated with perceived social support. Social skills, positive outlook in life and network structures help individuals to seek support in times of distress.

3.8.3. Influences of symptoms

Symptoms of specific psychological disorders such as depression and anxiety may become stumbling blocks and prevent an individual from receiving support from significant others. This is exacerbated if the symptoms are long-standing and severe (Brugha, 1995). For example, an individual who suffers from depression may begin to withdraw, may feel suicidal and may often cry, which could further alienate him or her and frustrate those who are willing to offer support because it appears to them that their support is ineffectual and not appreciated.

3.9. Conclusion

For purposes of this study, social support was conceptualised in terms of both structural sources of support (partners, parents, family members and healthcare professionals) and functional components (emotional, informational, instrumental, cognitive appraisal and networking).

How relevant is this component of social support theory in the current study? The main research question centres on the perception and the role of support (emotional, esteem, instrumental, cognitive, informational and network) during pregnancy, child-birth and postnatally. I am of the opinion that support received by women during pregnancy, child-birth and postnatally may shield them from developing psychological distress. This support may

come from family, friends, partners and professionals such as doctors, nurses and counsellors. Social support theory appreciates the relevance and the importance of relationships, whether formal (between healthcare professionals and women who have recently given birth) or informal (a woman and her partner, family, friends, parents and significant others) in mediating psychological effects during stressful times.

CHAPTER 4

RESEARCH METHOD AND DESIGN

4.1. Introduction

Willig (2008) emphasises that it is important for researchers to adopt an epistemological stance. In other words, as a qualitative researcher one needs to clearly state how one knows what one knows. This is vital because it will demonstrate and justify why one undertakes a project and how the methods will be utilised in a project (Willig, 2008). It is also important for the research process to be interconnected, meaning that the research question, data collection methods and data analysis are dependent on each other and coherent (Willig, 2008).

This chapter discusses the methodology and methods used in this study. It describes the phenomenological research design, in particular Interpretative Phenomenological Analysis (IPA) and qualitative interpretive paradigm. The research process is comprehensively discussed. Ethical issues are further discussed, with measures to ensure trustworthiness briefly explored. The role of the researcher and practicalities of conducting qualitative research are briefly discussed.

4.2. Paradigmatic choices: Interpretive qualitative research

This study explores African Black women's perception of social support and its role in either protecting or shielding women from experiencing psychological distress and negative emotions. An Interpretative Phenomenological Analysis design that is deeply rooted in the interpretive paradigm is used in this study. The assumptions of an interpretive paradigm according to Terre Blanche et al. (2006) are that the researcher is subjective and empathetic

because the participants are sharing their subjective experiences and perceptions. The researcher does not enter the field as an expert, but is guided by the participants and builds rapport with them. Qualitative research uses a bottom-up approach whereby participants generate their data which in turn allows their voices to be heard (Willig, 2008). Qualitative research takes the complexity of individual stories, narratives and experiences into account (Coyle, in Lyons and Coyle, 2007). The value of qualitative research is that it attempts to “capture the human experience within the context of those who experienced it” (Polit & Hungler 1995, p. 16). Denscombe (1998) mentions the beauty of research, in that, from the reader’s perspective, “observations, reports and records are transformed into written words” (p. 174) which then essentially means that there is more understanding of the phenomenon.

Terre Blanche et al. (2006) posits that an interpretive researcher believes that the reality to be studied, in this case social support and how it act as psychological mediator for women who have recently given birth, consist of people’s subjective experiences of the external world. The perceptions of the participants form a crucial part of their world and these perceptions need to be respected and acknowledged.

Babbie and Mouton (2001) describe seven characteristics of qualitative research which motivated my choice of this research strategy for this study. These characteristics are briefly described below and I indicate how they were used in the current study. Qualitative research is concerned with **naturalism**, which essentially means that data are collected in a natural setting instead of obsessing with laboratory observation and conducting experiments. I went to the clinic, in a postnatal ward, to interact with the women who have recently given birth in order to try and understand their world and how they interact with one another, significant others and health practitioners when attending ante-natal clinic, during childbirth and postnatally. Babbie and Mouton (2001) postulate that qualitative research is **process-**

oriented and captures events as they occur. When data were collected in the clinic, I tried my best to capture the processes as they unfolded. These processes were the interaction between nurses and participants and the interaction among the participants. I was concerned with capturing women's narratives on their experiences during pregnancy, childbirth and postnatally hence some narratives were retrospective. **Describing and understanding** is another one of the cornerstones of qualitative research as opposed to trying to explain a phenomenon. Coyle (in Lyons and Coyle, 2007) also concur and state that qualitative research “is concerned with understanding instead of [providing] causal explanations” (p. 14). When I became interested in this topic, what was running through my head was not trying to explain what women go through during pregnancy, childbirth and after giving birth. My aim was to understand how women experience support from their partners, friends, family, nurses and doctors and the effect it this has on them. As academics and people in general, we have our own conceptions of how the world operates and we try and make sense of it. Naturally, as people we often want to be understood which partly means that our opinions should be superior to those of others. Qualitative research works in an opposite way. It is important for a researcher to wear the same glasses as those worn by participants.

Carla Willig (2008) explains that qualitative research is “concerned with meaning, which looks at how people make sense of their world and how they experience events.” (p. 8). This type of research is not about the researcher; he or she may be an expert on the subject under inquiry, but the participant is an expert on his or her life. Babbie and Mouton (2001) emphasise that it is a pillar of qualitative research for researchers to **see through the eyes of their participants**. I, as a researcher had my own conceptions of what women go through during pregnancy, childbirth and after giving birth. These conceptions have been accumulated during the course of my life through reading academic books and journals,

magazines and observation. Using the qualitative paradigm allowed for the **bracketing** of these conceptions and forced me to engage in a conversation with my participants instead of using a structured question and answer format. It is important for the researcher to understand social actions in terms of their specific **context** because contexts may easily influence how one behaves socially; for example, the woman who stays with her supportive family can behave differently from a woman who stays alone and without support. Coyle (in Lyons and Coyle, 2007) adds that “context should be both on a micro-social level, where such things as partnerships, family relationships, friends, occupational networks are taken into account and at macro-social level whereby issues such as gender, social class, ethnicity and sexuality are taken into consideration.” (p. 17-18). The holistic nature of qualitative research, context and interdependence of patterns is vital in qualitative research and it allows for an in-depth understanding of human experience (Denscombe, 1998).

Qualitative research should strive to generate new ideas from the raw data in the form of narratives from participants. The qualitative researcher makes sense of this data by extrapolating themes and generating an understanding or a theory. The idea is not to enter the ‘field’ with the theory and trying to prove or disprove it as that may limit the level of engagement with participants. Willig (2008) uses a concept called ‘representativeness’ to argue that qualitative research is not concerned that much with generalising to the population; instead, this type of inquiry is concerned with generating an understanding of the subject under inquiry. From my sample size, it is evident that I was not concerned with quantifying and generalising but instead was concerned with understanding emotions, cognitions and interactional patterns of the participants.

Babbie and Mouton (2001) and Lyons and Coyle (2007) emphasise the importance of a researcher as an instrument. Collecting useful and relevant data is dependent on the

researcher. The researcher should lay aside his or her preconceptions, preconceived ideas and biases. Establishing rapport with the participants is vital so as to elicit responses that are rich and relevant for the phenomenon under inquiry. The researcher must also remember that he or she is the co-constructor of the world, together with the participants. They influence each other and, most importantly, the researcher is a tool for data collection. How he or she conducts himself or herself is pivotal in the data collection process (Denscombe, 1998).

Another important concept in qualitative research is reflexivity. According to Willig (2008) reflexivity is “an awareness of the researcher’s contribution throughout the research process and acknowledgement of the impossibility of remaining 'outside of' one's subject matter while conducting research” (p. 10). According to Willig (2008) there are two levels of reflexivity, which are personal reflexivity and epistemological reflexivity. The former is concerned with the researcher’s values, beliefs, political commitment and interest. The latter is concerned with how the research question is defined, what can be found, and how the design of the study and method of analysis constructed the data and findings. Later in this chapter, I will give a detailed account of how these two levels of reflexivity were addressed. Coyle (in Lyons and Coyle, 2007) warns researchers that “too much reflection should be avoided because it may create an impression that analysis is more about the researcher than about the researched” (p. 20).

In their review of the history of qualitative research, Denzin and Lincoln (2005) point out the value of qualitative research, in that it provides a researcher with thick descriptions, which means that the experiences are viewed and understood from the eyes of those who experienced them. Patton (1990) concurs with the strength of qualitative research in that one “goes to the field without a set of rules or hypotheses to discover something hidden, hence qualitative researchers are called explorers or discoverers” (p. 85). Whatever a qualitative

researcher may have planned prior to the journey can be refuted or may even be flawed or wrong.

Coyle (in Lyons and Coyle, 2007) advises that qualitative research should in future integrate qualitative and quantitative elements and use qualitative methods for longitudinal research. After this inquiry, further studies may occur where I investigate the experiences of women who have been diagnosed with postnatal depression, which is qualitative in nature, and also investigate the prevalence, incidence, trends, patterns and demographics of such participants in order to understand postnatal depression quantitatively.

Coyle (in Lyons and Coyle, 2007) warns against the tendency to devote too much time and resources to method, to the detriment of answering the research question. Qualitative researchers are also reminded (by Denscombe, 1998) that descriptions are never 'pure' because they have been contaminated by the researcher and for this reason the value of reflexivity is emphasized. Maykut and Morehouse (1994, in Denscombe, 1998, p. 221) elaborate further and mention that "tolerance of ambiguity and contradictions" are part and parcel of qualitative research because the real world involves and is made up of uncertainties which are most often unpredictable.

Qualitative research has its own disadvantages, the most important being the inability to generalise research findings (Denscombe, 1998). This was perhaps the main limitation for this specific inquiry. Denscombe (1998) also adds that findings are always interpreted by the researcher, and in interpretative analysis this is even more clearly the case. During the coding and categorisation phase, the meaning is decontextualized (Denscombe, 1998) because, in most cases, the analysis happens in offices and without taking participants' context into account which could lead to meaning getting lost in 'translation'.

4.3. Research design

A research design is a strategic framework that guides the researcher in the research process (Terre Blanche et al., 2006). The design guides the researcher to adhere to his or her plans when conducting the study. The design that I used for the study was exploratory, descriptive and contextual in nature. According to Creswell (2003) this type of inquiry aims at achieving the rich, contextually informed results.

The research question was: What role does social support from the partner, family, friends and professionals play in protecting women from developing psychological distress? I explored African women's perceptions in depth to shed light on how they perceive social support in their immediate environment.

Neumann (2006) argues that the context is important in research that wants to understand the social world. This study took context into account because I was of the opinion that the same behaviours can have different meanings in different cultures. The population where the study was conducted had received little research attention; many studies that have been carried out on social support during pregnancy, childbirth and post-natally have been done on other races.

The design that I used was an interpretative phenomenological design. Willig (2008) emphasizes that phenomenology tries to “return to things themselves, as they appear to us as perceivers and to bracket what we think we know about them” (p. 52). In other words, our preconceived ideas and attitudes do not matter much when we embark on phenomenology, at least according to transcendental phenomenology. Working with women who had recently given birth from a phenomenological (transcendental) perspective allowed me to bracket my presuppositions, assumptions, ideas and interpretation, but as we will see later, it is often

impossible to do so and hence I ended up using interpretative analysis as developed by Smith (Smith & Eatough, 2007; Willig, 2008). Epoche (blocking biases and assumptions, for example by means of bracketing) is one of the cornerstones of gaining an understanding of a phenomenon (Willig, 2008), but is difficult to attain. This means that the least one can do is to reflect critically “on our customary way of knowing” (Willig, 2008, p. 54) while constructing an interpretation of the participants’ world. For purposes of this inquiry, my approach was interpretative in a sense that it is the interpretation of participants' account of emotions, cognitions and thought processes during pregnancy, childbirth and postnatally, that I engage with.

Willig (2008) makes a succinct distinction between two schools of thought within phenomenology, which are descriptive phenomenology and interpretative phenomenology. Descriptive phenomenology, which is firmly rooted in transcendental phenomenology, by its nature, posits that it is possible for researchers to minimise their interpretations and to focus on descriptions, that which “presents itself to us as humans” (p. 52). In other words, it is possible for a researcher to analyse and make sense of a phenomenon without being overly influenced by his ideas, values, politics, way of life and presuppositions. This type of phenomenology is concerned with the world as it presents itself and with a phenomenon as it occurs naturally. There is an awareness that interpretations play a very big part in how researchers analyse participants' perceptions and experiences; however, the main focus should be on what people bring before the researcher, meaning that interpretation should be minimal. Husserl (in Willig, 2008) believes that transcendental phenomenology helps researchers to transcend their biases and presuppositions by the process of reflecting and by understanding the experiences of participants from the frame of reference of participants. Interpretative phenomenology falls within the hermeneutic tradition and argues that lived

experiences are already meaningfully organised and interpreted through language since it is the tool used for knowledge production in everyday life. The hermeneutic argument is rooted in the idea that conceptions, everyday experiences, values, schooling, has a profound effect on our cognition; we cannot divorce how we know (and our experiences) from our participants' lived experiences. According to interpretative phenomenology, we must work with our presuppositions and assumptions to reach a better understanding of a phenomenon. Patton (1990) argues that the hermeneutic researcher must “have a strong interest in the phenomenon under study, an insightful mind and be a discoverer” (p. 71).

In this study, I decided to use interpretative phenomenology, specifically Smith's Interpretative Phenomenological Analysis (IPA) because it acknowledges that it is impossible to gain direct access to participants' lived experiences. The analysis of the participants' experiences is seen as an interpretation by a researcher facilitated by their interaction and a co-creation of understanding. Smith and Eatough (2007) discuss three pillars of IPA, which are phenomenology, hermeneutics and idiography; one cannot understand IPA without being conversant with these three theoretical approaches (Biggerstaff & Thompson, 2008; Shinebourne, 2011). As the name suggests, IPA is deeply rooted in phenomenology, which is concerned with people's lived experiences, and with trying to understand the subjective meanings that people ascribe to their experiences (Biggerstaff & Thompson, 2008; Shinebourne, 2011; Smith & Eatough, 2007). This study aimed to understand women's experiences during pregnancy, childbirth and post-natally and the meaning they make with the support structures available to them.

Smith and Eatough (2007) mention interesting concepts - double hermeneutic, emphatic hermeneutic and critical hermeneutic (p. 36) – which are all relevant in IPA and which I saw playing out in the interaction between the participants and myself.

IPA acknowledges that the analysis of participants' experiences is interpretative in nature (Biggerstaff & Thompson, 2008; Shinebourne, 2011; Smith and Eatough, 2007; Willig, 2008) and therefore the researcher plays an active role in co-creating meaning and understanding of participants' experiences. This process is called **double hermeneutic**, whereby “the researcher tries to make sense of how the participants make sense of his or her experiences” (Smith & Eatough, p. 36), but then the researcher also has to go a step further by engaging in meta-analysis and “second order sense-making of someone else’s experiences” (p. 36). This was evident in my interaction with the participants in that I attempted to put myself in the shoes of the participants and to engage in ‘standing back’ to allow the participants to explore their own emotions. I also engaged in second order sense-making by constantly trying to imagine how they saw me and my attempts to imagine their worlds, and adjusting my behaviour accordingly.

This brings me to the discussion of **emphatic hermeneutic** and **critical hermeneutic** (Shinebourne, 2011; Smith & Eatough, 2007). The former involves putting oneself in the shoes of the participants in order to tune oneself to the same “mental faculties” (Smith & Eatough, 2007, p. 36) that the participant currently uses. The latter broadly refers to “standing back” (p. 36) and critically asking questions of the participants’ accounts. As a researcher one needs to find a “middle ground” between emphatic and critical hermeneutics because participants may feel and sense that they are being questioned when one leans towards a more critical hermeneutic; on the other hand being too emphatic may pull a researcher into the participants' world to a point where interpretation, for the sake of analysis, becomes impossible.

Idiography completes the triadic structure of IPA (Shinebourne, 2011; Smith & Eatough, 2007). Idiography fits in with qualitative research in that both explore human experiences in-

depth. Idiography allows for deep and detailed analysis of participants' experiences because there is value in such unique experiences (Shinebourne, 2011) precisely because they cannot be quantified.

In conclusion, IPA as formulated by Smith does indeed have a theoretical basis that is deeply rooted in phenomenology. In addition, since it is a qualitative method, IPA allows for the interpretation of human experiences by the researcher; however, careful thought must be exercised during interpretation because sometimes meaning gets lost. The three philosophical underpinnings of IPA are interconnected in that there must be a phenomenon for interpretation to occur and phenomenon is best understood in an idiographic way.

4.4. Research process

4.4.1. Research participants

Neumann (2006) postulates that the main purpose of sampling in qualitative studies is to collect specific cases, events and actions that may deepen understanding of the phenomenon under study; unlike quantitative research, the purpose is not to obtain a random sample that is representative of a larger population. Qualitative research is concerned with meanings, understandings and themes that are discovered in, for example, in-depth interviews.

Purposive sampling was used to select participants for this inquiry. At times it is not easy to find participants who are willing to participate in a study, especially when the topic is emotional in nature and when the researcher is of the opposite sex (as I am), but purposive sampling increases the chances of obtaining participants who can provide useful information about the phenomenon. Mouton (2006) is of the opinion that using purposive sampling can be advantageous as it provides access to information-rich cases.

In total, I interviewed six participants. Their ages ranged from 18 to 25 years because I was cognisant of the legal age of consent in order to be interviewed. All the participants had a baby that was older than two weeks but younger than six weeks. Women who have babies within that range are required to attend a postnatal clinic. Sampling to redundancy was employed in that I felt that after interviewing six participants no new themes, issues and information arose from new interviews.

According to Terre Blanche et al. (2006), theoretical saturation occurs when one stops collecting new material because it no longer adds anything to available information that has been collected. The size of the sample was not determined in advance because I used sampling to redundancy.

4.4.2. Research setting and context

The setting was a public health clinic that women were referred to after they were discharged from the hospital. Most women in the district bring their babies to the clinic frequently.

The study was conducted in Madadeni Township, Newcastle, KwaZulu-Natal. Madadeni is a semi-urban township which is divided into seven sections. With regard to infrastructure, it has tarred roads, electricity, proper houses, running water and proper sanitation. The majority of inhabitants are below 50 years (Census, 2011). The township has four clinics and one public hospital. Each clinic has ante-natal services, a hospital welcomes women who are in labour and the hospital personnel facilitate parturition. After a day or two, women who have given birth are discharged from the hospital if there are no complications. They are required to visit a clinic with their babies after six days and thereafter to adhere to set appointments. The participants were women who were attending the post-natal appointments, with a baby

that was between two and six weeks old as I wanted to speak to women who still had fresh experiences of the pregnancy, childbirth and postnatal period. It is clear from the above that formal support systems, such as clinics, a hospital and personnel, are in place in Madadeni that may help women during these periods. As mentioned earlier, the participants were Black African women and were first time mothers.

4.4.3. Entry and establishing researcher roles

Willig (2008) emphasizes reflexivity on the part of the researcher. It is important for the researcher to be aware of his or her contribution throughout the research process and, more importantly, to acknowledge certain impossibilities. Willig (2008) differentiates between personal reflexivity and epistemological reflexivity. **Epistemological reflexivity** involves interrogating the methods and the research process, specifically “how the design of the study and the method of analysis ‘constructed’ the data and the findings” (p. 10). In my case I acknowledge that the research question was limiting in the sense that at the ‘back of my head’ the questions that I had set kept creeping in, as did the ‘answers’ I was expecting to get as a result of my theoretical reading, and consequently at times the conversation about a specific experience or topic was inadvertently cut short. However, it is also true that at times my preconceptions, and all the various methodological elements that went into the study, helped me to better understand what the research participants were telling me. **Personal reflexivity** “involves how our values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research” (p. 10). This more personal element certainly played a role in my study. The motivation to conduct this inquiry was borne out of exposure to maternity wards, and listening to women's stories after giving birth and the challenges and difficulties they encounter. My gender as a male was challenging in its own

right. Nurses kept asking: "Why are you doing this project?" Politically, as a male and a researcher, I am in a position of power (Koné, Sullivan, Senturia, Chrisman, Ciske, & Krieger, 2000; Mountian, 2013) and I was aware of these power dynamics. I was fortunate enough that, despite this, the participants were willing to share their stories.

Gaining entry to a public institution is fraught with obstacles. I identified myself as a research psychology student who would be collecting data for research purposes. Prior arrangements were made with the Department of Health to allow me access to the site. Even when access had been granted from the Department of Health, some hospital staff still felt uncomfortable with a researcher around. I made prior arrangements to visit the clinic staff before I undertook my study. I explained to them the aims and objectives of the study and the significance the study would have in women's mental health. I had previously worked in Madadeni as an assistant researcher in two very successful studies, and for that reason it was easier for me to use my social and professional networks. It was very important to establish rapport with the participants because they played the most important role in this study. I conducted one-on-one interviews with them that tapped into their personal information and they were willing to share.

The role of the researcher is of paramount importance in qualitative inquiry. The qualitative researcher is an instrument for data collection and analysis (Creswell, 2003). He or she conducts interviews as opposed to simply giving participants questionnaires to complete. He or she has control of the data collecting process, and hence it is important to be trained in how to collect data by interviewing. Fortunately I already had some experience in collecting data by conducting interviews. Facilitative communication skills, flexibility, organising skills, critical thinking skills and reflexivity, are among the skills that are useful to qualitative

researchers (Green & Thorogood, 2014), and again I was fortunate that at the time of the study I had already had some opportunity to start honing these skills.

4.4.4. Data collection methods

We tend to take interviews at ‘face-value’, without acknowledging the context and the broader processes involved (Willig, 2008). It is vital to reflect on the interview process, meaning and experience for both the interviewer and the interviewee. At the end of the interview, I asked each of the participants to reflect on the interview and whether they would like to add something that was not mentioned during the interview. Semi-structured interviews were conducted by using an interview guideline developed by myself. The interviews allowed for flexibility and became a structured conversation between myself and the participants. As much as we say semi-structured interviewing is non-directive, it is the researcher who asks questions and who steers the ship in the right direction. Smith and Eatough (2007) remind researchers that the purpose of the interview is to probe and ‘dig’ to find out more about a particular response. The interviewer is a guide rather than a dictator. The purpose is to make sure that the conversation does not diverge too far from an agreed upon topic, but is also not completely dominated by the researcher's priorities. It is important for the researcher to find a balance between controlling the conversation and allowing the participant to talk about the phenomenon or experience under inquiry in such a way as to shed light on the research question (Willig, 2008). The questions I used were open-ended, allowing the participants to answer in depth. The interview guideline was mainly to guide me to enquire about similar issues for all the participants, without unduly limiting individual variation. Each interview lasted approximately one hour.

I used techniques such as probing to elicit content rich information from the participants. The interviews were conducted in the mother tongue of all the participants, so that they would be able to express themselves freely. The interviews were then translated, by myself, to English and transcribed. I did not make use of systematic back-translation to check the accuracy of the translation as I felt that the additional effort was not warranted in this case, but I did consult with colleagues and friends who are fluent in English and isiZulu in cases where I was unsure about particular words or phrases.

4.4.5. Data analysis

The interview questions were open-ended which allowed for an opportunity for participants to share their experiences in an open manner where they could elaborate and answer questions in an in-depth manner. This led to rich and detailed information. The next question was: What then? The main principle of IPA, as is the case with all qualitative research, is to acknowledge and interpret participants' perceptions and experiences, and to try and understand what they mean (Shinebourne; 2011; Smith & Eatough, 2007; Willig, 2008), but there is an acknowledgement that the researcher cannot directly and completely enter the participants' world and experience. According to Tesch (1990), data analysis starts after the first interview, and this was also the case in the current study. I started, informally, to try and make sense of the data from the start, and this guided me in subsequent interviews and in deciding that a point of saturation had been reached.

All six interviews were recorded, transcribed and translated in order to facilitate structured and detailed interpretative phenomenological analysis. I did the transcription and translation myself, which helped me to have a clearer understanding of how participants' experiences and understanding of the nature of social support during pregnancy, childbirth, and post-natal

experiences shape their emotions and thought patterns. I was afforded the privilege of hearing the participants' stories, recording them, transcribing them, translating them and identifying recurrent themes. The advantage of using IPA is that the whole process of reading and re-reading allows researchers to immerse themselves in the text in order to find themes that will be helpful in genuinely understanding the phenomenon (Willig, 2008). I also used member checking, which involved identifying themes, and then going back to the participants to ask them whether this was a true reflection of their stories. Although the participants generally agreed with the analysis, they did in some cases contribute different perspectives and additional material, and the analysis was accordingly amended. The analysis was performed by making use of the original transcriptions in isiZulu. The illustrative extracts presented below were translated to English by me.

Smith and Eatough (2007) identify 'steps' in the IPA process which consist of, first, a detailed reading of transcripts in order to get an overall holistic view of participants. This is also echoed by Weber (1990) who emphasizes reading and re-reading the text to gain a clearer understanding of what was said. Second, a researcher who analyses data must begin identifying critical themes into clusters and check them against the data. Third, themes are refined, condensed and examined to find interrelationship and connections between them and, finally, a narrative account of the interplay between the interpretative account of the researcher and participants' account of their experiences in their own words is sketched out.

Smith and Eatough (2007), Willig (2008) and Whitebourne (2011) identify four stages of IPA:

Stage 1: Initial reading of the transcript. This is the most important stage in the analysis because the researcher wants to get the overall feel of the interview. Weber (1990) contends

that even with thematic analysis it is vital to read and re-read the text. It is suggested that one begins by writing notes, paying careful attention to detail. At this stage the researcher can also decide to write a reflective account or an interpretative account of each interview (Smith & Eatough, 2007). I did my own transcription and it was therefore relatively easy for me to get a feel of the text because it was still fresh in my memory.

Stage 2: Identifying and labelling themes. One needs to return to the transcript and use notes that were written in the margin to identify themes. In other words, the usage of notes and a transcript will clarify themes. Themes and the actual data must be connected (Smith & Eatough, 2007). In other words, themes must emanate from the data that were produced by participants. Care should be taken that while introducing theories and psychological constructs, participants' stories and subjective meanings should not be overridden. This does not do justice to principles of IPA, where interpretation is vital but the subjective component remains of paramount importance (Smith & Eatough, in Lyons & Coyle, p.55, 2007).

Stage 3: Linking themes and identifying thematic clusters. This stages calls for narrowing of themes where connections are identified between preliminary themes. Some themes could be removed or integrated into new themes. This is a stage where superordinate themes are identified (Smith & Eatough, 2007). Willig (2008) emphasizes that this stage is characterised by the "introduction of structure into the analysis" (p. 58).

Stage 4: Producing a summary table of themes with illustrative quotations. In this stage one organises superordinate themes into a table with their constituent sub-themes, with illustrative quotations. The themes and quotations must be accompanied by references (page and line numbers) where extracts can be found in the transcript (Willig, 2008). The next

chapter will discuss the results in detail, accompanied by the summary of themes in tabular form, with quotations.

4.5. Ethical considerations

In any study, ethical issues are central and must be implemented – both to avoid harm to participants and to prevent legal confrontation after the study. Permission from the Department of Psychology, University of South Africa was obtained for the commencement of the study. Permission was also obtained from the KwaZulu-Natal Department of Health. Before each interview was conducted, I reminded the participants in their mother tongue, isiZulu, that participation was voluntary. In essence, informed consent means that participants have a choice to be involved in the study. They also have the right to refuse to participate at any stage of the research process. I implemented that principle by allowing one woman to withdraw after her baby began crying and she felt uncomfortable. Participants were free to answer the questions with which they felt comfortable and did not need to answer those with which they felt uncomfortable. Willig (2008) also emphasizes the rights of participants, in that they must be fully informed about the research procedure. Deception should be avoided at all cost (Willig, 2008), and I maintained that principle in that the purpose of the research was clarified. The value of confidentiality was discussed with each participant. I assured them that the discussions would be used for research purposes only and that their names were not necessary. Anonymity was maintained throughout the research process. Participants' names were not revealed at any stage in the research process. I clearly stated the purpose, aims and objectives of the study and indicated the significance of the study and what will be done with the findings. Participants were informed that results may be published in a Masters dissertation and in academic journals, but that their names would not be published. One of

the requirements by the KwaZulu-Natal Department of Health was to provide a copy of the study results to their research unit so that they could disseminate them to the actual site that the study was conducted and ideally also to the participants. This fits in perfectly with the principle of debriefing that Willig (2008) alludes to. The participants signed a consent form indicating that they understood these conditions and agreed to participate in the study. I used a voice recorder during the interviews with each participant for later analysis. Permission to record the interview was negotiated with each participant. All the participants agreed to be recorded. The Clinical Psychologists who work at the hospital indicated that the issue of referral is of concern to them. As Clinical Psychologists, they depend on the nursing staff at the maternity ward to refer patients whom they suspect to be susceptible to postnatal depression and those who display psychological distress. This presents with two problems. First, nurses in maternity wards are not trained to see subtle symptoms of postnatal depression or subtle psychological distress. Second, women who have given birth spend little time postnatally, to be exact, two to three days, in the hospital. According to DSM-IV-TR and ICD10, the woman must present with symptoms for two weeks. By the time two weeks have elapsed, she would have been long discharged.

Discussions were held with personnel in the Clinical Psychology Unit at Madadeni Hospital who indicated their willingness to receive and deal with referrals of participants who may be susceptible to post-natal depression or who may seek further psychological help. None of the participants required such referral.

It became my duty and full responsibility to ensure that the conversations, recorded material and transcripts were safely secured. They were only available to myself and my supervisor. When the research process was finally finished the data, which comprised of recorded interviews and transcripts, were destroyed.

4.5.1. Measures to ensure trustworthiness

The goal of this qualitative study was to accurately represent participants' knowledge of the role that social support play during pregnancy, childbirth and post-natally.

For qualitative researchers, it is important to clearly show how one maintains trustworthiness in one's study. According to Lincoln and Guba's model of trustworthiness (1985), researchers must strive for credibility, transferability, dependability, confirmability and authenticity. **Credibility** was attained by the fact that my study was peer reviewed (my supervisor reviewed it and it was submitted for examination). **Transferability** in this context means that my study richly explored the narratives of African women who have recently given birth, and the role that social support from significant others play in mediating the effects of stress during pregnancy, childbirth and postnatally. I achieved **dependability** in my study by identifying consistencies in participants' perception with regard to the role that social support plays during pregnancy, childbirth and post-natally. I strived for **confirmability** by maintaining neutrality. I understood that as I enter the research field, I need to bracket my perceptions, attitudes, preconceived ideas and stereotypes about maternal issues, reproductive issues, relationship dynamics and supportive structures within an African context. I also needed to take care not to enter the field as a counsellor. Finally, **authenticity** was achieved in this study because the themes discovered were the true reflection of participant's voices, in that after identifying themes, I went back to the participants and asked them whether this was the true reflection of their narratives.

4.6. Practicalities of doing research

Research is a specific skill and as such one can learn it, but exposure to actual research is invaluable in making sure that one's skills are honed. Prior exposure to data collection was advantageous in helping me foresee potential obstacles in the data collection process.

Negotiating entry in the actual research site is often difficult because one has to go through institutions and bureaucratic officers in order to reach participants (Schwiesow, 2010). Research has often been misconstrued as an investigative activity. As a consequence, the reception that I received from the hospital personnel was somewhat suspicious. One woman was of the opinion that I was there to "dig" and "write about our failures".

In a way, it was difficult to achieve rapport with the staff, even though my research was not with them and about them. One woman remarked about my age, stating that I was young. Providing paperwork and official documentation that the study had been approved by the Department of Health proved to be useful because I was eventually perceived as less of a threat and an investigator. I was even provided with an office where I could interview the participants. During the initial stages of research planning one often allocates limited time for data collection (e.g., two weeks), without foreseeing that sometimes we do not have total control of life and circumstances. These taken-for-granted delays could include inclement weather, sickness or death in the family, and being involved in the accident.

4.7. Conclusion

It is clear that research is a process (Blankenship, 2010) and the more comprehensively it is planned, the better the chances of successfully executing it. It is often suggested that research is a journey (Gadon, 2006) and that the journey is sometimes fraught with obstacles ranging

from methodological clarity to practicalities. More often than not, social science research involves human subjects, and for that reason establishing rapport with participants and the powers that be is of utmost importance because they can break or make a study.

CHAPTER 5

RESULTS AND DISCUSSION

5.1. Introduction

The chapter begins by outlining and summarising each participant narrative regarding their family history, relationship dynamics in the family, their perceptions of the relationship (if any) they have with their partner and, most importantly, the kind of support they have received from significant others, including healthcare professionals, during pregnancy, childbirth and postnatally. This is followed by a presentation of the main themes extrapolated from the transcripts. Finally, themes emerging from data are discussed in relation to the existing literature on social support.

Pseudonyms are used throughout the discussion to protect the identity of the participants.

5.2. Summary of participants' narratives

I start with a short summary of each participant's narrative in order to provide a sketch of the lived context within which the recurring themes that are discussed later should be understood.

Participant 1 (Joy)

Joy is a 20-year-old who stays in a household with her aunt, her cousins (her aunt's children) and her siblings from her biological mother. They all have babies. Joy's mother works in Johannesburg and her father died. She has a good relationship with her siblings and cousins, but sometimes their relationship becomes tainted because of infighting among their children, with every mother protecting her child. Her aunt treats her better than her siblings, which leads to complaints and protests from them.

Joy has a good relationship with her partner and he supports the baby. She confesses that she thought of having an abortion because she was not sure whether her partner would support the baby. She changed her mind because she realized that the baby is a gift. She was disappointed in her pregnancy because she wanted to pursue tertiary studies. After falling pregnant, her family decided to withhold financial support for further studies. She decided to look for part-time jobs and succeeded, hence working while pregnant. When she started attending the ante-natal clinic in the fifth month of her pregnancy, she was told she was pregnant with twins.

Her mom, sister and brother have been supporting her financially. She made a conscious decision not to have friends because they gossip. Her partner said he would support the baby and he has duly done so. She was satisfied with the treatment she received at the clinic while attending ante-natal classes, but it was a different ball-game altogether at the hospital. After giving birth, her twins were hospitalized and doctors were rude towards her and seemed to blame her for everything bad that was happening to the twins.

She has always perceived herself as an independent person and would like to continue perceiving herself in that light. According to her, sometimes when things are not going well between a mother of a child and her partner some women displace their anger and frustration onto the baby. They shout and beat their babies.

Participant 2 (Winnie)

Winnie is 25 years old, not attending school and not working. She stays with her half-sister in Newcastle and they have a very good relationship. Her family stays in Pretoria and the relationship between her and family is not good; they are not supportive. The only person who showed love towards her in her family was her granny who has since died. The reason

why she left her family was because she could not leave her sister behind – they are close and she is very supportive.

Winnie has a good relationship with her partner, but during pregnancy the partner was not completely supportive. He hardly called and did not visit her at the hospital. She felt sad and was always crying because her boyfriend was not listening to her. Her only pillar of strength was her sister who could take leave from work to visit her at the hospital.

Winnie does not have friends because she feels they are a bad influence. She is grateful for the help that she received from the hospital. Nurses gave her pampers and baby's clothes. This is apparently a government initiative for those women who cannot afford to care for their babies. One nurse offered her a job to be a domestic worker at her house, once her baby was a few months old. She feels that she received enough support from the nurses.

Participant 3 (Amanda)

Amanda is an 18-year-old who lives with her mother, father, sister and brother. She has a good relationship with her family, but there was a subtle change when they heard that she was pregnant. She used to get everything she wanted from them before falling pregnant. Her mom was disappointed with her for falling pregnant at an early age and could not talk to her for a few days. Her dad simply withdrew. It made her feel guilty and she in turn withdrew. When the family gathered in the lounge, she would remain all alone in her room, hearing their laughter, but could not join in because she felt like an outcast. The support she received from her partner helped. He has been supportive, financially and emotionally. He always accompanied her during her clinic visits.

She is fortunate to have a large extended family, including uncles and a granny who are supportive, although they were initially disappointed when they heard about her pregnancy.

She is sad that she is no longer the centre of attention in her family. The baby has been given preferential treatment and this makes her sad but at the same time she is glad that her little one is supported.

Amanda has one friend with whom she talks about almost anything. The friend was supportive but also shocked when she first heard about her pregnancy. Amanda's dream is to see her child strong, healthy and living a long life. She has never heard of postnatal depression.

Participant 4 (Palesa)

Palesa is a 19-year-old who lives with her mother, sister and three uncles. Her dad father has passed away. She has a good relationship with her mother and with everybody at home. She feels that she disappointed her mother by falling pregnant because her mom used to tell her to finish school, to work and to be independent before having a baby. She does not have a good relationship with her sister. According to her, the bad relationship started when her sister advised her to have an abortion.

Her sister is a greedy person who only thinks of herself. Palesa is of the opinion that her sister is not in a position to tell her to have an abortion because she (her sister) kept her baby. She feels her sister is jealous of her; she wants attention and is jealous of her working boyfriend who supports her and the baby. By contrast, her sister's boyfriend is dependent on her for financial support.

Palesa's uncles are very strict, and they shouted at her when they heard about the pregnancy. Her mother did not talk to her for few weeks, but her boyfriend was supportive emotionally and financially. She was very scared to visit the clinic, so she bought a home pregnancy test and the results were positive. She told her partner first, who was supportive. Her mom was

shocked and could not talk to her for some time, but eventually she came around to the point of bringing her breakfast in bed which made her sister jealous.

Her partner always visited her in hospital, but her family rarely came, and this hurt her deeply because the hospital is within walking distance from her home. Her partner is a 'serious man' because he has also paid for 'damages' – another reason why her sister is spiteful, since her boyfriend has not yet paid for 'damages' even though she (her sister) was pregnant first. Palesa worries that her sister's jealousy will have a negative effect on her child, but she is content with the support she receives from her family and partner.

She has a friend who is very supportive. She bought her fruit, looked after her at school during pregnancy, and visits her at home. She treats her baby as if it was hers. She gives her good advice such as to ignore her sister's rants and jealousy.

Palesa was a bit worried after giving birth. Her baby had complications – shortness of breath and bubbles coming out of his mouth and nose. Apparently Palesa had to do some ritual. She had to find a widow who was wearing mourning clothes and the widow was supposed to wrap Palesa's baby around with her mourning clothes. After that ritual her baby became fine, and all the complications disappeared.

Participant 5 (Naledi)

Naledi is 24-year-old who feels closest to her granny because her mom works away from home. She has a very good relationship with her granny, who has been very supportive, financially and emotionally. Naledi has never stayed with her dad. She split up with the father of the child because he denied impregnating her. The relationship between them was fine before the pregnancy, but after he heard about the pregnancy, he left her. Luckily her

family gave her strength and supported her. She does not know why her boyfriend left, but she told him in the fifth month of pregnancy.

Naledi kept hoping that her boyfriend would change and accept responsibility, but it never happened. Currently she stays with her uncle's fiancée who is very supportive. They have a very good relationship, but she sometimes thinks that she is a burden because her uncle's fiancée has children of her own to take care of. The reason why Naledi moved in with her uncle's fiancée was because she was staying alone and she fell sick and needed to stay with someone who could take care of her. She is of the opinion that women have a natural ability to care for their babies, but circumstances lead some women to think about abortion. She has never thought of having an abortion. When women are pregnant, they are vulnerable and get angry very easily. She is of the opinion that women are dependent on their partners for support.

Participant 6 (Ntombifuthi)

Ntombifuthi is a 24-year-old and is doing N6 at a technical college. She stays with her four aunts who are all very supportive. Her parents separated (her mom stays in Nongoma, a rural village in KwaZulu-Natal, and her dad stays in Newcastle with another woman), but she has a very good relationship with both parents. Before pregnancy, she had a very good relationship with her father. He supported her financially, called her on a daily basis and fetched her from college. She confided in him, but not about everything, especially not her HIV status. She always could talk to him about family problems, but she nevertheless found it tough to tell him about pregnancy.

Her dad wanted her to finish college studies before having a baby, and this may be the reason why he was deeply hurt and shocked when he found out about her pregnancy. She tested

positive for HIV, but she gets very good support from her aunts. Her boyfriend is also supportive emotionally, financially and physically. He still accompanies her to the clinic for check-ups.

It was very difficult for her to tell her dad about the pregnancy; in fact, her mom relayed the news, and at first she could not meet her dad because she was scared, but eventually her dad confronted her. Another reason for keeping pregnancy a secret was because she wanted her dad to provide money for her studies. She felt that if he knew about the pregnancy that would be the end of her studies – her dad would in no way have given her money. Since then, he has in fact continued to give her money, but did decrease the amount he gives her monthly.

Her partner was not surprised about the pregnancy and accepted his responsibility. During the second and third month of her pregnancy, her partner started drifting away. He would tell her not to visit him because he does not find “that big belly desirable”. She says if he had not changed his mind sooner, she would have cut him off from her child’s life. She is adamant that she would have told her child that his or her father died a long time ago.

Things are back to normal again. The partner is back and supportive, and she also has a very good and supportive friend. They attend college together and share a room, and can talk about anything. She has made peace with her dad’s reaction to her pregnancy.

5.3. Presentation of results

Table 1 is a summary of the main themes and sub-themes that emerged from my analysis of the transcripts. In addition to the titles of the themes and sub-themes, I also provide representative extracts illustrating each theme and sub-theme. The participant's name and the line number in the transcript are also provided, in order to enable cross-referencing to the raw

data. I discuss each of the themes and sub-themes listed in Table 1 in more detail in the following section.

Table 1: Main themes and sub-themes emerging from the transcripts

Main themes	Sub-themes and illustrative extracts	
Theme 1: Perception of relationships	Family situation	
	<i>Stable</i>	<p>“I can say that the relationship is good because we support one another.” (Amanda, line 12)</p> <p>“It’s alright, she treats me well.” (Palesa, line 12)</p> <p>“My granny supported me in everything even today she gives me so much support. (Naledi, lines 20-21)</p> <p>“We have a very good relationship, we are very close.” (Ntombimfuthi, 18-20)</p>
	<i>Unstable</i>	<p>“Eish, it is not alright especially when it comes to children, we often have arguments” (Joy, 18-19).</p> <p>“It is not good, my granny died complaining about the treatment they gave me” (Winnie, 42)</p>
	Impact on intimate relationships	
<i>Pregnancy unexpected - "shock"</i>	<p>“He was shocked and said he will not tell his parents.” (Joy, 21)</p>	
<i>Strengthened by pregnancy - "acceptance"</i>	<p>“yes, we are an item, I’m going with him as we speak” (Winnie, 87)</p> <p>“He said ok and he knew about it (Palesa, 78)</p> <p>“He said he knew I was pregnant” (Ntombifuthi, 98)</p>	

	<p><i>Partner taking responsibility</i></p> <p>“He is the one who told me that I should go to the clinic for a check- up.” (Amanda, 75)</p> <p>“He was also still at school but he supported the child till today” (Naledi, 52)</p>
	Friendships
	<p><i>Attitude towards friendship</i></p> <p>“I just do not like friends” (Joy, 206)</p> <p><i>Sources of information and guidance</i></p> <p>“I also have neighbours that we are close with, I tell them my problems and they support me and give me advice” (Winnie, 98-99)</p> <p><i>Tangibility of friendships (real friends)</i></p> <p>“She is around, we are still friends” (Amanda, 153)</p> <p>“I was very happy and realised that she is a very good friend” (Palesa, 201)</p> <p>“Yes, I can say I have a friend” (Ntombifuthi, 149)</p>
Theme 2:	Personal reactions
Disclosure	<p><i>Emotional -</i></p> <p>“It came as a shock, I was frightened” (Joy, 90)</p> <p>“<i>shock</i>”, “<i>fear</i>”, “<i>hurt</i>”</p> <p>“I was frightened and scared because I thought my dad will give me a hiding” (Amanda, 24-25)</p> <p>“It was difficult. I was hurt because my dad was disappointed at me” (Ntombifuthi, 66)</p> <p><i>Physical -</i></p> <p>“I had to drop out of school for the whole year.” (Naledi, 49)</p> <p><i>discipline, neglect, punishment</i></p> <p>“I used to think why do they neglect me?” (Winnie, 77)</p>
	Parental response
	<p><i>Blame - “neglecting future”, regret</i></p> <p>“They said we do not want to progress in life, they could not take me to tertiary.” (Joy, 119-121)</p> <p><i>Uninvolvement</i></p> <p>“They said nothing”(Winnie, 139)</p>

Theme 3: Reactions as transitory	Transitory responses	
	<i>Emotions</i> -	“She was angry for a few days, she shouted at me.” (Amanda, 43)
	“worry”, “shock”,	“She was angry and did not talk to me.” (Palesa, 28)
	“disappointment”,	“She was worried.” (Naledi, 56)
	“anger”	“He was shocked and disappointed” (Ntombfuthi, 48)
	<i>Behaviour</i> -	“She shouted at me.” (Amanda, 43)
	“shouting”, “avoidance”	“She did not talk to me.” (Palesa, 28)
	Partner Impact	
<i>Emotions</i> -	“He was shocked” (Joy, 215)	
“shock”		
<i>Supportive</i> -	“He is the one who told me that I should go to the hospital” (Amanda, 75)	
<i>acknowledge, involved, acceptance</i>	“He said ok and he knew about this.” (Palesa, 78)	
<i>of roles and responsibilities</i>	“He echoed my sentiments and said that he knew I was pregnant” (Ntombfuthi, 98)	
<i>Non-supportive</i>	“I felt he was not there, he did not support me.” (Winnie, 116)	
<i>uninvolved</i>		
<i>denial of paternity</i>	“He behaved strangely and told me that this baby was not his.” (Naledi, 79)	
Disclosure to friends		
<i>No sharing</i>	“I do not have friends.” (Joy, 206)	
	“I do not have close friends” (Winnie, 169)	
<i>Emotions of shame</i>	“I did not tell her, guess I was ashamed.” (Amanda, 156)	

<i>Disbelief from friends</i>	“When I told her she did not believe me and said she wants to see the belly for herself.” (Palesa, 191-192)
Significant others	
<i>Emotional responses</i> - “shock”, “disappointment”	“My brother did not speak to me for a while, he was disappointed” (Joy, 187, 191) “He was shocked at first” (Amanda, 65)
<i>Behaviour</i> - “shouting”, acceptance	“My uncles shouted at me but they eventually accepted that what is done is done.” (Palesa, 61) “My sister shouted at me” (Winnie, 147)
<i>Person told first</i>	“I told my mother’s sister” (Aunt) (Joy, 167) “He (boyfriend) is the first person I told” (Amanda, 76-77) “I told my boyfriend” (Palesa, 76) “She asked me and I denied at first but I had already told her sisters” (Ntombifuthi, 82-83)
Behavioural change	
<i>Treatment of pregnant girl softens</i>	“She was caring, asking whether I was alright” (Joy, 178)
<i>Involvement in the process</i>	“I would say it got better, they no longer shouted at me, they visited me at the hospital and they are no longer as angry as before, they are happy that the baby is here and healthy” (Amanda, 91-92)
<i>improved interaction</i>	“She got used to the idea that I was pregnant and started showing affection” (Palesa, 29)
<i>Less shouting</i>	“I’m grateful that they still give me support” (Naledi, 68)

	<p>My mother eventually accepted because I was about to finish my studies but me and my dad are drifting apart. I am his child, with a child” (Ntombfuthi, 59-60)</p> <p>“He came to visit me after I was discharged from the hospital, he came with the baby’s clothes” (Winnie, 117)</p> <p>“He is the one who told me that I should go to the clinic” (Amanda, 75)</p> <p>“He could come in the morning, during the day and in the evenings. He always came” (Palesa, 117)</p> <p>“My partner is very supportive” (Ntombfuthi, 114)</p>
Emotional change	
<p><i>“happy”</i></p> <p><i>“affection”</i></p> <p><i>“amazing”</i></p>	<p>“She treated my child as if it was her own and told me that she is a second mom” (Palesa, 180)</p> <p>“My brother eventually came around, he is no longer angry at me” (Joy, 195-197)</p> <p>“She came and visited me at the hospital, she could bring everything I asked her and she took day offs at work to visit me. She was very happy for me.” (Winnie, 147)</p> <p>“He was ok and he visited me at the hospital.” (Amanda, 160)</p> <p>“They eventually accepted that what is done is done” (Palesa, 66)</p> <p>“She is alright, amazing and happy for me” (Ntombfuthi, 61)</p>
No change	
	<p>“No change because they initially said nothing” (Winnie, 161)</p> <p>“I hope he will come around one day and admit that it is his child” (Naledi, 139)</p>

		"I have not asked him yet" (Joy, 86-87)
Theme 4:	Proactive behaviour	
Partner role	<i>Bringing baby clothes</i>	"He came with the baby's clothes." (Winnie, 133)
	<i>Encourage to attend clinic</i>	"He is the one who told me that I should go to the clinic" (Amanda, 75)
	<i>Frequent visits and acceptance of paternity</i>	"I am going with him as we speak, he accompanied me to the clinic" (Winnie, 87)
		"He came to visit me after I was discharged from the hospital" (Winnie, 132)
	"He was ok and he visited me at the hospital" (Amanda, 66)	
	"He could come in the morning, during the day and in the evenings. He always came" (Palesa, 117)	
	Denial	
		"I hope he will come around one day and admit that it is his child" (Naledi, 86-87)
Theme 5:	Joint responsibility	
Social connectedness and isolation	<i>Collaboration between parents, a partner and friends</i>	"She (friend) is alright, amazing and happy for me" (Ntombifuthi, 161)
		"She (friend) treated my child as if it was her own and told me that she is a second mom" (Palesa, 203)
		"My partner is very supportive" (Ntombifuthi, 114)
		"They (parents) allowed me to get enough rest, prepared food for me. They really spoiled and loved me" (Palesa, 101)
	Isolation	
	<i>"no friends"</i>	"I just don't like friends, they gossip about other people" (Joy, 211)

	<p><i>“purposeful isolation of self”</i></p> <p>“I just don’t like friends, they gossip about other people” (Joy, 211)</p> <p>“No one supports me in my family” (Winnie, 27)</p> <p>“They hardly spoke with me and I spent most of my time alone” (Amanda, 170)</p>
Theme 6:	Physical reactions
Reactions after childbirth	<p><i>“HIV”, “Jaundice”, “Dyspnea”</i></p> <p>“My twins had jaundice and one twin had swollen hands and feet” (Joy, 246)</p> <p>“They also told me that one of my baby’s blood sugar level was decreasing because of undernourishment” (Joy, 269-279)</p> <p>“I had stress to the extent that I lost weight” (Joy, 83-84)</p>
	Psychological reactions
	<p><i>Questioning decision to continue pregnancy</i></p> <p>“I was sad, I often cried, asking myself why does he not come to visit me?” (Winnie, 134)</p> <p><i>Depression</i></p> <p>“I felt like crying” (Amanda, 103)</p> <p>“I felt sad toward my family because they were the people who were supposed to look after me” (Palesa, 120)</p> <p>“I was deeply hurt but what consoled me was the fact that this baby is his” (Naledi, 86)</p>
Theme 7:	Inability to provide financially for the baby
Adjustment challenges after childbirth	<p>“Child neglect, failing to buy milk for the baby” (Joy, 311),</p> <p>“They struggle to buy clothes for their babies” (Winnie, 237)</p> <p>“My parents won’t be able to buy food and clothes for both of us” (Amanda, 276)</p>

	<p>“Basic stuff such as food and clothes for the baby” (Palesa, 256)</p> <p>“Failing to provide for the child” (Naledi, 185)</p>
	<p>Physical challenges and demands to be taken care of</p>
<p><i>Adjusting to the new role of being a mother</i></p> <p><i>Strained relationships</i></p> <p><i>Lack of support from the family</i></p>	<p>“Physical complications after giving birth especially if it is a caesarean method” (Palesa, 251)</p> <p>“Waking up during the night and checking on my baby, I can’t sleep well” (Amanda, 218-219)</p> <p>“The father of my child did not support the baby, I had to fend for myself” (Joy, 305-305)</p> <p>“breaking up with your boyfriend” (Joy, 312)</p> <p>“Being left by your boyfriend” (Ntombifuthi, 218)</p> <p>“Not having someone to support from the family” (Joy, 313)</p> <p>“If she does not get support” (Naledi, 161)</p> <p>“I think the stress can be reduced after the baby is born if there is enough support from the family” (Amanda, 209-210)</p>
<p>Theme 8: Fragmentation of the primary healthcare services</p>	<p>Lack of interest in patient care</p> <p>“They do not care that we come afar” (Joy, 377-378)</p> <p>“They should not treat us like dirt” (Amanda, 287)</p> <p>“Take good care of their patients” (Palesa, 314)</p> <p>“Treat us like human beings” (Naledi, 204)</p> <p>“They are rude to us and tell us to wait even when they are not busy” (Naledi, 207)</p>

Professionalism: questionable ethics

“I would like for them to treat us equally”
(Joy, 371)

“Therefore we do not even get our clinic
dates” (Joy, 380)

“I think they should offer advice in a polite
and proper manner” (Amanda, 285)

“There are nurses who do not do their
work, they simply sit there and chat
completely neglecting patients” (Palesa,
314-315)

“They should have sense of urgency”
(Naledi, 206)

*Ante-natal
information provision* “They must offer insight and education on
how to rear a child, how to take good care
of a child” (Palesa, 289)

5.4. Discussion of themes emerging from the data

As previously mentioned, the main aim of this study was to explore how social support shapes women's emotions and cognitions during pregnancy, childbirth and postnatally. It was vital to explore how significant others' behaviour and feelings during this period in turn shape these women's emotions and cognitions. Psychology as a discipline has always been concerned with individuals' emotions, behaviour and cognition and with how these are shaped. Studies have shown that negative emotions, behaviour and cognitions may lead to maladaptive behaviour.

5.4.1. Perception of relationships

5.4.1.1. Family context

The participants were asked to describe the perception of their family relationships to ascertain whether they were stable or unstable. This was to gauge the environment that they find themselves in. Most participants live with either one of their parents or with extended family such as uncles or a grandmother. The relationship between them and their parents is generally stable. This question was asked in a manner that allowed participants to describe the relationship retrospectively, before pregnancy. Unsurprisingly, those participants who stayed with extended family members described their relationships in a more positive light and were much closer to their uncles, aunts and grandmothers as compared to their parents. The main reason for parents not staying with their children was attributed to the fact that they work far, in cities and towns that provide more work opportunities.

There are also some participants who perceived their family relationships as unstable. This instability was usually said to be caused by conflicts that were fuelled by parent(s) favouring

one child over the others. One participant reflected that her grandmother was the only one who ever cared for her. Her parents were not involved in her upbringing. Allowing participants to reflect on the relationship dynamics provided the context for the researcher to understand where the participants come from, and who the family members were that were involved in their lives on a daily basis.

5.4.1.2. Intimate relationship context

Most participants were in an intimate relationship when they became pregnant and for the most part the relationship was, according to them, good. As much as the pregnancy was unexpected for some, some partners were receptive and took responsibility for their actions. This is seen in three participants who reported that their boyfriends suggested they visit the clinic to check whether they are pregnant or not. When they were informed about the outcome of the result, they were not surprised and said they already knew that the participants were pregnant. Pregnancy was also perceived as strengthening the relationship. Sadly, after some partners were told about the outcome they began to drift away and one went as far as denying the paternity.

5.4.1.3. Friendships

Friendships are seen as important sources of support in times of need, and pregnancy is seen by some as a period when support becomes a necessity in order to cope with stress associated with it. The participants had different perceptions and relationships with friends. Some had a negative attitude toward friendship, seen in remarks such as “I do not like friends” and “friends gossip”. For some, friends are a source of information and support and are useful in times of need.

5.4.2. Disclosure

5.4.2.1. Personal reactions

For most participants discovering that they were pregnant came as a shock. It brings into question the participants' knowledge of reproductive health, bearing in mind that most of them were in stable relationships. One would wonder the reasoning behind them not using protection such as condoms, especially taking into account the high HIV incidence rate in South Africa. Common emotions experienced upon discovering that they were pregnant were shock, fear and hurt. The latter emotions were fuelled by fear of how their parents would respond to such news. One participant said she was fearful that her parents "will give me a hiding". Another participant was hurt because she felt she "had disappointed my parents".

The emotional burden was also accompanied by a fear of physical consequences such as punishment from authority figures, which are usually their parents. For one participant her nightmare became a reality when parents decided not to pay for her studies. Another reality facing the participants who were still at school was the fact their studies would be disturbed in one way or another. The Department of Education allows pregnant women to continue attending school until such time as birth is imminent, but owing to the shame surrounding falling pregnant at an early age, most pupils decide to halt their studies until after they deliver their babies.

Interestingly, most participants spoke about their reaction after telling significant others such as their parents, a partner or a friend. This means that their reaction was not only in response to the pregnancy per se, but also in response to how these significant others behaved towards them. Five participants felt negative emotions and had negative cognitions, but only one reported these negative emotions and cognitions before informing her parents about

pregnancy. She was very scared and confessed that she thought of abortion, but did not have guts to continue with it. One participant reported feeling happy in the early stages of her pregnancy. She said:

“I felt happy during my pregnancy. My family and friends supported me, but mostly my partner. I felt that we were in this together.”

As indicated earlier, five participants reported negative emotions and cognitions after telling significant others. It may be argued that their negative emotions were at least partly the result of their interactions with, and directed at, these significant others.

5.4.2.2. Parental responses

It is the participants' perceptions that most parents responded by blaming themselves after hearing about their girl's pregnancy. Most of the blame seemed to be centred on their own failure to take care and be involved in their children's lives. They felt that they were not involved enough to know what was happening in their children's lives. The pregnancy was in some cases seen by parents as a symptom of rebellion on the part of the pregnant women. It should be remembered that the participants were still dependent on their parents for financial and emotional support. In other words, several were staying with their parents and most of them were unemployed. From the transcripts (see also Table 1), it is evident that the parents' initial responses were transitory. Initially the parents displayed negative emotions such as worry, shock, disappointment and anger, coupled with negative behaviour towards their children, including, shouting and avoidance. As the parents got used to the idea of pregnancy, they began to accept the reality and began supporting and becoming involved in the whole process. The parents were worried about the well-being of their pregnant daughters.

The reaction of parents was negative, at least at first, in all cases. According to participants, it was because parents felt that it was not yet time for them to be pregnant. One participant stated:

“My mom was very disappointed with me because I was still in matric. She had wanted me to finish school and find employment before getting pregnant.”

There were differences in the emotions expressed by participants’ mothers and fathers. The latter usually expressed strong negative emotions such as anger, disappointment and shock. One participant did not speak with her father for the first four months of the pregnancy:

“It was a weird feeling, I was staying with him under one roof but he gave me a cold shoulder for four months.”

Mothers, on the other hand, typically cried and withdrew. One participant narrated it as follows:

“We used to be close, now she hardly speaks to me and it breaks my heart, I feel as if I failed her.”

Several of the participants started to blame themselves for how their parents felt about pregnancy. One young woman told me that she felt extremely guilty about her pregnancy and that she could not bear spending time with her parents. She said:

“When I was pregnant, I stayed in my room for most of the time. I could hear the laughter in the lounge but was too embarrassed to join in.”

It is evident that most parents had strong negative feelings when they discovered that their daughters were pregnant.

5.4.2.3. Partner Impact

When the partners were told about pregnancy, some were shocked by the news but, again, the feelings were transitory. Most partners took the news in a positive light and began to be involved in the process. They began to acknowledge and accept the roles and responsibilities of becoming a parent. They also began to support the pregnant woman. In some cases, however, partners were non-supportive and uninvolved to a point of denying the paternity. The partner of a woman who is pregnant or who has recently given birth plays a very big role in predicting how the woman will cope during this period. One participant said:

“It is sad not to be supported by your family during pregnancy, childbirth and postnatally, but to be neglected by your partner is more sad and painful.”

Four of the women who were interviewed experienced negative reactions from their partners. One reaction of partners was to feel scared. When I probed further regarding the reasons why the partners were feeling scared, a range of reasons were given. One woman said:

“My boyfriend was scared when he learnt about my pregnancy, he was scared because he did not know how he’ll tell his parents, you know, my boyfriend is not working and his parents will be mad at him for having impregnated me.”

According to these women, this feeling of being scared is what led to some of the negative behaviour by their partners. Some partners tried to run away from their responsibilities by drifting away and completely denying paternity. One woman said:

“It was very painful for me when my boyfriend denied that he was the father of my child, he said there is no way he could be the father.”

Another young woman said:

“When I told him about pregnancy, he drifted away. He told me not to visit him anymore. When I was hospitalized, he did not even bother to visit me at the hospital or even call me”.

Unfortunately for some women, the pregnancy led to the end of a relationship. One woman told her story as follows:

“We fought a lot during pregnancy, which led to us splitting. He is no longer in my life and does not even know this child ... He behaved strangely and told me that this baby is not his and was not apologetic about it but I am still waiting for him to come back and apologize.”

How do these women feel after being neglected by their partners? The woman who reported that her boyfriend denied being the father of her child showed a strong character and was always hopeful that he will come around and also felt that the support she received from her family, especially her grandmother, was helpful. This is her story:

“I was deeply hurt but what consoled me was the fact that I knew that this baby is his and I hope he will come around one day and admit that it is his child because these things happen and are normal, for people to deny responsibility but hopefully he will change. My family gave me support, they were very supportive.”

Some women were fortunate and received support from their partners. Their partners were happy when told about the pregnancy. One woman said:

“My partner was very happy when I told him about the pregnancy, I guess he expected it”.

It became evident during the interviews that how women cope with their pregnancy, childbirth and postnatal period, has a lot to do with their partners' behaviour. The more caring the partner, the better the women cope with stressors experienced during this period. One woman narrated her relationship with her partner after telling him about the pregnancy:

“He cared for the first two months of my pregnancy and he started to drift away. He continued with his childish behaviour for five months. By then I had decided that I will raise the child on my own and when he finally decided to come to his senses, I would have told my child that he died before you (the child) were born.”

5.4.2.4. Disclosure to friends

How one feels about relationships has a profound effect on how one deals with disclosure, who to tell and ultimately the supportive structures available during times of need. Some pregnant women decided not to share the news of their pregnancy because of the attitude they have towards friends; one participant went on to say that she “does not like friends, they gossip”. For some participants, friends are not available because they do not have them. They are in a way, socially isolated.

Emotions of shame are often experienced by pregnant women towards their peers. They feel ashamed for having fallen pregnant at a young age. One woman was hurt by the disbelief of her friend when she told her about the pregnancy. For most of these women, how they are treated by friends, partners and family members could be detrimental to how they process and adapt to the reality that they are pregnant.

In some instances, significant others (which include aunts, uncles and grandparents) were the first to know about the pregnancy. This is due to the fact that the participants stay with them

because their own parents work far away and sometimes only comes home during weekends and holidays. As was often the case with parents, partners and friends, significant others also responded with shock to the news that the participants were pregnant.

5.4.3. Reactions as transitory

As seen earlier, parents, partners and significant others responded with shock, disappointment, anger and disbelief to the news of pregnancy. This constellation of negative emotions is seen by these pregnant women as detrimental to their health and that of the unborn child. For most participants, however, there seemed at some point to have been a paradigm shift by the significant others from how they initially responded to the pregnancy. During the conversations with the participants it was unclear whether there is anything in particular that happened which could have triggered this sudden change of perceptions.

Behavioural and emotional change from the significant others was clearly noticed by the participants. The treatment of most of the young women softened, and parents began to be involved and to inquire about the well-being of the expectant mother. One participant recalled how her mother “allowed me to rest, brought me food in bed and asked whether I am ok”. The parents’ frustrations and shouting dissipated and there was a clear improvement in their interaction with participants. The participants reported that some relationship dynamics between them and significant others began to improve in the third trimester. In particular, the relationship between new mothers and their parents improved. According to participants, the reason for a change of heart from their parents was because the parents accepted that there is nothing that they could do to change the situation. One woman said:

“My parents finally came around, they accepted the fact that I have a baby now.”

Another woman felt disappointed at her dad:

“Even though my dad accepted pregnancy and the baby, he restricted financial support. I am still dependent on my dad but pregnancy changed everything, he decided to stop giving me his money.”

According to the participants, their mothers were more forgiving compared to fathers. This shows in the former’s behaviour. Some women said their mothers became more supportive of them and their babies. One said:

“My mother calls me every day and asks about my wellbeing and that of my child.”

The support from parents, especially mothers, plays an important role in helping new mothers to adapt to the new role of being a parent.

Transition is not always an obvious process. Some participants reported that their partners and parents had still not accepted and acknowledged the news of pregnancy. One participant remarked how hurtful it was for her that her father had decided to stop supporting her financially and another participant was heartbroken because her boyfriend still denied his paternity.

5.4.4. Partner role

The literature (Deave et al., 2008; Widarsson et al., 2012) has begun to explore the role of expectant fathers in the process of pregnancy; and there are increasing calls to include fathers in antenatal classes and in research. The participants’ accounts during the conversations shed some light on how invested some partners were in the process of pregnancy. According to their accounts, most partners displayed proactive behaviour and took at least some

responsibility for caring for the baby. They bought baby's clothes, encouraged participants to attend post-natal clinics, and frequently visited them either in hospital or at home. This in turn had a positive effect on these women because they felt they were "not alone". Unfortunately there were also partners who were less than supportive and even reluctant to accept paternity.

5.4.5. Social connectedness and isolation

Parents (if still alive), partners, friends and significant others (uncles, aunts and grandparents) were indicated as playing a very significant role in supporting the participants during pregnancy, childbirth and postnatally. Collective responsibility on their part was perceived to be vital in making participants feel connected and loved during the stressful period. Joint responsibility (friends, partners, parents) was also useful when it came to caring for the baby. One participant was grateful to her aunts for taking care of the child at night because she was not experienced enough and was temperamental, particularly because her sleeping patterns were disturbed. Self-isolation became one coping strategy by some participants who felt ashamed of falling pregnant at a young age. Parents were usually guilty of expressing disapproval of pregnancy by neglecting and rejecting their pregnant daughters. One participant felt saddened by how her parents handled the news. She had decided not to join her family during evening gatherings and, for her, self-isolation worked, albeit temporarily.

5.4.6. Reactions after childbirth

According to the participants, giving birth was exhausting, and for that reason they were looking forward to the postnatal period; however, many reported negative reactions that they began experiencing after childbirth. For clarification purposes, two broad categories of

reactions were identified. These were physical reactions and psychological reactions. The former were usually in the form of official medical diagnoses. These included Human Immuno-Deficiency Virus infection (HIV), the development of jaundice and dyspnea. The reason these medical conditions caused distress for participants was that they were often accompanied by blame on the part of the medical practitioners. The doctors kept blaming the participants for the development of these ailments in their new-borns. One woman narrates it thus:

“My twins had jaundice and one twin had swollen hands and feet. They also told me that one of my baby’s blood sugar level was decreasing because of undernourishment and the doctors blamed me for negligence.”

She went on to say that the blame broke her heart. She felt inferior and saw herself as unworthy of being a parent. This prompted her to demand that her twins be discharged and be handed over to her so that she could take care of them. This was problematic because it put the lives of her new-borns at risk.

The psychological reactions included symptoms that could be congruent with the clinical onset of depression as described in the DSM-IV-TR (2000). These included crying, feeling sad, suicidal ideation and “feel like dying”. Some participants questioned whether they had made a wise decision by not having an abortion. For them, they had thought the postnatal period would be better and that people who are supposed to be supportive would eventually provide support. This may not be about support per se, as challenges facing women postnatal will be further explored in the following section.

5.4.7. Adjustment challenges after childbirth

Inability to provide financially for the baby was one of the main concerns expressed by the participants, as has also been found in some previous research (Jackson, 1998; Schetter 2011). One woman asserted that:

“Unemployment is the root cause of all the difficulties postnatal women face. If you are unemployed, it is impossible to look after your child. Some partners disrespect their unemployed partners, they look down on you.”

A sense of failure to provide for the baby was aggravated in instances where the partner neglected his responsibilities toward his child (see also Jackson, 1998). Basic stuff such as nappies, milk formula and clothes were frequently mentioned in the discussion with the participants. They felt that a child must be provided with such items, and that failure to do so is symptomatic of being unworthy as a parent. One participant shared a story about how the regional Department of Health had provided her with basic supplies for her baby. These included nappies and milk formula for the baby. This, according to her lifted, a ‘yoke’ from her shoulders. Some participants' babies were delivered by means of a caesarean section, and that in itself was challenging. The post-operation complications became a challenge because there was an increased need to be taken care of.

Adjusting to the new role of being a mother has been cited as one of the challenges new mothers find themselves in (Rasmussen et al., 2013; Tudiver & Tudiver, 1982). The participants indeed reported that it was difficult for them to adjust to their new role, especially since it was their first pregnancy. One participant narrated her struggle to adjust her sleeping patterns because the baby woke up frequently at night. Another participant was angry because she had to give up her lifestyle in order to accommodate her child. For some

participants, living with extended family members eased some their workload because their aunts and grandmothers could take turns looking after the baby while they got some rest.

Strained relationships are difficult to deal with, and bringing a child into an environment that is not loving is emotionally draining. Participants mentioned that some relationships were not mended even after the baby was born. This, for some participants, led to alienation, and one participant remarked that she “had to fend for myself”. Another participant was unforgiving toward her partner and said: “I will tell my daughter that her father is dead.”

Lack of support from the family was also strongly believed to negatively affect women who had recently given birth. One participant said:

“Receiving a cold shoulder from your family is one of the difficulties I have seen my friends going through.”

Family for these women is vital, especially when their intimate relationship with their partners takes a fall. The situation becomes very challenging if the very same people (family) that she depends on for support reject her.

5.4.8. Fragmentation of the primary healthcare services

Most participants were not satisfied with the treatment they received from the healthcare practitioners, including doctors and nurses. Among their concerns was a lack of interest in patient care. One participant described the situation as follows:

“The nurses are rude, they are lazy, shout and neglect us, there was a woman who was sleeping next to me, she kept telling the nurses that it was time but they told her

that she knows nothing, it is them who will tell her when it's time. She went to labour on her own!"

Some women asked for patriotism from the healthcare practitioners. One woman exclaimed:

"I wonder how these people became nurses and doctors, they do not care about us!"

The participants were critical and questioned the ethics of nurses and doctors. One participant was also sceptical of the lack of antenatal information provision. She explained that as a young woman who has fallen pregnant for the first time, she would have appreciated advice and information from the healthcare professionals. She suggested that "they must offer advice on new mothers about how to care for their children".

From the above, it is evident that pregnancy, childbirth and the time immediately after giving birth is an emotionally stressful period for most women. During this period, the women depend on support from family, friends, partners and healthcare professionals to counteract negative emotions and subsequent negative behaviour that may result in a lack of social support from significant others. A simplified view of this process is shown in Figure 3.

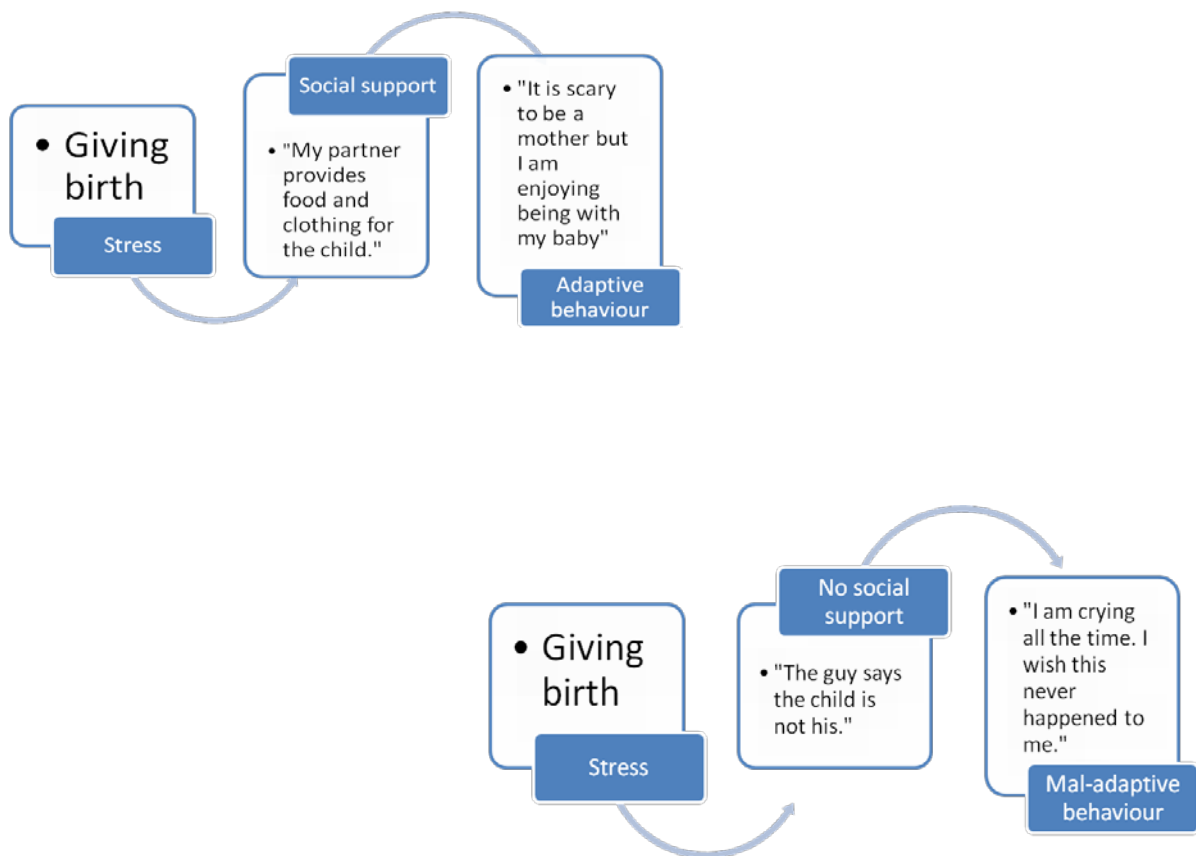


Figure 3: Simplified diagramme of the social support process

Figure 3 shows how social support helps women who have recently given birth to cope with the stress of giving birth. Giving birth is a stressful experience but social support (in this instance from the partner) helps these women to cope with the stress, and this ultimately leads to adaptive behaviour. Lack of social support may lead women to engage in maladaptive behaviour such as depression and avoidance.

5.5. Conclusion

The complex constellation of social support (or lack thereof) from family, friends, partners and significant others had a clear impact on the emotions, cognitions and general mental health of the women who were interviewed for this study. Most of these women felt negative

emotions after giving birth and by and large these emotions appeared to originate from external factors, specifically the opinions and actions of significant others.

In addition to feeling hurt by family members and friends, some women also experienced emotional injury from health professionals. In one instance, doctors and nurses kept blaming a mother for the ill health of her child, saying that she was too young to have a baby.

Fortunately, it was not doom and gloom for all participants. One woman looked back at the time of her pregnancy and compared it to her present postnatal period. She reported negative feelings during pregnancy, but now she said:

“Now I am alright and have no problem with my child.”

It was interesting to notice the thoughts of the participants after they had given birth. In spite of difficulties they encountered during pregnancy, they generally reported positive thoughts postnatally.

CHAPTER 6

CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

6.1. Summary and conclusion of study

Social support theory was the foundation for this inquiry. To put matters into perspective, different types of social support were specifically chosen for this study. These were emotional support, tangible support (Lakey & Cohen, 2000; Schaefer, 1981; Wandersman et al., 1980) and informational support (Jacobson, 1986). In addition, the esteem component (Wandersman et al., 1980) of social support and the network component (Schaefer, 1981) of social support were central in understanding the experiences of and support structures available to the participants during pregnancy, childbirth and postnatally. There is a limited amount of recent research on social support, especially in the South African context. Much of the theoretical literature on social support constructs is also somewhat dated (Brugha, 1995; Jackson, 1998; Jacobson, 1986; Sarason et al., 1985; Schaefer et al., 1981) and, possibly because social support constructs are so subjective, it has been difficult to validate them (Brugha, 1995). Nevertheless, social support theory did appear to be useful in framing and structuring the current study.

The operational definition of social support integrates the *sources* of support and *functions* of support. Research on the sources of support taps into who provides support in times of need, and into how relevant and useful each kind of support is (Leahy-Warren, 2011). Research on the functions of social support closely interrogates the intricacies of the types of social support, which includes emotional support, tangible support and informational support. As seen previously, the measurement of these constructs is not uniform and is often subjective. ‘Support’ can mean different things to different people, and therefore it is difficult to find

consensus across studies. For purposes of this inquiry, I specifically asked the participants to mention individuals who provided support during pregnancy, childbirth and post-natally; and they were further asked to elaborate on the types of support provided to them by giving practical examples.

Interpretative Phenomenological Analysis (IPA), the research approach I used in this study, is deeply rooted in phenomenology and the hermeneutic school of thought (Moerer-Urdahl & Creswell, 2004; Smith & Eatough, 2007; Willig, 2008). By its nature, IPA allows for the interpretation of participants' experiences by a researcher, which is both a strength (in that it facilitates nuanced understanding of participants' life worlds) and a weakness (in that there is always the danger of misinterpretation). As a researcher who had established rapport with the participants, member checking was possible – after completing the initial thematic analysis, I went back to the participants to ask whether the themes extrapolated from the interviews are a reasonable reflection of their responses (Goldblatt, Karnieli-Miller, & Neumann, 2011; Harper & Cole, 2012). There was general agreement among the participants that the themes and how they were presented were a true reflection (even if by no means the only possible true reflection) of their experiences during pregnancy, childbirth and in the postnatal period.

Research (Deave & Johnsson, 2008; Deave et al., 2008; Leon, 2008; Widarsson et al., 2012) has shown that pregnancy is a traumatic experience, coupled with emotional upheavals (Dalfrá et al., 2012; Rich-Edwards et al., 2006; Stocky & Lynch, 2000; Tudiver & Tudiver, 1982) and mood swings (Smith et al., 2014) that could easily push a pregnant woman 'over the edge', especially when support is limited or inappropriate (Bashiri & Spielvogel, 1999; Bina, 2008; Cox, 1996; Milgrom et al., 2008). Social support on the other hand has been shown to help pregnant women in adapting and transitioning smoothly to motherhood (Chan et al., 2002; Chandran et al., 2002; Nakku et al., 2006). Pregnancy and motherhood are

perceived as either a crisis or a transition (Glavin & Leahy-Warren, 2013; Peterson et al., 2009; Pines, 1990; Rasmussen et al., 2013; Tudiver & Tudiver, 1982), with the implication that support (from significant others, parents, friends, a partner and health professionals) is vital for adaptation for a pregnant woman during pregnancy, childbirth and in the postnatal period. The current study again demonstrated that for some women pregnancy is indeed a crisis, especially if it is unplanned and if the father of the unborn child denies paternity or shirks his responsibilities. For those women who are in stable relationships, pregnancy is seen as a transition to the new role of motherhood, especially if it is a first child.

The psychology of pregnancy, particularly the psychoanalytic perspective, explains pregnancy as a challenging moment when a woman is required to revisit her past and to evaluate the relationship that she had with her mother (Leon, 2008; Pines, 1990). If the evaluation is positive, she will develop a positive relationship with her child, but if she evaluates the relationship as having been negative she will project her negative past onto her child, leading to negative coping mechanism called regression (Leon, 2008). The family perspective perceives pregnancy as a transitional period during which new roles and responsibilities are defined in a new familial setting. In this study the relationship with family, particularly parents (but it did not stretch back to childhood), was explored and there was no evidence that those who had negative relations with their parents would regress and might displace their feelings and emotions to their babies. This of course in no way disproves the relational perspective, but it certainly was not strongly supported either. The same is true of the family perspective. The participants all became pregnant in the context of a relationship, but not within a marriage setting. Most research by family therapists that postulate that pregnancy is a transitional period during which new roles are identified in a family system is therefore not directly applicable to the context in which the current study

was conducted. The integrated approach is more comprehensive and inclusive in that individual, sociocultural, relationship and community influences are said to intertwine to provide obstacles and enabling mechanisms for a pregnant woman in dealing with pregnancy, childbirth and the postnatal period (Scheffer, 2011).

Fathers have received little attention in research on pregnancy and on the role they could play during childbirth and after the baby is born. This study attempted to understand, via the mothers, the role partners (fathers) play during this process. According to women who participated in the study, their partners could have been more involved, especially during pregnancy and soon after the birth of the baby. In particular, emotional support from their partners seemed to be vital for the participants, followed by tangible support, which includes buying simple necessities such as clothes for the baby and milk formula.

6.2. Limitations of the study

The purpose of this inquiry was to investigate and explore supportive structures that are available to pregnant women during pregnancy, childbirth and postnatally, specifically whether social support protects women from psychological distress and postnatal depression. The public health system in South Africa is faced with many challenges, including mismanagement, the high prevalence of HIV, and the physical and mental needs of women during pregnancy and childbirth (Benatar, 2013). Mental health in a public health system also faces many challenges, including insufficient resources and gaps in service delivery (Petersen & Lund, 2011). A Clinical Psychologist based in the hospital where the study was carried out confirmed the lack of resources and capacity to deal with the ever-growing number of people requiring mental health services, including pregnant women. Clinical Psychologists rely on maternity nurses to screen those women who appear to be susceptible to postnatal depression.

However, the nurses do not possess sufficient psychological knowledge with regard to emotional or psychological distress which could precipitate postnatal depression. This creates a situation where women who are susceptible to postnatal depression are left to deal with the emotional burden by themselves.

It is very difficult to find participants who have been diagnosed with postnatal depression; hence I ended up selecting women who had recently given birth so that they could share their experiences with regard to social structures and the social support that is available to them during pregnancy, childbirth and postnatally. The nature of the interviews was personal; some participants found it difficult to answer some questions which were emotional in nature.

Another limitation of the study, alluded to in an earlier chapter, relates to my gender. There can be little doubt that participants might have revealed some more intimate details of their experiences to a female researcher. However, I would like to think that I did establish good rapport with the participants, partly also because I am not that much older than they are, so that they were not overly inhibited by the fact that I am male. It is also likely that at least some of the perspectives they were able to share with me as an apparently sympathetic young professional man would not have emerged if I had been differently placed in terms of gender, age and status.

6.3. Recommendations for future research

As much as there are difficulties in the public health system with regard to screening and referring women who are susceptible to postnatal depression, there is a need to explore postnatal depression among African women. Most studies have been carried out in developed countries to the exclusion of developing countries.

In order to understand postnatal depression and psychological distress during pregnancy, childbirth and postnatally, more emphasis should be placed on the exploration of risk factors, particularly for women from low socioeconomic backgrounds and those who make use of public health services.

As seen previously, the South African public health system faces many challenges including lack of resources and capacity, in part caused by the fact that it has to compete with the private sector for suitably qualified professionals. Many professionals choose the private sector because of the attractive monetary benefits that are far beyond what the public (government) sector could offer. This leads to a situation where the public sector does not get enough professionals (psychologists) to offer psychological interventions to the community. Psychology professionals, as a collective, will have to find a way and a role they could play in providing support for women who are depressed and those who do not have support structures. However, it must be noted that that it is not the responsibility of the nursing staff only to screen and refer patients to clinical psychologists. All medical doctors are trained to identify psychological problems and distress, and refer appropriately to the respective multidisciplinary team.

There is a need for capacity development in the public health sector and the Department of Health could well benefit by providing opportunities for Psychology graduates with an Honours degree (and a six month internship) to screen women who are susceptible to postnatal depression and if necessary refer them to Clinical Psychologists. This could address the shortage of suitably qualified professionals (with psychological knowledge and background) who could help with referring those 'at risk' to Clinical Psychologists, especially taking into consideration that the Health Professions Council of South Africa

(HPCSA) and the Professional Board for Psychology have a division for Registered Counsellors who only need an Honours degree in Psychology (and a six months internship).

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APPENDIX A: INFORMED CONSENT FORM

Researcher: Khonzanani Mbatha
MA Research Psychology (Research Consultation)

Supervisor: Ms Boshadi Semanya
Department of Psychology
University of South Africa

Dear Participant

The aim of this study is to explore participants' social support structures that are available to women during pregnancy, childbirth and postnatal. Participation is voluntary and you are requested to take part in an interview which will be recorded. The interview will last between 45 minutes to an hour and there might be a need for a follow-up interview. You may discontinue the interview at any point or skip any questions you do not feel comfortable to answer without any negative consequences.

All information obtained during the course of this study is strictly confidential and will only be used for research purposes towards my dissertation. Data that may be reported in scientific journals and in my dissertation will not include any personal information which could identify you as a participant in this study.

Thank you for your cooperation

Yours sincerely

Khonzanani Mbatha

I _____ certify that I have read the consent form and volunteer to participate in this research study

Signed _____ at _____ (Place) on _____ (Date)

APPENDIX B: INTERVIEW GUIDELINES

Ask the participant to describe her current family situation. Who she stays with? The relationship patterns with parents, siblings, extended family members?

Ask the participant to briefly describe the intimate relationship patterns, whether she has friends? What is the nature of their friendship?

Retrospectively look at those relationships (parents, partner, siblings, extended family members and friends) before pregnancy?

Ask the participant to elaborate on the circumstances surrounding the pregnancy such as her initial reactions when she found out that she was pregnant? Whom did she tell first?

How was the reaction of the parents, partner, sibling (s), friend (s), and extended family members? And how it made her feel?

The kind of support (if any) she received during pregnancy. Specify the type of support (in her own words). Remembering that pregnancy is usually 9 months, was there any change of behavior from significant others (if so what was the change and why [her own words]) the sudden change?

Ask the participant to take me through the period when she was pregnant especially looking at the difficulties (if any) that she encountered and change in her routine.

Ask the participant to share her experiences of the ante-natal visits? How was the interaction between nurses and themselves (pregnant women), interaction among them as a group?

Ask the participant to share her birth experience.

Who was 'there' or who was offering support to her and elaborate on the type of support?

If the partner was supportive (specify the kind of support?). How did support (or lack thereof) make her feel?

Again the focus shifts to the health professionals (nurses and doctors)

How long are they required to stay in the hospital after giving birth?

Finally the participant is asked to share her experiences after giving birth? The postnatal reactions of significant others?

Briefly elaborate and specify on the support (if any) received after giving birth, including sources (who) of support? How she feels about the support? And the postnatal interaction at the clinic?

Difficulties she encounter postnatal or difficulties similar women encounter after giving birth?

The participant is asked whether she knows or has ever heard of postnatal depression. They are asked to describe in their own words?

Appendix C: Ethical clearance Letter (DoH)



HEALTH
KwaZulu-Natal

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
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3200
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Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM 180/10
Enquiries : Mr X Xaba
Telephone : 033 – 3952805

Dear Mr K. Mbatha

Subject: Approval of a Research Proposal

1. The research proposal titled '**Social support as a mediator of post-natal depression among African women in Madadeni township**' was reviewed by the KwaZulu-Natal Department of Health. The proposal is hereby **approved** for research to be undertaken at Madadeni hospital.
2. You are requested to take note of the following:
 - a. Make the necessary arrangement with the identified facility before commencing with your research project. The hospital Manager indicated they will allow you to conduct the study at this hospital.
 - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X Xaba on 033-3952805.

Yours Sincerely


Interim Chairperson

Date: 09/11/2010

Provincial Health Research Committee
KwaZulu-Natal Department of Health

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

Appendix D: Ethical Clearance Letter (UNISA)



Department of Psychology

01-11-2010

ETHICAL CLEARANCE OF A RESEARCH PROJECT INVOLVING HUMAN PARTICIPANTS

Project: Social support as a mediator of post-natal depression among African women in Madadeni township

Researcher: Mr. Khonzanani Mbatha

Supervisor: Ms. Boshadi Semanya (Department of Psychology, Unisa)

The proposal was evaluated for adherence to appropriate standards in respect of ethics as required by the Psychology Department of Unisa. The application was approved by the Ethics Committee without any conditions.

A handwritten signature in black ink, appearing to read 'P Kruger', is written over a light blue horizontal line.

Prof P Kruger

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