Three Black Mother's Experiences of Postnatal Depression

Marineesa Majola

Submitted in partial fulfilment for the requirements for the degree of Master of Social Science in Counselling Psychology in the School of Applied Human Sciences, College of Humanities, University of KwaZulu-Natal

Supervisor

Ms Kerry Frizelle (MSS)

2018

DECLARATION

I declare that this dissertation is my original work. All citations, data and borrowed ideas have

been duly acknowledged as being cited from other authors. The work is being submitted for the

degree of Master of Social Science (Counselling Psychology) in the College of Humanities, University of KwaZulu- Natal, Durban, South Africa. The research reported in this dissertation has not been submitted previously for any degree or examination in any other University.

Student Number   _207507932_____

Signature   _____

Date   _____

ACKNOWLEDGEMENTS

To The Almighty for making this research possible,

To my research Supervisor, Kerry Frizelle, for first saying yes to this research study, for your enduring guidance, referral of extra material, constant encouragement and finally for making me a critical scholar. Under your guidance and expertise, I was challenged and I owe a great deal of my knowledge, perspective and professional identity to you.

To the brave women and mothers who openly shared your experiences of motherhood. You allowed me the platform to address a topic I am passionate about. Therefore without you this research study would truly not have been possible,

Most importantly, to my mother and my family, for your patience, support and guidance.

ABSTRACT

This qualitative study explored the lived experiences of postnatal depression from the perspective of three Black African women living in South Africa. A large body of the present literature is from the Western perspective based on White middle-class women. Qualitative research on Black African women's experiences of postnatal depression in South Africa is underrepresented. Quantitative literature currently available in South Africa focuses on identification and treatment of postnatal depression or on the relationship between postnatal depression and child development. While this quantitative body of research is important and highlights the context of motherhood it does not open the lived experience of postnatal depression up for exploration (Mauthner, 1998). The present research study aimed to open up the experience of postnatal depression for qualitative exploration from the position of Black South African women. Given the study's exploratory position, the study explored how mothers experience motherhood and the factors that these mothers felt contributed to their postnatal depression. Three Black African mothers' who were diagnosed with postnatal depression were purposively selected to share their experiences. Data was collected through the use of semi-structured interviews and analysed using interpretive phenomenological analysis. Analysis of the data illustrates that, from the perspective of the participating mothers, wider social expectations of motherhood, adjustment to motherhood, social pressure and perceived fear of judgement contributed to women developing postnatal depression. It is recommended that mental health and public health professionals should consistently provide all mothers regardless of their circumstances and demographics with information on motherhood including childbirth and labor.

TABLE OF CONTENTS

List of Appendices

CHAPTER ONE
INTRODUCTION

In this introductory chapter the idea that motherhood is a social construct, rather than an innate biological truth will be introduced. The reasons for the study will be discussed alongside its aims and the questions it aims to answer. A brief overview of the research design and thesis structure will be provided.

1.1.   Motherhood as a social construct

Discussions about women's role in society predate the 20th century. In Greek mythology, the story of Demeter and Persephone reigns significant (O'Reilly, 2010). In this mythological tale, Persephone, who is the daughter of Demeter, is abducted by Hades, the God of the Underworld. Demeter sets out on a quest to find Persephone. During her abduction, Persephone undergoes a transformation and develops into a woman (O' Reilly, 2010). O'Reilly (2010) argues that this tale is synonymous with social constructions of motherhood and femininity because as a mother Demeter neglects all other aspects of her life in order to rescue her daughter and through her role is portrayed as protective, nurturing, and devoted. Demeter's self-sacrificial nature and complete devotion to Persephone's safety marks a Western traditional view of mothering and what motherhood is about. An assumption can be drawn from this tale; that mothers should be self-sacrificing and completely devoted to their children. Chodorow (1999) further argues that motherhood is socially presented as a biologically determined phenomenon. Women's mothering is viewed as a natural act (Chodorow, 1999). Even from a young age, through role training, girls are taught to be mothers and that they should mother (Chodorow, 1999; Hadd, 1990). Motherhood is socially portrayed as instinctual, inevitable and unchanging. What is ignored by such essentialist ideas of motherhood is the way in which this role is socially constructed and mediated.

The traditional view on motherhood continues to dominate; however, a wave of critical thinking has emerged over time, notably through feminist theorists. Feminist theorists openly question and challenge dominant gender discourses because of the way in which they position women in society; namely as submissive, natural homemakers and caregivers. Feminist theory argues that motherhood is not a natural or biological function (O'Reilly, 2004). Motherhood is, rather, a cultural *practice* which is redesigned in accordance with

shifting economic and societal factors (O'Reilly, 2004). Feminism is concerned with providing alternate explanations to subject matter (Chodorow, 1999). In the context of mothering, feminist writers do not rely on but, rather, overtly challenge biological assumptions (Chodorow, 1999).

Hays (1996) first introduced the term 'intensive mothering' to refer to expectations that mothers should be the main care-givers of their children, dedicate a great deal of time to mothering their children and consider mothering as more important than paid employment (Hays, 1996, cited in O'Reilly, 2004). The premise is that good mothering involves mothers who remain at home with the sole aim of taking care of their children. As a result of this expectation mothers may experience guilt when they try to conform to the demands of intensive mothering (Hays, 1996, cited in O'Reilly, 2004). Intensive mothering poses cultural concerns about a mother's ability to provide adequate mothering if they are, for example, employed (Damaske, 2013). The problematic assumption is that employment interferes with a woman's ability to appropriately mother her child if she is engaged in other activities. Similar to the concept of intensive mothering, Damaske (2013) introduced the term 'the mommy mystique', which refers to the widely held belief that women are responsible for child-care, child rearing and making decisions that are in the best interest of their children. Furthermore, in being so positioned, women are simultaneously held accountable for anything that may go wrong. Under such circumstances, she must resolve these issues in private. The assumption then is that motherhood is a double-edged sword; if mothering is done 'correctly' mothers are glorified and in the event of the inverse mothers are blamed and vilified (Warner, 2005). The discourse on motherhood, therefore, subjects mothers to intense scrutiny (Damaske, 2013).

Motherhood is an institution (Rich, 1987). The institutionalization of motherhood refers to the way in which society has allocated certain responsibilities and duties exclusively to women (Nicolson, 1998). The argument is that women mother because the role has been culturally reinforced by society (Hadd, 1990). Hadd (1990) coined the phrase 'the cult of motherhood' to refer to the socially constructed belief that there exists an innate and sacred bond between a mother and her child and as a result of this mothers have a need to tend to their children exclusively. Despite the prominence of motherhood as a social institution and the universal expectation that all women will become mothers, the everyday reality is that the actual practicalities and realities of motherhood are mostly invisible (Nicolson, 1998).

Motherhood is a private and personal relationship, however, this experience is influenced by the social context in which women are embedded (Hadd, 1990).

Historically, women's role in society has been largely prescribed occupationally, economically, socially, politically and domestically. All of the above factors are intertwined. Writing about the Western context, Hadd (1990) argues that the Industrial Revolution changed the role of the family. It was accepted and expected that women would remain at home to mother children while men worked outside of the household (Hadd, 1990). Science and popular culture combined to assert that women's place was at home with their children (Hadd, 1990). As such many women were financially dependent on men. Post Industrial Revolution, women's position and role in the household and society began to shift. Women increasingly entered the employment sector, but this sector was still prescriptive because women's labour was restricted to certain fields of employment and they were still expected to be mothers and to mother children, solely.

Warner (2005) posed the question: "What kind of life is it when you have to choose between becoming a mother and remaining yourself?" (p. 53) in reference to the choices offered to women. According to Warner (2005) motherhood forces women into a balancing act, a choice between one's pre-motherhood and one's post-motherhood identities. Warner (2005) refers to the 'The Mess of Motherhood', which is a result of the contradictory messages that women have to decipher and the hidden anecdotes that may be surmised if women do not live up to the ideal of motherhood. 'The Mess' further refers to the fact that women are led to believe that their life's journey leads them to motherhood and as a result women buy into a vision of motherhood that sets them up to be left feeling dissatisfied with their lives (Warner, 2005). Due to the pressure (heterosexual) women impose on themselves; many begin to resent their male partners (Warner, 2005) who are not affixed to the same standards or pressure. Warner (2005) argues that many women are likely to experience anxiety and depression as their expectations of motherhood do not match their experiences of motherhood (Warner, 2005). Many women lose themselves in their motherhood role and this loss can be experienced as depression (Warner, 2005). In their article on mental health, Held and Rutherford (2012) argue that given the discursive position that women are solely responsible for child-rearing, an unhappy or depressed mother is perceived as a mother who has not fully adjusted to her role as a mother. An unhappy mothering experience contradicts the dominant discourse of motherhood as happy and joyful (Held & Rutherford, 2012; Nicolson, 1998).

Postnatal depression is conceptualized as depression that occurs within the first year of childbirth (Nicolson, 2001). The symptoms of postnatal depression are similar to the symptoms of clinical depression as outlined in the American Psychological Association (Nicolson, 2001) and these include a depressed mood, loss of interest in enjoyed activities, changes in appetite, weight and sleep, psychomotor activity, fatigue, feelings of worthlessness, difficulty concentrating and recurrent thoughts of death (Beck, 1999). Further symptoms associated with postnatal depression include anxiety, a sense of being overwhelmed and irritability (Kruckman & Smith, 2000). The prevalence rates of postnatal depression are currently variable, however, an estimated average of 13% of women become depressed following childbirth (Beck, 1999). The current risk factors associated with the development of postnatal depression are conceptualized within the biopsychosocial model of mental disorders (Pierre & Lynn, 2007). Factors associated with the development of postnatal depression identified include, amongst others, a lack of social support after childbirth (Beck, 1999; Kruckman & Smith, 2000), previous history of depression (Bashiri & Spielvogel, 1998; Beck, 1999), stressful life events (Robertson, Grace, Wallington & Stewart, 2004), marital status (Nakku, Nakasi & Mirembe, 2006) and traumatic birth experiences (Oakley, 1980; Parry, 2006). Hormonal changes following childbirth have also been associated with the development of postnatal depression (Beck, 1999; Dalton, 1980).

The Edinburgh Postnatal Depression Scale (EPDS), a 10-item self-report questionnaire was developed to detect postnatal depression (Cox, Holden & Sagovsky, 1987). The questionnaire measures mood, sleep patterns and appetite disturbances in the last seven days (Cox, Murray & Chapman, 1993; Henning, 2015). A cut-off score of ≥ 11 is used to determine postnatal depression (Cox et al., 1987). This screening tool was first developed in the United Kingdom and it has since been validated for use in many countries, South Africa included (Lawrie, Hofmeyr, de Jager & Berk, 1998).

The history of postnatal depression can be traced back to the 19th century (Westall & Liamputtong, 2011). Various explanatory models have been presented in an attempt to understand postnatal depression. These will be discussed in the following chapter. What is significant to note is that a certain stigma exists around postnatal depression and this stigma may be as a result of the way in which motherhood has been socially constructed (Littlewood & McHugh, 1997). Given that contemporary motherhood is viewed as a natural and feminine

quality, postnatal depression, which is associated with motherhood, is viewed as unnatural and society condemns the unnatural mother (Littlewood & McHugh, 1997). Shaikh and Kauppi (2015) conducted a study on postnatal depression and in this study the researcher's provide a critical foundation for understanding postnatal depression. According to Shaikh and Kauppi (2015) social constructionism is concerned with how meaning is derived in society and how society attaches meaning to social conditions. By this premise, postnatal depression is understood as a socially constructed condition.

1.2. Reasons for the study

The aim of this study is to provide a qualitative, phenomenological exploration of three Black African women's experiences of postnatal depression. Three Black African women were selected for the study as they represent a minority in the face of research on postnatal depression. Most of the research focusing on postnatal depression is from the Western perspective which documents the experiences of white middle-class women (Mauthner, 1995; Miller, 2007; Nicolson, 1998; Shaikh, Montgomery & White, 2011). Current information available on postnatal depression in South Africa is based on quantitative measures with a focus on prevalence (Ramchandani, Richter, Stein & Norris, 2009; Tomlinson, Cooper, Statin, Swartz & Molleno, 2006), aetiology, symptoms and consequences. One study which explored women's experiences of postnatal depression reported on Indian women's experiences (Kathree & Petersen, 2012). While the above body of quantitative research is invaluable in understanding postnatal depression, it does not account for how Black African, South African women account for and experience postnatal depression. This is the focus of the current study. A further aim of this study was to attempt to deconstruct social and cultural myths of motherhood in order to reduce the pressure that women place upon themselves to conform to the ideals of motherhood (Biltsza, Eriksen, Buist & Milgrom, 2005). Various authors argue that medicalized childbirth and the social construction of motherhood prevents women from acknowledging their struggles of motherhood (Kauppi, Montgomery, Shaikh, & White, 2011; Oakley, 1980) and receiving the kinds of support they need. The present study, therefore, also aimed to explore the extent to which mothers internalize problematic constructions of motherhood and whether this leads to troubled experiences around motherhood, which manifest as postnatal depression.

1.3. Research questions

The present study aimed to explore the following questions:

(1) How do three Black African, South African mothers construct motherhood?

(2) What are the factors that these mothers perceive as contributing towards their postnatal depression?

(3) How do these mothers negotiate their postnatal depression?

(4) How do these mothers cope with postnatal depression while simultaneously assimilating the role of motherhood?

(5) What do these mothers feel can be done to help other mothers with postnatal depression?

1.4. Research design

This study is a qualitative study based on an interpretative phenomenological perspective. Interpretative phenomenological analysis is a branch of qualitative research that is concerned with examining individuals' lived experience, more particularly how individuals make sense of their experiences and the interpretations that individuals subscribe to a given phenomenon (Eatough & Smith, 2008; Smith, Jarman & Osborn, 1999). In this case, the study explores the lived experiences of three Black African women who have been diagnosed with postnatal depression. This is an appropriate design because the present study aims to understand how these mothers make sense of and experience postnatal depression. Of significance in interpretative phenomenological analysis is that the researcher also plays a pertinent role in the research as the researcher interprets the participants' experiences (Eatough & Smith, 2008).

1.5. Thesis structure

This introductory chapter provided an overview of motherhood as a social construct and how this social construction continues to inform current motherhood ideology and practices. Chapter two consists of a review of previous literature on motherhood and postnatal depression. This chapter serves to demonstrate how the social construction of motherhood may serve as a precursor to women developing postnatal depression. Chapter three consists of the methodology of the present study. This chapter includes the research design, sampling procedures as well as a description of interpretative phenomenological analysis which is the method used to analyse the data. Chapter four consists of an analysis as well as a discussion of the analysis in relation to relevant literature and theory. Chapter five entails the conclusion, the study's limitations as well as the implications for future practice.

The introductory chapter has aimed to provide a rationale for the study and has indicated the gap in the literature that it aims to address.

CHAPTER TWO
LITERATURE REVIEW

2.1. Introduction

The literature review covers a body of literature and research on postnatal depression. The review begins with a definition and an explanation of postnatal depression. Three dominant explanatory models associated with the development of postnatal depression are then discussed. This chapter presents a linear discussion of a womens' transition and journey into motherhood, which includes the experiences of pregnancy and childbirth and how these processes have been medicalized over the years and are associated with the development of postnatal depression. This chapter explores the dominant discourses on motherhood and the consequences of such discourses on a woman's ability to mother. The need for a focus on postnatal depression in the South African context is discussed. The chapter ends with the theoretical framework which underpins the present study.

2.2. Definition of postnatal depression

Pregnancy, childbirth and motherhood are recognized as sensitive periods that have an effect on a woman's mental health (Mauthner, 1998). Three types of psychological problems can impact on women's mental health around this time (Chrisler & Johnston-Robledo, 2002; Mauthner, 1998) namely; the baby blues, postpartum psychosis and postnatal depression. The baby blues, which occurs between 3-10 days after childbirth is characterized by weeping, sadness, irritability, confusion (Romito, 1990; Wisner, Parry & Piontek, 2002), anxiety, mood changes, insomnia and dysphoria (Chinawa et al., 2016) . Postpartum psychosis, which occurs within the first two weeks following childbirth is characterized by disorganized thoughts, odd behaviours, hallucinations and delusions (Romito, 1990; Wisner et al., 2002). Lastly, postnatal depression, which is the current research study's focus, is defined as "depression that occurs during the first 12 months following childbirth" (Nicolson, 1998, p. 27). Other definitions identify postnatal depression as a form of non-psychotic depression that occurs within the first year of childbirth (Beck, 2000; Stewart, Robertson, Dennis & Wallington, 2003). What these definitions have in common is the recognition that postnatal depression is depression that occurs *after* childbirth. Similar to depression, postnatal depression is accompanied by, amongst other symptoms, a low mood and loss of interest and enjoyment in activities (Murray, Cooper & Hipwell, 2003), sleep disturbances, excessive

guilt and suicidal ideation (Canadian Psychiatry Association, 2004; Lazarus & Rossouw, 2015), fatigue and lack of appetite (Fowles, 1998; Lazarus & Rossouw, 2015).

Many studies attempt to establish the prevalence rates of postnatal depression. In Western contexts, current prevalence rates illustrate that approximately 7% to 20% of women experience depression after childbirth (Beck, 1999; Forman, Videbech, Hedegaard, Salvig & Secher, 2000; Zinga, Phillip & Born, 2005). In African contexts, studies illustrate that 22.4% (Chinawa et al., 2016; Dattijo, 2016) of women become depressed after childbirth. In Asian countries prevalence rates of postnatal depression range between 3.5% to 63.3% (Klainin & Arthur, 2009). And in South Africa, which is the focus of the current research, past studies have suggested that 34.7% of women experience postnatal depression (Cooper, Tomlinson, Swartz, Woolgar, Murray & Molteno, 1999).

Currently two paradigms exist in explaining and understanding the etiology of postnatal depression. The first is the medical model, which explains that internal factors such as personality and biophysical factors cause postnatal depression in women (McIntosh, 1993). Within this model, biophysical factors such as hormone changes following childbirth have been implicated in the development of postnatal depression (Martinez, et al., 2000; McIntosh, 1993; Nicolson, 1998). From this perspective, postnatal depression is conceptualized as an illness or disease. The second paradigm that explains the etiology of postnatal depression is the social model. Within this model, social factors within the individual's circumstances are implicated in the development of postnatal depression (McIntosh, 1993). From this perspective, postnatal depression is believed to be a woman's reaction to entering motherhood, her role in society and the family and her position in relation to men (Miles, 1998; Nicolson, 1998). Other research supports this view, whereby other social factors such as marital status, unplanned pregnancy, infant gender and negative life events are associated with the development off postnatal depression (Nakko et al., 2006). From the social perspective, the stressors and demands of motherhood have been further implicated in the development of postnatal depression (McIntosh, 1993). Mauthner (1998) argues that the difference between the two paradigms is that the medical model objectifies women's experiences following childbirth, while the social perspective subjectifies women's experiences following childbirth.

2.3. Criticism of the medical model of postnatal depression

As previously mentioned, within the medical model, postnatal depression is understood as an illness or disease (Liamputtong & Naksook, 2005). This model has been critiqued by feminist scholars based on the overall position that it ignores the wider sociopolitical context in which women's role in society are embedded. One of the criticisms of the medical model is that it colludes with dominant constructions of motherhood as a natural, happy and problem free experience and views women who fall out of this norm as pathological (Mauthner, 1993). According to Mauthner (1993) classifying postnatal depression as an illness or disease, hides the social nature of women's problems. The medical model portrays women as passive recipients of postnatal depression (Mauthner, 1993). The medical model is further critiqued for being deterministic as it fails to consider individual and varied circumstances that impact on women's daily ability to mother (Mauthner, 1993). A further criticism of the medical model is that the individual mother is blamed while the wider sociopolitical context in which women's experiences are embedded is ignored (Mauthner, 1993).

A final criticism of the medical model is that women's voices are disregarded (Mauthner, 1993). This means that women's individual accounts related to their experiences is not acknowledged. The consequence of ignoring women's subjective accounts is that it engenders reluctance for women to share in their experiences (Mauthner, 1993). Mauthner (1993) argues that a feminist understanding should be adopted towards understanding postnatal depression because it explores postnatal depression from the perspective of women thus providing a voice for women to speak about their subjective experiences. Lewis and Nicolson (1998) further implore that a restructuring of knowledge on depression after childbirth is required, one that encompasses women's subjective experiences.

2.4. Pregnancy, childbirth and early motherhood

Childbirth marks a significant event in any woman's life as it is recognized as a rite of passage (Oates, et al., 2004). Oakley (1980) argues that childbirth is a biological act that is shaped by culture. As pregnancy and childbirth are tasks associated with motherhood, it is assumed that women should know naturally how to birth a child. According to Oakley (1980) childbirth is now a medically driven phenomenon. Oakley (1980) introduced the concept 'medicalization of childbirth' to highlight how women are subjected to medical technology to facilitate childbirth. This implies that women have limited control over their bodies (Oakley,

1980). In Baker, Henshaw and Tree's (2005) study women felt that they were inadequately prepared for the birthing process. Women further felt disregarded and ignored and this had a negative impact on their childbirth process.

In Parry's (2008) study on women's choice of childbirth, the researcher found that many women consciously chose midwifery care over medically assisted childbirth. Women found that midwifery care afforded them the opportunity to play an active role in their birthing process and provided the women with women-centered and emotional care (Parry, 2008) where their needs were taken into consideration and they were further provided with emotional support during labor and childbirth (Parry, 2008). Research on women's negative experiences of childbirth and labor has been largely documented. Research shows that highly assisted births into which women are inadequately orientated results in women developing posttraumatic stress disorder (Touhy, 2008; Weisman et al., 2000; Zaers & Ehlert, 2008). If a woman felt ill-prepared for birth and required high technologically assisted delivery, this led to her questioning her adequacy as a woman and as a mother because of her internalized assumptions that giving birth is a natural and easy process.

A study conducted by Miller (2007) explores primiparous (first time) mothers' experiences of birthing and motherhood. In the study, the women held the belief that birthing is a natural process and had anticipated that they would know how to birth a child. However, the women struggled with the birthing process. Not only were they shocked with the birthing process, but they also felt betrayed by their bodies. Of further significance is that the women's disappointment in their birthing experience was associated with the discourse around childbirth being an optimistic and positive experience for mothers. The women in Miller's (2007) study felt let down by the ideal of childbirth. Berggren-Clive's (1996) study on women's experiences of depression following childbirth portrays how the medicalization of childbirth is linked to postnatal depression. The women in the study described how traumatic and medicalized births led to women feeling ill-prepared for the birth which impacted on their self-esteem and was associated with the development of postnatal depression. In the study, some of the women underwent emergency caesarean sections due to complications. Women were isolated and not consulted during the birthing process and this had a significant impact on their perceived lack of control. The negative birthing experiences conflicted with women's expectations of birth which resulted in feelings of disappointment in self and other. Staneva and Wittkowski's (2012) also found that the notion of childbirth as a natural process

is implicated with the development of postnatal depression. Upon experiencing childbirth, the women realized that their expectations of birth did not match their actual birthing experience. The birthing expectations that women develop are due to the sociocultural context that dictates how women should experience major life events.

Childbirth as a medical phenomenon was further critiqued by Taylor (1995). Taylor (1995) delineates that medicine is "an institution of social control that frames women's unhappiness, alienation, and discontent in psychiatric terms" (p. 26). Taylor (1995) conducted a qualitative longitudinal study in which 52 women were interviewed postpartum in order to understand their experiences as mothers and the association between their circumstances and postnatal depression. Four major emotional states emerged from the study; guilt, anxiety, depression and anger. Guilt occurred because the mothers' feelings for their new born baby did not match their expectations. Anxiety was associated with care and nurturance because women were afraid of caring for their babies as they feared that they would not meet the needs of their babies. Depression, which was associated with feelings of sadness, hopelessness and worthlessness, occurred when women perceived themselves as failures to achieve the maternal ideal of fulfilment and satisfaction in motherhood. Lastly, anger was associated with the feeling the mothers' had towards significant others in their lives including partners and their new born child. Anger towards partners arose out of the women's realization that their partners failed to share in the childcare and domestic duties. Anger towards the new born child arose out of the realization that the women realized that motherhood entailed self-sacrifice and that the women felt the needs of the child 'had to' be placed above their own.

Taylor (1995), who's research was predominantly from the perspective of white middle-class women, argues that postnatal depression is a "socially constructed emotion that is associated with the white middle-class model of motherhood as a caring, nurturing relationship that is primarily women's responsibility" (p. 41). Taylor (1995) further argues that because women's experiences of motherhood deviate from the norm, women are labelled as ill. Women's suffering is then understood according to a medical and psychiatric context as opposed to a structural and political context (Taylor, 1995). This has consequences as it emphasises an individual medical solution rather than a collective structural solution (Taylor, 1995). Of significance in this argument is that, according to Taylor (1995), postnatal depression explains that women do not conform to the maternal ideal and this challenges the dominant discourses of motherhood. Ussher (2006) maintains that pathologising women's

distress following childbirth implies that women are suffering from an illness, which is abnormal. Rather, one should attempt to understand that women's experiences following childbirth are an understandable response to mothering in a context where women attempt to live up to impossible mothering ideals of femininity and motherhood. Taylor's (1995) research, although conducted in the West, is valuable in that it recognises the role that the social, structural and political contexts have on women and their mothering experiences.

2.5. Motherhood

2.5.1. The transition into motherhood

Mother is a term used to refer to women who give birth to a child and cares for and raises a child (Card, 1996). *Mothering* refers to "a socially constructed set of activities and relationships involved in nurturing and caring for people" (Glenn, Brown & Forcey, 1994, p. 357). *Motherhood* is a task or stage of women's development (Phoenix, Woollett & Lloyd, 1991). It encompasses the daily management of children's lives and the daily care provided for them (Phoenix et al., 1991). The transition into motherhood in itself is difficult.

In Barclay, Everitt, Rogan, Shmied and Wyllie's (1997) study the mothers' experienced a lack of confidence to mother and they experienced a sense of being overwhelmed. The women in the study realized that they had to rely on their own resources in order to cope with motherhood and ultimately adjust to their new motherhood role. Although the women in the study were not diagnosed with postnatal depression the authors recognize that women who become mothers have to undergo a period of reconstructing themselves and the significant losses such a process engenders. This study demonstrates that the transition into motherhood requires a renegotiation of relationships in which new mothers have to incorporate their new sense of self as a mother, which is initially difficult to do. By this token, motherhood involves a move from a "known, current reality to an unknown, new reality" (Mercer, 2004, p. 226) a reality that requires an adjustment to an unknown role.

A further change that women have to adjust to upon entering motherhood is changes in physiology, body size, function and shape (Nicolson, 1998). According to Nicolson (1988) dominant views of mothers as happy, healthy and energetic maintains a hold on the public and clinical imagination and it is due to this imagery that depression after childbirth is seen as a problem that needs to be treated. Given that motherhood is considered a move from one

identity state to another, of importance is that motherhood is not a unitary experience for women and that women do not experience it similarly (Arendell, 2000).

2.5.2. The good mother and the bad mother

The socially constructed view of motherhood sets the standard in terms of what is good mothering and bad mothering (Choi, Hershaw, Baker & Tree, 2005). The good mother, Takseva (2017) maintains, is constructed as one who puts her children's needs first, suppresses her own needs, never tires and never loses patience. A good mother is one who is satisfied in her new social role (Kauppi et al., 2011). A good mother is one who is able to intuitively determine what her child needs when he/she signals distress (Chodorow, 1999). The good mother is one who stays home and makes her children's development her primary focus (Gorman & Fritzsche, 2002).

In their study on the good mother stereotype, Gorman and Fritzsche (2002) examined university students' perceptions of mothers' commitment and satisfaction to motherhood based on the mother's employment status. The authors found that employed mothers are viewed as less committed to their role as mothers than unemployed mothers. The researchers found that women who stopped or temporarily halted their employment following childbirth were viewed as self-less and, therefore, a good mother.

Parker (1995), a psychoanalytic feminist, engages with the idea of good and bad mothering. The good mother is presented as one who is able to handle a baby's aggression, destructive impulses, is able to contain her own and still demonstrate love towards her child (Parker, 1995). A bad mother is one who is unable to contain a baby's aggression and punishes the baby due to pent up anger (Parker, 1995). The good mother is equated with being passive and feminine (Parker, 1995). Women who fail to achieve this maternal ideal are seen as resisting femininity (Parker, 1995). This suggests that the maternal ideal is a status achieved by women to assert their femininity and that women who do not achieve this are perceived as unfeminine. Negative reactions to motherhood are seen as a failing on the part of the bad mother, rather than an outcome of the unrealistic expectations and demands of motherhood. The idea of the idealized good mother forces women to face the difficulty of trying to achieve this role in isolation as few would want to be seen as bad by sharing their experiences (Walls, 2007). It results in women criticizing themselves and their efforts at mothering. Almond

(2010) uses the term 'modern maternally correct' mothers to describe women who strive to be perfect as mothers because it is expected of them.

Silva (1996) recognises that traditional views of motherhood regard marriage and motherhood as synonymous concepts. Therefore, to be a good mother one has to be married (to a man) and marriage should be accompanied by motherhood. This view in itself implies that women who are not married and are mothers are problematic, that is, bad mothers. Siegel (1990) maintains that the good enough mother concept means that women are judged by patriarchal standards which assumes that mothers are unremittingly available to their children. Nicolson (1998) also argues that the discourse of motherhood is rooted in a patriarchal society which she contends provides little room for deviation. To support this view, Siegel (1990) implores us to accept women's limitations in meeting all of their children's needs. To take it further, motherhood should be viewed as a *process* of adjustment as the term recognizers that cognitive, emotional, behavioural, social, cultural and even economic circumstances can facilitate and hinder women's transition into this life role.

2.5.3. Expectations versus reality

Rich (1986) argues that motherhood is surrounded by certain expectations which require women to have a maternal instinct, to be selfless and love their children unconditionally. Rich (1986) argues that these expectations do not reflect the true experiences of motherhood. Rich (1986) contends that the institution of motherhood is not a reality, however, it shapes circumstances of individual's lives by creating prescriptions and conditions which dictate how women should act or not act. Parker (1995) maintains that women who are caught up in the myths of motherhood experience a shock when they experience failure to live up to the imaginary status. Kauppi et al. (2011) demonstrate how social constructions of motherhood impacted on the participating women's experiences of motherhood and how this ultimately resulted in the women experiencing depression following childbirth. According to these authors, women feel pressured to conform to established standards of motherhood and this results in women experiencing a sense of being overwhelmed when their expectations of motherhood do not match with their experiences of motherhood. Lazarus and Rossouw (2015) also found that when actual experiences of motherhood fail to complement prior expectations, women are more likely to experience depression because they believe that they are not engaging in mothering correctly.

The social construction of motherhood as a happy event was further implicated in the development of postnatal depression in the study by Lewis and Nicolson (1998). The study demonstrates how discourses surrounding motherhood led mothers in the study to experience incongruence between their expectations upon entering motherhood and their actual experiences of motherhood. The study by Staneva and Wittkowski (2012) demonstrates that the dissonance between women's expectations and their actual experiences of motherhood contributes towards the development of postnatal depression. As previously mentioned, the dominant ideology of the good mother maintains that women are naturally able to adjust and cope with motherhood. However this was not experienced by women in Bilszta, Eriksen, Buist and Milgrom's (2005) study which found that women who internalize the maternal ideal are at risk of developing postnatal depression when they perceive that they have failed to live up to this ideal.

The mother's in Knaak's (2010) study held core beliefs of what constitutes good mothering. These core beliefs included the ideas that good mothers breast feed their children, are completely attentive to their child and that bonding with one's child is natural and instant. However, the women in the study struggled to reconcile with these previously held expectations and as a result experienced depression after childbirth. Motherhood is assumed to be a women's destiny and primary identity and getting it 'right' defines a woman (Mauthner, 2010). Mauthner (2010) contends that women experience postnatal depression when they cannot live up to culturally derived and unrealistic standards.

2.6. Maternal role attainment

'Maternal role attainment' is defined as a complex social and cognitive process that is influenced by changes in a woman's which leads to a woman achieving the maternal role identity (Rubin, cited in Mercer, 2004). The attainment of a maternal role occurs through a process of information gathering, observations, consultations with experts, role playing and fantasies about one's self (Rubin, cited in Mercer, 2004). According to Rubin (cited in Mercer, 2004) maternal role attainment includes an analysis of one's self-image, ideal image and body image. Of significance is that maternal role attainment is not transferred to a subsequent child (Rubin, cited in Mercer, 2004). This suggests that each child a woman has, requires a new restructuring and consolidation of the maternal identity. Thornton and Nardi (1975) proposed four stages of role attainment. These stages begin from pregnancy to the

postnatal period and the theory relays the process in which women begin to mother and later gain competency in their mothering abilities.

Mercer (2004) critiques the attainment of a maternal role as it creates the impression that the maternal identity is acquired through a linear and homogenous process regardless of a woman's circumstances. For example, in her paper, Mercer (2004) argues that a woman's maternal identity continues to change and this change is influenced by the relationship a mother has with her child, her social circumstances, and her competence and confidence in her mothering abilities. As such Mercer (2004) calls for a restructuring and renaming of the maternal role attainment to 'becoming a mother' as this delineates the continual process of renegotiation, integration and growth of women's maternal identity.

Motherhood is a transition and women should not be expected to naturally and instinctively adapt to it. Women are misled to believe that they must immediately adapt to the role of mother and engage in mothering effortlessly and as a result women question their worth and abilities as mothers when their processes of mothering are not represented in the dominant discourse on mothering. It is ultimately this very discrepancy that is associated with the development of postnatal depression. It is these very prescriptions of motherhood and mothering which suggest that there is only one way to mother. A review of the literature indicates that women occupy various roles in society and these contribute towards psychosocial pressure which impacts on women's mental health (Doucet, Letourneau & Stoppard, 2010). Motherhood is one of the roles that women occupy and the standards set for mothering is implicated in the development of postnatal depression.

2.7. Consequences of Motherhood

2.7.1. Loss

The socially constructed view of motherhood presents motherhood as joyous and fulfilling. It is celebrated culturally, with rituals and practices set aside for new mothers (Nahas & Amasheh, 1999). Furthermore, the joys of motherhood are openly shared and spoken about. As celebrated and joyous as motherhood can be, the changes, challenges and responsibilities that accompany motherhood are not as openly acknowledged or spoken about. Hence this section is aimed at addressing the difficulties and challenges that women experience when

they become mothers rather than focusing on the positive experiences when women enter motherhood, which undoubtedly exist.

Motherhood, as previously mentioned, is a move from one identity to another. It is a move from being a non-mother to being a mother. This identity is presented as a naturally acquired identity. However, acquiring this identity results, simultaneously, in the loss of a previous identity as it marks a redefinition of a woman's identity (Lewis & Nicolson, 1998) and ultimately a reconstruction of self (Barclay et al., 1997). To this end motherhood is marked by a series of losses (Barclay et al., 1997; Lewis & Nicolson, 1998). These losses, Nicolson (1998) maintains, are losses that a woman has to grieve and come to terms with. One of the losses alluded to above is the loss of identity and sense of individual self (Oakley, 1980). According to Nicolson (1998) "with the first childbirth the old status of non-mother is annihilated because of the central importance of 'mother' in relation to female identity and the ideological symmetry between "woman and mother" (p. 85). The premise is that both identities have equal reward. Therefore, when a woman becomes a mother, even though the original identity of being a woman is lost she cannot mourn the loss due to social constraints and the unconscious acceptance of these constraints (Nicolson, 1998). Becoming a mother can result in the loss of autonomy, identity and independence (Lewis & Nicolson, 1998). This loss, Lewis and Nicolson (1998) contend, can result in the development of postnatal depression. Nicolson (1998) further contends that becoming a mother represents a move towards a social status and these results in the loss of a former identity.

In her study on women's experiences of postnatal depression, Nicolson (1998) found that women experienced loss of autonomy, identity and employment status upon becoming mothers and these losses resulted in the development of postnatal depression in women. A further finding was demonstrated in Mauthner's (1995) study and in the study by Bilszta et al. (2005) whereby women experienced the loss of a previous life they had before their babies were born. Staneva and Wittkowski's (2012) study also demonstrates how becoming a mother results in some women experiencing a loss of time, sexuality and occupational identity. Oakley (1980) argues that lost identity after the birth of a child can be seen as a form of bereavement (Oakley, 1980). According to Oakley (1980) motherhood overshadows one's sense of personal identity. Oakley (1980) further contends that a woman will never recover a full sense of her own personal identity after she becomes a mother. This, Oakley (1980) maintains, is due to cultural categorization of the reproduction of motherhood. Once a woman

becomes a mother, the maternal identity supersedes all other facets that also define who she is.

Kauppi et al. (2011) contend that the postnatal period should be considered as a metamorphosis for women. Women shed part of their former selves including relationships, roles and activities which are incompatible with motherhood as they adapt to their social roles. Therefore by understanding that motherhood requires a reconciling and restructuring of an old identity with a new identity, one should recognize that this process requires certain degrees of adjustments which women need to make and come to terms with.

2.7.2. Shame and guilt

Rich (1986) maintains that mothers feeling of having failed their children results in maternal guilt. Rich (1986) further speaks of the anger that every mother has towards her children based on impossible expectations. As previously mentioned, motherhood and mothering consists of many tasks and activities which women are expected to fulfil. A new mother is expected to provide for her new born baby with "a tremendous amount of attention, love and care" (Romito, Saurel-Cubizolles & Lelong, 1999, p. 1651). Similarly, a new mother is expected to be delighted at the prospect of being a mother (Romito, 1990). Failure to live up to the perfect mother ideal results in women internalizing it as personal failure (Hennig, 2015). If a new mother is unhappy at this prospect she may experience guilt and subsequently she is blamed for not living up to society's expectations of her role (Kauppi et al., 2011; Marshall, 1991; Takseva, 2017). The women in the study by Bilszta et al. (2005) also experienced feelings of shame and disappointment which contributed towards their postnatal depression when they experienced a loss of control over their lives when they became mothers.

2.7.3. A culture of silence

Much of the literature on women's transition into and experiences of motherhood documents that there exists a culture of silence whereby women opt to remain silent about their struggles with motherhood. Lewis and Nicolson (1998) aimed to understand 36 mothers' experiences around their transition into early motherhood and found that mothers experienced many challenges upon becoming mothers. Mothers were, however, afraid to speak about their negative motherhood experiences. Lewis and Nicolson (1998) recognize that the social

construction on motherhood prevents women from acknowledging and even speaking about their negative experiences as mothers. In her book "The mother knot", Jane Lazarre (1976) presents a raw and unashamed account of her motherhood experiences. She experienced a degree of ambiguity around her pregnancy and being a mother and describes her misery and frustrations when her infant would cry incessantly and proved difficult to soothe. The author further points to the lack of support from other mothers and her experiences of suffering in silence after her initial frustrations were met with rebuke and condemnation. A culture of silence exists around postnatal depression. Women are afraid to speak about their struggles in motherhood and as a result suffer in silence (Homewood, Tweed, Cree & Crossley, 2009).

The culture of silence surrounding women's experiences of motherhood was further evident in Mauthner's study (1995).   In her study on women's accounts of their postnatal depression, the women either remained silent, pretended to cope with motherhood or withdrew from their social relationships when they perceived that their experiences of motherhood contrasted with other mothers' experiences of motherhood. These mothers labelled themselves as bad mothers and felt that they were doing something wrong. The mothers in the study perceived other mothers to be much happier and competent in their mothering role (Mauthner, 1995). The women in the study believed that they would be rejected or alienated if they spoke of their experiences on motherhood. This precipitated and perpetuated a cycle of silence, withdrawal and isolation (Mauthner, 1995).

Miller (2007) argues that women who remain silent about their normal difficulties and uncertainties with motherhood help unintentionally perpetuate the myth that motherhood is instinctive and natural. This was evident in the study by Biltsza et al. (2005) which explored women's experiences of postnatal depression. The researchers found that upon their transition to motherhood, women believed that they would know how to mother and that they would cope with mothering infants. However, the women struggled to cope with motherhood but were afraid to acknowledge and seek out help due to fear of being stigmatized. Beck's (1999) study on women's experiences of postnatal depression found that women were reluctant to discuss how they really felt about their mothering difficulties due to feelings of shame.

Frizelle and Kell (2010) sought to explore the impact that the social context had on women's mothering abilities. Through focus group interview with six white-middle class South African women, the researchers found that women's mothering existed in accordance with the

dominant discourses of motherhood, which continue to prevail such as the premise of the ever present mother who has naturally taken to her motherhood role. The researchers further found that a silence exists around motherhood which is generated by the women's belief that they should be able to inherently cope with motherhood. This belief was in relation to the dominant discourse on motherhood that women should be able to cope with motherhood. When these women struggled with coping with motherhood they remained silent because they believed that would be a poor reflection of their mothering abilities. This study provides valuable insight into how women internalize dominant discourse on motherhood and use this as a frame of reference as to how mothering should be done. Ultimately dominant discourses on motherhood impacted on women's mothering abilities.

2.7.4. Maternal ambivalence

Parker (1995), a feminist psychoanalytic theorist, critically engages with the term maternal ambivalence, which refers to the presence of both loving and hating feelings towards one's child. Maternal ambivalence refers to mixed feelings a mother has about her child (Parker, 1995). It is a conflict a mother feels at different times of a child's development (Parker, 1995). Of further importance is that maternal ambivalence can be experienced with any child a mother has be it the first, second or third child. Almond (2010) adds that maternal ambivalence further refers to the feelings of anxiety, shame and guilt that a mother feels about having these feelings.

Research conducted by Lonia, Katowa-Mukwato, Dixey and Maimbolwa (2014) indicates that women do experience maternal ambivalence. Rich (1986), for example, unabashedly acknowledged that she felt love and hate for her infant son. The authors argue that ambivalence is a normal process and experience of motherhood. Almond (2010) also sees maternal ambivalence as a normal and inevitable process of mothering. Parker (1995) argues that maternal ambivalence is not a problem in itself; rather it is how a mother manages these mixed feelings she has about her baby that may have problematic outcomes. According to Almond (2010) viewing maternal ambivalence as a normal response to mothering will encourage women to seek help without fear of judgment or condemnation. Almond (2010) recognizes that most cultures have little tolerance for maternal ambivalence.

Maternal ambivalence can be understood as conflicting with social constructions of motherhood and expectations that are imposed on women to engage in motherhood in a rigid

and stereotypic manner (Mertan, 1976). Maternal ambivalence is a process that is experienced by mothers; however, it is rejected by society and defended against by mothers as it negates the maternal ideal. This then silences women who do experience ambivalence. As a result, the experience of maternal ambivalence may contribute towards the development of postnatal depression in women. Fry (2007) makes the point that women are exposed to the sanitized and mythical version of motherhood and that failure to achieve this imaginary status is experienced as a failure (Kedgley, 1996; Nicolson, 1999).

2.7.5. Mother blaming

Mother blaming refers to "mothers being held responsible for the actions, behaviours, health and well-being of their children (even adult) children" (Jackson & Mannix, 2004, p. 150). Women are subsequently judged if they do not fit in with society's standards of idealized motherhood and if they behave in ways which is considered inappropriate for mothers (Jackson & Mannix, 2004). According to Jackson and Mannix (2004) mother blaming is a phenomenon that emanates from family, friends, society, health, health professionals and women themselves. Jackson and Mannix (2004) conducted a study on mother blaming in which 20 women were interviewed about their experiences of mother blaming. The researchers found that women felt that there was a burden placed upon them by others. The study illustrates how external pressures of idealized motherhood were then internalized by the women. The women in the study felt the burden of blame in the context of their children's deviant behavior and physical ill-health. Of further significance is that women were reluctant to consult with health professionals due to perceived fear of blame and judgement. Women questioned themselves as mothers and attributed self-blame for their children's behavioural and emotional problems. Ultimately the burden of blame imposed on women resulted in feelings of guilt, inadequacy, anger and self-blame.

Elvin-Nowak and Thomsson's (2001) study on the social construction of motherhood in Sweden, highlights how women develop a sense of unchallenged responsibility in the context of child care and how this responsibility becomes engrained to the extent that if children engage in deviant behavior, women place the responsibility of blame on to themselves.

2.8.   The media and its association with postnatal depression

The media also plays an important role in perpetuating the maternal ideal and in further prescribing women's role in society. McIntosh's (1993) study demonstrates how expectations

of motherhood were informed by romanticized notions in the media. The study further demonstrates how women perceived themselves as bad mothers when they could not identify with romanticized notions of mothering as depicted by the media. A similar finding is illustrated in Kauppi et al. (2011). Magazines on pregnancy are further associated with women becoming depressed after childbirth. Magazines glorify motherhood by illustrating the positive images associated with motherhood and simultaneously neglecting to illustrate the negative experiences that women go through as mothers. These magazines illustrate the nuclear family, with a mother, father and baby present. This image itself is hurtful to many women as research shows that lack of support from one's partner is implicated in women developing postnatal depression.

2.9. Research on postnatal depression in South Africa

As mentioned previously, the prevalence rates of postnatal depression are variable however in Western culture an estimated 10-15% of women develop postnatal depression (Lawrie et al, 1998). In South Africa, an estimated average of 34.7% of women has been diagnosed with postnatal depression (Peltzer & Shikwane, 2011). A review of the literature illustrates that a psychological, social and biological factors are associated with women developing postnatal depression (Beck, 1999). Psychological factors associated with women developing postnatal depression are stressful life events, history of depression and anxiety during pregnancy (Abdollahi, Sazlina, Zain, Zarghami, Jafarabadi & Lye, 2014). Social factors such as unplanned pregnancy (Beck, 2001), lack of support during and after pregnancy (Cooper & Murray, 1998) and low socioeconomic status (Beck, 2001) have been associated with the development of postnatal depression. The biological factor associated with women developing postnatal depression is hormonal changes (Dalton, 1996) such as changes in progesterone and estrogen levels after childbirth (Beck, 1999). A metasynthesis carried out by Beck (2001) further identified that low self-esteem, child care stress and infant temperament as factors that pose the greatest risk that contributes towards women developing postnatal depression.

As mentioned previously, the Edinburgh Postnatal Depression Scale (EPDS) is a screening tool used to assess postnatal depression. Given its primary use as a screening tool for postnatal depression, the EPDS is quantitatively used to diagnose, treat and prevent postnatal depression in primary health care settings. To illustrate, Forman et al. (2000) conducted a longitudinal study to identify the prevalence rates of women with postnatal depression.

Through the use of the EPDS, large samples of women were assessed from the pre to the postnatal period. The study found that 5.5% of women had postnatal depression. Factors identified in the development of postnatal depression were low socioeconomic status (SES), lack of social support and social isolation.

The need for identification and interventions for postnatal depression was illustrated in the study conducted by Mallikarjun and Oyebode (2008). In their study the researchers focused exclusively on the prevention of postnatal depression. The researchers found that postnatal depression has adverse effects on women, their children and the family. As a result of the risk postnatal depression imposes on the family, the researchers recommend that women are screened for postnatal depression. Such screening included the use of EPDS and, thereafter, further psychiatric assessments as required. The study identified psychosocial, psychological and pharmacological interventions in treating postnatal depression. Psychosocial interventions include antenatal and postnatal classes as well as parenting classes. Psychological interventions include psychotherapy and pharmacological interventions include antidepressant medication (Mallikarjun & Oyebode, 2008). In a study conducted by Abdollahi et al. (2014) the researchers recommended that women who display high risk of postnatal depression should be assessed further and should be provided with individual treatment. Radoš, Tadinac and Herman's (2013) study investigated the prevalence of postnatal depression through the use of the EPDS, the Beck Depression Inventory (BDI-II) and the Structured Clinical Interview (SCID). The results of the study show that 8.1% of women had postnatal depression. Implications' following these results was the recognition for support for women such as prenatal classes or counselling during the postpartum depression.

The use of the EPDS has even grown internationally. For example Husain, Husain, Chaudry, Atif and Rahman (2006) conducted a study to assess the prevalence of postnatal depression in a sample of Pakistani women. Through the use of the EPDS as a screening tool for postnatal depression, the researchers found that 36% of the women had postnatal depression. Their postnatal depression was related to stressful life events and poor social support during the postpartum period. The recommendation following this study was the need to provide further support to new mothers. De Tychey et al. (2005) conducted a study to assess the prevalence of postnatal depression in a cohort of French women. The results of the study indicate that a higher proportion of women are depressed during the prenatal period (20%) as opposed to the

postnatal period (11%). The recommendation following this study was the need for primary, secondary and tertiary level interventions. Interventions suggested include parenting classes for pregnant women.

A quantitative study was conducted in South Africa to assess the psychosocial risk factors associated with postnatal depression (Mills, Finchillescu & Lea, 1995). The study investigated risk factors between a group of white middle-class women diagnosed with postnatal depression and a control group. The researchers found that postnatal depression develops within a biopsychosocial frame. A biological factor associated with postnatal depression was premenstrual tension during pregnancy. A psychological factor associated with the onset of postnatal depression was conflict in the marital relationship. In addition to this a difficult relationship with one's mother was associated with women developing postnatal depression. This was a factor because women reportedly received less practical support from their mothers and this lack of support caused women to experience difficulty in motherhood which contributed towards their postnatal depression. Other quantitative studies in South Africa also focus on screening and diagnosis of postnatal depression. For example, Stellenberg and Abrahams (2015) conducted a study to determine the prevalence and risk factors of postnatal depression in a rural district in South Africa. Given the study's quantitative nature, screening tools were used to identify women with postnatal depression. The researchers found that 50.3% of the women had postnatal depression. The recommendations following this study were the need to screen women early on for postnatal depression as well as provide treatment for postnatally depressed women in an attempt to facilitate sound maternal and infant mental health. Peltzer and Shikwane's (2011) quantitative study specifically focused on investigating the prevalence of postnatal depression in HIV positive women in Mpumalanga, South Africa. The researchers found that 45.1% of women reported depressive symptoms in the postnatal period. The above illustrations serve to demonstrate quantitative research is focused on measuring the prevalence, risk factors and treatment of postnatal depression. What can be surmised is that quantitative studies aim to discover the truth about postnatal depression as opposed to attempting to understand women's subjective experiences (Buultjens & Liamputtong, 2007).

There is also huge body of qualitative research internationally on postnatal depression, predominantly from the perspective of white middle-class women. For example Hanley and Long (2006) conducted a qualitative study which sought to explore how women from high

socioeconomic backgrounds experience postnatal depression. The study further explored how women make sense of their postnatal depression and how these impacts on the type of support the women seek. The researchers found that loss of employment status following childbirth, lack of support from family and social relationships and poor socioeconomic status contributed to women developing postnatal depression.

In their study which explored women's experiences of postnatal depression Buultjens and Liamputtong (2007) found that women attribute multiple causes to their postnatal depression. Women in the study attributed differences in their expectations of motherhood and their experiences of motherhood as the cause of their postnatal depression. Women's experiences of motherhood differed in that women had initially anticipated that motherhood would be easy and manageable. However, women soon became overwhelmed with their new mothering role. In addition to this women struggled with integrating their new mothering role with their existing life. The study further found that negative birthing experiences including complications during birth and traumatic caesarean sections as well as a lack of support from hospital staff after birth in terms of educating mothers on how care for their new born child contributed to their postnatal depression. Women further attributed the baby's temperament as a cause of their postnatal depression. Temperament referred to difficulty soothing the baby and the lack of sleep women experienced as a result of child care.

A study conducted by Coates, Ayers and de Visser (2014) explored women's experiences of postnatal distress. Through semi-structured interviews with a sample of predominantly white middle-class women, the researchers identified four salient themes which were contributed to women developing postnatal depression. Two of the themes which were significant to this study will be discussed. The first was the dissonance between women's experiences of motherhood and their expectations of motherhood. Within this theme, women expressed distress over avoidance of negative emotions, distress over childbirth, difficulty breastfeeding and feelings of guilt and self-blame. Avoidance of negative emotions was related to ambivalence that some women experienced in their mothering role. Women reported feeling detached from their new role and sought to avoid confronting the negative emotions they experienced. In the context of childbirth, women reported unexpected or difficult birth plans. Women further expressed disappointment in their breastfeeding experiences. Their distress centered on the difficulty women experienced during breastfeeding because women believed that breastfeeding would be natural for them. Self-blame was related to women's

disappointment in negative birth experiences. Women in the study felt let down by their bodies and as such blamed themselves for negative childbirth experiences. The second theme which was associated with women developing postnatal depression was difficulty adjusting to the new mothering role. Women in the study found it difficult to adjust to motherhood due to the maternal ideal and as a result developed postnatal depression.

Kathree (2012) conducted a qualitative study on Indian South African women's experiences of postnatal depression. The researcher found that a combination of biopsychosocial factors such as a history of postnatal depression, poor socioeconomic status, lack of adequate support and interpersonal difficulties including domestic abuse contributed towards women developing postnatal depression. A later study conducted by Kathree, Selohilwe, Bhana and Petersen (2014) explored the explanatory models of illness of women diagnosed with postnatal depression. Similar findings were reported in that women attributed their low socioeconomic status, unwanted pregnancy, interpersonal conflict and domestic violence as well as poor social support as the cause of their postnatal depression.

An article by Godderis (2010) argues that postnatal depression is framed within a gendered discourse and that it is now recognized as a social problem due the deleterious impact it has on children and the families of depressed mothers. Godderis (2010) contends that due to gendered discourses, men and women have different responsibilities. With the assumption being that for women, it is solely childcare. From this perspective, Godderis (2010) argues, postnatal depression is positioned as a problem solely due to the potential effects it may have on a child's emotional and behavioural development. In a review of the literature, Godderis (2010) maintains that due to its social implications, postnatal depression is framed in the context of risk-governance. This means that governmental efforts are made to identify women who are at risk of developing postnatal depression based on their individual circumstances. Godderis (2010) makes reference to the postpartum triad in reference to the three postpartum mental illnesses that women experience after childbirth. As mentioned previously, these are the baby blues, postpartum psychosis and postnatal depression. Godderis (2010) states that as a result of the high percentage of women who fall in the continuum of the postpartum triad, governmental initiatives were developed to identify women at risk for developing postnatal mental illness. This then results in, what Godderis (2010) terms, the "high-risk mother" profile, to identify women who are susceptible to developing postnatal depression. The "high-risk mother" is one who has single marital status,

has mental illness during pregnancy, experienced a stressful life event and has poor social support (Godderis, 2010). This process of screening and identification remains a point of contention for Godderis (2010) as she argues that this implies that at a population level, data can be used to identify women's individual subjective experience.

Godderis (2010) further argues that such screening measures present the assumption that women can control their risk of developing postnatal depression. Godderis (2010) maintains that women's own rights are disregarded, women's expression of emotional distress is overlooked and the main attention is given to the child and her family. What can be deduced from this article is that the method of screening and labelling women's distress after childbirth is quite an individualized process and Godderis (2010) argues that this process ignores the wider socio-political context that may in fact be contributing to women developing postnatal depression. Moreover, women are required to monitor themselves, identify if they are at risk for developing postnatal depression and act towards preventing postnatal depression. This then places the responsibility and an unrealistic expectation onto women to ensure sound mental health in order to ensure the well-being of her family. Godderis (2010) suggests that a focus for identifying women at risk for postnatal depression can be adopted to women individually through a network of the health care system, family, friends and by women themselves. This individual and subjective form of surveillance of women at risk facilitates and redefines responsible and moral motherhood (Godderis, 2010) as opposed to overlooking the social, cultural and economic context that shapes women's mothering.

The medical model on postnatal depression has been quite dominant in explaining postnatal depression (Buultjens & Liamputtong, 2006). However this model fails to acknowledge the social constraints that embodies motherhood (Buultjens & Liamputtong, 2007). In their study on women's own accounts of their postnatal depression Buultjens and Liamputtong (2007) argue that the medical model disregards emotional and physical exhaustion which is also associated with mothering. From the above studies and a review of the literature it appears that women are afraid to confide about their feelings and difficulties associated with motherhood because motherhood is often associated with positive feelings of joy and tenderness (Beck, 1999). International studies on women's experiences of postnatal depression are largely from the perspective of predominantly white middle-class women (see for example, Buultjens & Liamputtong, 2007; Hanley & Long, 2006; Mauthner, 1998;

Nicolson, 2001; Oakley, 1981). There is, however, limited qualitative research on postnatal depression in Africa and South Africa which focuses exclusively on Black women's experiences. Furthermore there is little research available in South Africa focused on the context in which women mother. This overlooks the experience of mothers themselves. The present study thus serves to challenge the wider structures that keep the institutionalization of motherhood in place. The present research study further allows women's voices to be heard as opposed to being silenced by existing quantitative research (Buultjens & Liamputtong, 2007). The present study thus recognises that there is a need to consider the context in which women mother rather than focusing on risk and the possible impact on the child and the family and in this way overlooking the experience of the mothers themselves. There is a need to challenge the wider structures that keep the institution of motherhood in place.

2.10. Theoretical framework

Underlying much of the research and theorizing about mothering and motherhood discussed above are two theoretical frameworks, social constructionism and feminism. It is these two perspectives that have informed the current studies design, analysis and interpretation.

Social constructionism refers to a theoretical orientation on human behaviour (Burr, 2003). It is based on four major assumptions. The first assumption is adopting a critical stance towards taken-for-granted truths (Burr 2003). This refers to the premise that one should question information that is presented as a given. From this position reality is not objective rather one is encouraged to be suspicious and critical of upheld assumptions. The second assumption is historical and cultural specificity which refers to the premise that our understanding of the world is "historically and culturally specific" (Burr, 2003, p. 7). Furthermore, given that understanding and knowledge is historically and culturally based, one's knowledge may not be collective rather knowledge and meaning is relative (Burr, 2003). The third assumption is that "knowledge is sustained by social processes" (Burr, 2003, p. 4). This refers to the premise that our knowledge of the world is derived from our interactions with others as knowledge is (co)constructed (Burr, 2003). The last assumption is that knowledge and action go together (Burr, 2003). This refers to the premise that different constructions create different actions (Burr, 2003). As such, meaning and understanding which is created by individuals based on a certain historical and cultural perspective drives human behaviour. Furthermore, one's construction of the world is relative to power relations as they dictate acceptable ways for people to behave (Burr, 2003). What can be ascertained from the four

assumptions is that knowledge and truth are subjective constructs which occur contextually and as such one should be mindful and question discourses.

In a paper presented by Shaikh and Kauppi (2015) the authors present the argument that postnatal depression is a socially constructed phenomenon. The authors draw on the work of Harris (2010) and state that two forms of social constructionism exist. The first is interpretive social constructionism which refers to the basic premise that meaning of things is learned through social interaction based on people's perspectives (Shaikh & Kauppi, 2015). The second is objective social constructionism and this is based on the premise that social phenomena are real (Shaikh & Kauppi, 2015). Furthermore, in the context of objective social constructionism something is constructed when a real phenomenon bases its existence on other social factors (Shaikh & Kauppi, 2015). As a whole interpretive social constructionism explains "how things are defined as they are" (Shaikh & Kauppi, 2015, p. 461) and objective social constructionism explains "why things occur as they do" (Shaikh & Kauppi, 2015, p. 461).

According to Shaikh and Kauppi (2015) postnatal depression first began in the biomedical field by the medical community who were left responsible for naming and classifying it as a unique condition. Given its presentation, in terms of the range of physiological and emotional responses that women displayed, postnatal depression was soon classified and recognized as either postnatal depression or major depressive disorder. Upon its classification and its diagnostic value women began self-labeling their experiences as postnatal depression. Women's self-diagnosis was in reference to the romanticized view of motherhood as happy and healthy (Shaikh & Kauppi, 2015). Women whose experiences of motherhood differed from the romanticized ideal sought to make sense of their experiences and as such labeled themselves with postnatal depression.). Women's self-diagnosis emerged through social interaction with health care providers, family and other mothers (Sword, Busser, Ganann, McMillan and Shinton, 2008, cited in Shaikh & Kauppi, 2015). Upon the recognition of postnatal depression, social movements such as postnatal support groups further emerged and supported postnatal depression as a mental disorder. In addition to this, the emergence of policies against infanticide and maternal suicide further legitimated postnatal depression (Shaikh & Kauppi, 2015). Given the above linear progression of postnatal depression Shaikh & Kauppi (2015) argue that postnatal depression is a combination of biomedical, historical, social, cultural and structural dimensions and as such is a socially constructed phenomenon.

As such postnatal depression is a socially constructed phenomenon as it is based on reality from the perspective of individuals governed by certain contexts. Postnatal depression is socially constructed culturally, contextually and relationally.

Mollard (2015) argues that a feminist perspective on postnatal depression recognizes and takes into account all factors that make up women's experiences such as psychological, biological and cultural. From a feminist perspective a woman who experiences postnatal depression is not viewed as defective (Mollard, 2015). Rather each woman's own experiences are separate and meaningful to her. A feminist perspective gives voice to women's suffering and it provides an outlet to understanding women's own experiences of what was previously understood and conceptualized as a biological phenomenon. A feminist perspective to understanding postnatal depression questions the discourses on motherhood. This perspective contextualizes women's experiences and recognizers the impact the dominant ideology and discourses surrounding motherhood have on women's identity, self-concept and role in society. A feminist perspective allows one to legitimately question previously held assumptions. It further engenders a culture which recognizers the individuality of each women. It provides a voice to the underrepresented and truth is a subjective concept embedded in subjective experiences.

Ussher (2006), from a feminist perspective, argues for a relational perspective to postnatal depression. A relational perspective frames an understanding of postnatal depression as existing outside of women (Ussher, 2006). According to Ussher (2006) postnatal depression needs to be understood according to women's relational and cultural context. This relational and cultural context encompasses the expectations imposed on women and mothers that are accepted as 'taken-for-granted truths'. Ussher (2006) maintains that the role that women play in society and the way in which they are positioned in relation to men and their household frames postnatal depression. Ussher (2006), like her predecessors (Mauthner, 1993; Nicolson, 1998; Rich, 1986) further challenges the medical unilineal model of postnatal depression. According to Ussher (2006) framing postnatal depression in the context of an illness implies that it is clinical and occurs in a consistent, homogenous and linear way. This framing then, ultimately denies the social and discursive context of women's lives and sets up the assumption that women are passive recipients and that postnatal depression acts upon them. Discursive in this context refers to visual representations, ideology, culture and power (Ussher, 2006). Ussher (2006) strongly argues that women are not passive and that "postnatal

depression sufferer' results from an active negotiation of emotion, embodied change, current life events and lifestyle, and cultural, medical and psychological discourse about postnatal depression" (p. 111). According to Ussher (2006) positioning postnatal depression as normal or understandable is not enough. Ussher (2006) also calls for a reconstruction of postnatal depression. A restructured understanding of women's positive and negative postnatal experiences whereby women's negative postnatal experience does not subject them to being labelled or pathologised. Ussher (2006) highlights that woman's support network precipitates and protects her own development of postnatal depression. Ussher (2006) further maintains that a supportive structure allows a woman to confront and acknowledge her distress as she enters into motherhood. This climate of support allows women to negotiate and navigate their way into motherhood (Ussher, 2006).

Mauthner (1998), in her study on women's experiences of postnatal depression, provided a relational perspective to understanding postnatal depression. Mauthner (1998) also illustrated that external factors contribute towards women developing postnatal depression. These factors were in the context of four major domains; the first is the women's expectations of motherhood which was in relation to the discursive representation of motherhood contributed to women developing postnatal depression. Women's ideas on motherhood were based on the dominant discourses of good mothering. When their expectations did not match with their experiences, the women developed postnatal depression. The second is the moral dimension which refers to mother's belief that there is only one right way to mother. Women believed that they should place the needs of their children ahead of their own in an attempt to be perfect mothers. The third is the cultural context which refers to the society's values and beliefs on good mothering. From this domain, women believed that there is only one way to mother and when their experiences did not match their efforts to engage in mothering in the 'right way' they experienced themselves as failures and this contributed to the development of postnatal depression. The fourth is the interpersonal context which refers to the impact that other mothers and women's significant partners had on the women. Women in the study compared their mothering abilities with other mothers and when they assessed that their experiences differed, the women perceived their mothering abilities as abnormal and this contributed towards the development of postnatal depression. Furthermore women struggled to confide with significant others regarding their struggles in motherhood due to perceived judgement and the fear that if women asked for help this would be perceived as failures as mothers. These factors do not interact in a linear singular way (Mauthner, 1998) rather they

may interact simultaneously and cause women to become depressed following childbirth. What the above dominant factors have in common is that they are external to the women which then becomes internalized by women to the extent that they strongly believe that there is only right way to mother. A relational perspective therefore challenges the traditional perspective of postnatal depression in terms of the etiology and treatment. In the relational perspective to postnatal depression, women are at the fore in terms of their experiences, how they negotiate postnatal depression and make sense of motherhood. Ultimately, the relational perspective provides a women-centered perspective to postnatal depression.

2.11.   Summary of chapter

Dominant discourses in society have positioned women to see themselves as solely responsible for child care and to see themselves as either good or bad mothers. The medical model of postnatal depression ignores the social, political and economic circumstances which impacts on women's ability to mother. The consequence of this is that women lose their identity, experience a sense of shame and guilt and are ultimately afraid to speak of their struggles in motherhood. The literature reviewed above illustrates how a social comparison exists between mothers and how this comparison may lead mothers to negatively perceive their mothering abilities. Furthermore, the literature suggests that women put pressure on themselves to be perfect mothers and that a combination of losing one's identity upon entering motherhood, experiencing a sense of failure in mothering and being afraid to openly speak about one's struggles in motherhood may cause women to become depressed following childbirth.

CHAPTER THREE
METHODOLOGY

3.1. Introduction

This chapter discusses the research methodology that was used to explore three Black African women's experiences of postnatal depression. Interpretative phenomenological analysis (IPA) was the method of analysis applied to the study. This chapter includes a detailed explanation of the method and process of data collection and analysis as well as the sampling method and procedure. The chapter provides relevant information about each of the participants, ethical considerations and covers the steps taken to ensure sound qualitative research.

3.2. Research approach

This exploratory study aimed to understand postnatal depression from the perspective of Black African, South African mothers. Due to its exploratory nature, the research study is located within a qualitative paradigm. The study makes particular use of interpretative phenomenological analysis developed by Smith (1997). Interpretative phenomenological analysis is concerned with "the detailed examination of individual's lived experiences and how individuals make sense of that experience" (Eatough & Smith, 2008, p. 179). The term phenomenological refers to the way in which individual's experience things (Eatough & Smith, 2008). IPA is a branch of qualitative research which emphasizes that in order to understand individuals, one has to understand the cultural and socio-historical exploration in which an individual's life is embedded (Eatough & Smith, 2008). Interpretative phenomenological analysis has its origins in health psychology as the researchers were interested in the way in which individual's make sense of illness. It is therefore concerned with expressing individual's subjective experience (Eatough & Smith, 2008). Within interpretative phenomenological analysis, meaning is obtained through an in-depth exploration of individual (Eatough & Smith, 2008).

In interpretative phenomenological analysis, language plays an integral role. Language is important as it is used to communicate the participants' experiences (Eatough & Smith, 2008). According to Eatough and Smith (2008) language constructs rather than describes reality and as such language is the means that adds meaning to the words that participants' use to express their experiences. Language therefore shapes experiences (Eatough & Smith, 2008) and in light of the present study language is a tool used to communicate and describe

the Black African women's experiences of postnatal depression. An interpretative phenomenological framework is further concerned with capturing the experiences and meanings that are associated with a given phenomenon (Eatough & Smith, 2008). Interpretative phenomenological analysis focuses on how individuals' experience a given phenomenon and how individuals' create meaning from subjective experiences. Therefore, through the instrumental use of language the researcher is able to understand participants' experiences of a given phenomenon and to explore the meanings that participants' subscribe to their experiences.

In interpretative phenomenology, the researcher forms an integral role in making sense of participants experiences (Smith & Osborn, 2007). This involves a two-stage interpretation process whereby "the participants try to make sense of their world and the researcher is trying to make sense of the participants trying to make sense of their world" (Smith & Osborn, 2007, p. 53). Interpretative phenomenological analysis is founded on the premise that there is a chain of connection between individual's talks, cognition and emotions (Smith & Osborn, 2007). According to Smith and Osborn (2007) individuals struggle to express their thoughts and emotions and the researchers' role is therefore to interpret individual's cognitive and emotive state based on what individual's say.

Interpretative phenomenological analysis is concerned with participants' experiences of a given phenomenon based on participants' interpretation of their experiences (Smith et al., 1999; Smith & Osborn, 2007). Given that interpretative phenomenology is idiographic in nature, this method of analysis recognizes that smaller sample sizes is preferred to larger ones (Fade, 2004) because it allows for a detailed interpretive account. In interpretative phenomenological analysis, data is collected through the use of interviews; be it structured, semi-structured or unstructured. The current research study made use of semi-structured interview guide which consists of a set of questions that were initially used as a guide (Eatough & Smith, 2008).

IPA, as previously mentioned, has its roots in phenomenology and symbolic interactionism which is founded on the premise that individuals form their own meanings based on their experiences and are not passive recipients of an objective reality (Biernacki & Wearden, 1981). Thus based on the above factors, IPA is most suited to the current study as the study explores three mothers' experiences of a given phenomenon. Furthermore, given that IPA

allows for a smaller sample size to foster richer understanding of a particular phenomenon, three mothers comprised the study's sample. IPA's premise of exploring and interpreting suggests that reality is subjective and is created through meaning which individuals learn to attach through their own subjective experiences (Smith & Osborn, 2007).

3.3. Research questions

(1) How do three Black African, South African mothers construct motherhood?

(2) What are the factors that these mothers perceive as contributing towards their postnatal depression?

(3) How do these mothers negotiate their postnatal depression?

(4) How do these mothers cope with postnatal depression while simultaneously assimilating the role of motherhood?

(5) What do these mothers feel can be done to help other mothers with postnatal depression?

3.4. Participants and sampling procedure

"IPA studies are conducted on small sample sizes" (Smith and Osborn, 2007, p. 55). In keeping with the principles of interpretative phenomenological analysis only three Black African women comprised the study's sample. The reason for small sample sizes is that "the aim of the study is to say something in detail about the perceptions and understandings of this particular group rather than prematurely make more general claims" (Smith & Osborn, 2007, p. 55).

I identified the participants in this study through purposive snowball sampling. Snowball sampling is a method of identifying research participants whereby the researcher draws samples through referrals based on people who share or who know of others that have similar characteristics that are of research interest (Biernacki & Waldorf, 1981). Furthermore, snowball sampling is the most suited sampling method when undertaking research of a sensitive nature (Biernacki & Waldorf, 1981). The participants were sampled through a non-profit organization, called the South African Depression and Anxiety Group. SADAG, as is colloquially referred to, is physically situated in Johannesburg, South Africa. The organization provides mental health support services to the country at large through telephonic and face to face counselling.

I contacted the organization's director via electronic mail and I informed the director about the aims of the study. I further provided the director with the research proposal and ethical clearance letter in order to facilitate rapport, trust and to familiarize the director with the study. Two months after our first contact session, the director contacted me via electronic mail and provided me with two referrals of women who met the criteria to participate in the study. The director of SADAG further informed me that she contacted the women and briefed them on the study and enquired about their willingness to participate in the study. After obtaining verbal consent from the two women, the director then provided me with their contact details. A week later I contacted each participant telephonically. I introduced myself and I enquired about a suitable time to contact the women in order to re-brief the women about the purpose of the study and to determine their availability to commence with the data collection process. During the telephonic conversation both women provided verbal consent to participate in the study and a suitable date and time was arranged for interviews to be conducted. The third participant was contacted through snowball sampling through the first participant. The requirements for participation were:

1. A Black African, South African mother
2. A mother who is older than 20 years of age
3. Has at least a Grade 12 level pass
4. Has been diagnosed with postnatal depression by a mental health professional

Below is a detailed description of each participant in order to allow the reader with greater familiarity with each participant.

Participant one is Thembelihle, who is 27 years old. Thembelihle is currently married and she has a three year old son. Thembelihle currently holds a Grade 12 level of education. She is selectively unemployed in order to maintain full-time care of her son. Thembelihle conceived her son when she was 24 years old. At the time of her conception she was engaged in full-time employment and at seven months gestation she decided to leave her full-time employment. Thembelihle was diagnosed with postnatal depression by a psychiatrist six months postpartum when she was treated medically for her depressive symptoms. At the time of the interview, Thembelihle was still on treatment for depression and anxiety and she is currently consulting a psychologist. Thembelihle was interviewed in a vacant lecture venue

over the weekend when there were no classes being held and little to no opportunity for interruption

Participant two is Ntombenhle, who is 34 years old. Ntombenhle currently has two children, a 12 year old daughter and a one year old son. She is currently separated from the father of her child and her daughter's father is deceased. Ntombenhle holds a Bachelor's Degree and is employed as an attorney. Ntombenhle's experiences reflected in the study are based on her son who she conceived when she was 33 years old. Ntombenhle separated from the father of her son at six months of gestation. She was diagnosed with postnatal depression by a psychiatrist four months postpartum. She is currently being treated medically for her depressive symptoms.

Participant three is Thandekile, who is 38 years old. Thandekile has two children, a 13 year old daughter and an 11 year old son. She is currently separated from her husband. Thandekile holds a National Diploma and is employed as a ground hostess. Thandekile's experiences reflected in the study are based on her 13 year old daughter who she conceived when she was 25 years old. She was diagnosed with postnatal depression by a psychiatrist at six months postpartum. She was treated medically for her depressive symptoms. (Consult Appendix C to obtain detailed information sheet for each participant).

3.5. Data collection method and procedure

Data was gathered using a semi-structured interview guide. The guide consisted of a set of questions which I used as a guide rather than a check list that I was dictated by (Smith & Osborn, 2007). Guided by interpretative phenomenological analysis, the semi-structured interview included open-ended questions to encourage free narrative and detailed responses from participants (Smith & Osborn, 2007). I further probed interesting and important areas that emerged during the interview (Smith & Osborn, 2007). Given that the study's aim was to gain a deeper understanding of subjective women's experiences on a phenomenon of a sensitive nature and in a non-threatening way, semi structured interview with open-ended questions was the most suitable form of data collection. Each interview lasted between 45 minutes to an hour and the interviews were all conducted in English.

Before starting the interview I checked to ensure each mother felt comfortable to conduct the interview in English and all the mothers said they were. Thembelihle was interviewed at the

University because it was a central location for her and myself. The interview was conducted on a weekend inside an empty lecture hall. The weekend was specifically selected as there were no scheduled classes and I had anticipated little to no interruptions during the interview. The participant's son was looked after by her husband. The interview was recorded with the use of the voice recorder setting on my laptop because the tape recorder I bought malfunctioned. From then on an executive decision was made to record all interviews on the voice recorder setting on the laptop. Each participant's confidentiality was maintained as the laptop was password protected and I am the sole owner and user of the laptop. Rapport was easy to establish with participant one because her husband is a lecturer at the University of Kwa Zulu-Natal who is currently engaged in his PhD. Thembelihle was able to understand my experiences as a researcher and appreciated the efforts involved in conducting and completing a research study. She was relaxed throughout the interview. When we experienced technical difficulties she was understanding, patient and accepting. There were no interruptions during the interview process which lastly 1 hour and 15 minutes.

Ntombenhle was interviewed three weeks after our first contact session. The initial interview date was re-scheduled due to unforeseeable circumstances on the participant's end and she did not have anyone to look after her child during the interview. I proposed that she bring her son along for the interview and I would arrange with my family member to watch over her son, however, she declined my offer because she was concerned that her son would be hyperactive and that he would display high attention-seeking behaviour. Ntombenhle was interviewed a week after we had re-scheduled. The interview occurred at a popular shopping mall, in a quiet and secluded restaurant selected by her because it was easily accessible for her. Rapport was easy to establish with Ntombenhle and this is due to her genuine willingness to help other mothers who may be having similar postnatal experiences. There were no interruptions during the interview process which lasted an hour.

I identified Thandekile for the study through Thembelihle. Thembelihle was familiar with Thandekile through a mutual friend. Thembelihle initiated contact with the mutual friend who then provided her with Thandekile's contact details. Thembelihle then contacted Thandekile and briefed her on the study and obtained her verbal consent to participate. I contacted Thandekile two weeks after I was provided with her contact details. There was a two week delay between the time I obtained her contact details and the time I contacted her telephonically due to unforeseen circumstances. Thandekile was interviewed at her home a

month after we initiated telephonic contact due to a busy schedule on both our ends. Rapport was easy to establish with Thandekile as we discovered that we lived in the same neighbourhood and as a result we were able to share similar neighbourhood experiences. Thandekile did appear nervous after we realized we share the same neighbourhood, however, I assured her of her right to confidentiality and this appeared to satisfy her. The interview lasted approximately 50 minutes and it was uninterrupted despite the fact that it was conducted at her home.

All the participants were informed about the confidentiality of the study and how their confidentiality would be maintained. This helped to make the participants more comfortable with the interview process. Steps were also taken to maintain each woman's psychological well-being as I constantly enquired as to each woman's willingness to continue with the interview or to re-schedule at another time when they experienced a sense of being overwhelmed during the interview process. I started each interview by asking each mother to share their journey into motherhood and this allowed the interview to unfold gradually and in a non-threatening manner.

3.6. Data analysis

As mentioned previously, data from the current study was analysed using interpretative phenomenological analysis. This method of analysis consisted of reading each transcript several times to gain familiarity with the data (Smith & Osborn, 2007) as well as to identity themes. The process of analysis that I followed is discussed below.

I started by reading the transcripts a number of times and this allowed me to immerse myself in the data to gain familiarity (Smith & Osborn, 2007). This process of familiarity was further enhanced because I interviewed the participants and transcribed their interviews in full. During this stage, I made notes of the salient information that emerged. On the left-hand of the margin, I noted information that was interesting or significant based on what the research participant said (Smith & Osborn, 2007). On the right-hand side of the margin, I made note of themes which emerged (Smith & Osborn, 2007). I followed this process for the entire transcript. This provided me an opportunity to identify the emergence of repeated themes (Smith & Osborn, 2007) and to note these themes in order to determine their strength and relevance in the next transcript. Given that three participants were interviewed, the data consisted of three separate transcripts.

The second stage of analysis consisted of tying and connecting themes together (Smith & Osborn, 2007) based on the degree of similarity and relevance of identified themes. During this stage, I listed the themes on a separate page and attempted to identify the connections between them. During this stage, I recognized that some themes clustered together based on their connections. As a result of the degree of relevance and similarity between themes, I separated themes according to superordinate (overarching) and sub-themes. In order to ensure that a theme was clearly represented, I continuously referred back to the transcript in order to re-check the theme against the participant's actual words (Smith & Osborn, 2007). This process further ensured that I made sense of what the participant said and it further ensured that I accurately interpreted what a participant said. Following this, I created a table of themes at the back of the page used to create the initial set of themes. Themes were arranged hierarchically so as to differentiate between salient and relevant themes from the non-salient themes. During this process Smith and Osborn (2007) encourage researchers to identify and keep salient themes and to discard irrelevant themes. Given that this was the first transcript and my first attempt at interpretative phenomenological analysis I made note of all themes and kept them in an attempt to provide a point of reference for the other two transcripts. Furthermore, I identified themes as salient if an idea was repeated later on in the transcript and if reference was made to the research aims.

During the third phase of analysis I repeated the first process of analysis with the other research participants' transcripts (Smith & Osborn, 2007). By initially noting superordinate themes and sub-themes I was able to apply the same themes which emerged in the second and third transcripts. I was further able to identify which themes were relevant and salient by referring to the first set of themes created. I noted new themes which emerged while reading the second transcript in the event that a similar theme emerged in the third transcript. According to Smith & Osborn (2007) by engaging in the same process of analysis for other transcripts allows one to identify new and different information which may be used to articulate extant themes.

The small sample size facilitated a process of in-depth analysis and it further allowed me to flexibly move back and forth between the first, second and third transcript. In the fourth and final stage of analysis I constructed a final table which captured superordinate themes. This allowed me to prioritize the data by listing themes from the most salient theme to the least

salient theme. Ultimately the process of analysis described above allowed a novice researcher like myself the ability to identify themes, group them in terms of relevance and salience and to determine which themes may be discarded based on the low level of salience and relevance to the study.

3.7. Qualitative considerations

3.7.1. Credibility

Credibility refers to the degree to which a study is based on well-established research methods (Shenton, 2004). Various strategies have been proposed by Lincoln and Guba (1985) to ensure research studies are credible. This section will only focus on the strategies deemed necessary and which were adhered to in maintaining the principle of credibility. Credibility is achieved by the researcher gaining familiarity with research participants before data collection is undertaken (Shenton, 2004). Credibility is also achieved by ensuring honesty in participants (Shenton, 2004). This refers to the premise that participants are informed of their right to refuse to participate in order to ensure their genuine willingness to participate. Lastly credibility in research is achieved through examining previous research findings in order to determine the degree of congruency between the present research study and previous studies.

Credibility in the present study was achieved through first telephonically contacting each research participant, introducing myself and informing them about the study including the study's purpose. An opportunity was provided to each participant to ask clarifying and follow up questions in order to address their concerns and ensure their comfortability and willingness to participate. Credibility was further achieved through informing the participants about their right to refuse to participate or to withdraw from the study at any time they so choose to do so. This strategy further ensured that participants did not feel pressured or coerced into participating. Lastly, credibility was achieved through conducting a thorough literature review of similar and dissimilar studies in order to clearly identify the gaps in the literature and to clearly demonstrate the rationale and need for the current study.

3.7.2. Transferability

Transferability in qualitative research refers to degree to which research findings can be applied in other settings (Shenton, 2004). Transferability is achieved through researchers providing thick descriptions of a given phenomenon in order to facilitate greater

understanding of the phenomenon (Shenton, 2004). Thick descriptions in qualitative research allows for other researchers to compare the given phenomenon in their own setting/situation (Shenton, 2004). Transferability can be further achieved through the researcher detailing the boundaries of the study (Shenton, 2004). The boundaries alluded to above refers to the number of participants used in the study, the criteria for participation, data collection strategies, number and length of data collection sessions and the time period for data collection.

The present study maintained transferability through the detailed explanations provided throughout the study with reference to the study's research topic, rationale, methodology and discussion session. The present study further maintained transferability by clearly illustrating the boundaries including the criteria used to select each participant, their demographics in order to breed familiarity with each participant and to allow readers the opportunity to engage in perspective taking. Furthermore data collection methods and the method of analysis were clearly illustrated.

3.7.3. Dependability

Dependability in qualitative research refers to the degree to which a study can be replicated (Shenton, 2004). Dependability is contingent upon the research design in terms of methodology applied. Dependability can be achieved through describing the research methodology which includes data collection, data analysis and the discussion session.

Dependability was achieved in the present study through detailed description of the methodology applied in the study. Detailed descriptions allow for greater familiarity with new and existing material (Shenton, 2004) and as such the present research strived to provide as much detail as possible for understanding, familiarity and replicability purposes.

3.7.4. Confirmability

Confirmability in qualitative research refers to the degree of objectivity in a study (Shenton, 2004). Confirmability is the researcher's ability to clearly reflect the participant's views and experiences without simultaneously including their own ideas. Given that qualitative research is subject to some degree of researcher bias, confirmability can still be achieved through the researcher acknowledging their own feelings and ideas about the given phenomenon (Shenton, 2004). Confirmability may be further achieved through the researcher illustrating

why a certain approach was adopted above others as well as highlighting the limitations of the study (Shenton, 2004).

Confirmability was achieved in the present study through the process of clearly illustrating participants' experiences through the provision of quotes. Furthermore confirmability was achieved through explaining the rationale used for a small sample size under the allocated method of analysis. Confirmability was further achieved through my process of clearly documenting the study's limitations and constantly being aware of my own emotional reactions to what I was reading.

3.8. Ethical considerations

Researchers have a duty to protect their participants' from any harm or loss and should further strive to preserve their psychological well-being and dignity (Willig, 2008). As a result, necessary steps were taken to ensure each participant was protected from harm and given the sensitive nature of the study; their psychological well- being was of utmost importance. The steps taken to uphold ethical research practice and protection from harm will be discussed below. This study was approved by the Humanities and Social Science Research Ethical Committee at the University of Kwa Zulu-Natal (See Appendix D).

3.8.1. Informed consent

Informed consent was obtained from each participant after they were thoroughly familiarized with the study in terms of the purpose, methodology and contribution to future research in maternal mental health. Participants were provided with consent forms to sign which details their permission to be a part of the study including the use of alternate equipment to facilitate data collection.

3.8.2. Confidentiality

Confidentiality was achieved through providing pseudonyms for each participant to protect the participants' identity. Recordings of interviews will be kept in a computer that is protected by password which will only be known by the researcher.

3.8.3. Nonmaleficence

This is an ethical principle which implores all health professionals to guarantee the physical, emotional and financial safety of their clients, patients and participants. This was upheld by

informing each participant about their right to refuse to participate in the study or to withdraw from the study when/if a participant so chooses to.

3.8.4. Storage and dissemination of results

The data collected in this study will be kept at the University with the Supervisor for a period of five years. Transcriptions for the study will be stored in a password protected safe with the researcher. Consent forms will be stored separately so as to maintain each participant's confidentiality.

3.9. Reflexivity

Reflexivity is a term associated with qualitative research which means that a researcher's own understanding of a participant's thoughts forms a large role of the interpretative process. According to Willig (2008) the researcher's own thoughts, assumptions and conceptions (Willig, 2008) play a role when interpreting a participant's experiences. As previously mentioned, in IPA the researcher provides an interpretation of the participant's experiences and this interpretation, therefore, is based on the researcher's own understanding of the participant's experiences based on a given phenomenon. By this token, the researcher's own thoughts form part of the analysis process as the knowledge produced is based on its "dependence on the researcher's own standpoint" (Willig, 2008, p. 69). To illustrate, the research is represented through the participant's world view and this world view is interpreted by the researcher based on the researcher's own thoughts and assumptions of the participant's world view (Willig, 2008). Reflexivity can be achieved by the researcher reviewing their own role in the research (Willig, 2008). In the present study it was important to engage in reflexivity for two reasons; the first is that reflexivity is encouraged in the adopted method of analysis for it allows the participants' and the researcher's voice to be heard. The second is that reflexivity ensures that the researcher is mindful and respectful of the participants' experiences and that their experiences are reflected as accurately as possible. Furthermore, given that the study is of a sensitive nature, being reflexive allowed me to continuously reflect on my own experiences including any counter-transference that may have arisen during contact sessions with each participant. Being reflexive allowed me to be aware of my own cognitions and emotions that emerged during data collection and data analysis and to interrogate the reasons for such.

Reflexivity in the present study further made me aware of the possibility that my non-mother identity may have led the participants to assume that I do not understand their mothering experiences. However, I took my non-mother identity as an opportunity to inform all the mothers that even though I am not a mother, I have engaged in mothering. Furthermore being reflexive in the study allowed me to reflect on my own identity as a Black African women and to interrogate how my context has shaped who I am and to use this same knowledge to understand how the women's contexts have shaped and impacted them. My identity as Black African women emerged during the data collection process with the mothers as they, at times, responded to my enquiries by saying "you know how it is as a Black woman". This research holds personal interest to me in terms of female empowerment and given that motherhood is quite an empowering identity for most women, I had to constantly 'catch myself' during interviews with the women and to ensure that I understood their experiences and not my own inference of their experiences.

3.10. Summary of chapter

This chapter provided the procedures used to carry out the research study. This included a description of interpretative phenomenological analysis, the sampling procedure and the method carried out to analyse the study's data. Furthermore, this chapter provided a description of steps taken to ensure sound qualitative research was carried out as well as steps taken to ensure ethical principles were maintained.

CHAPTER FOUR
ANALYSIS AND DISCUSSION

4.1. Introduction

The aim of this study was to explore three Black African mothers' experiences of postnatal depression. In this chapter, the research findings will be presented and discussed. The research findings are divided into seven themes in accordance with the study's objectives. The first section is dedicated to the women's journey into motherhood. This section includes the women's initial reactions to finding out they were to become mothers.

The second section is dedicated to women's experiences of motherhood and factors they have identified as the cause of their postnatal depression. Given the rich data and similarity in their experiences of postnatal depression and motherhood as well as the guidelines of interpretative phenomenological analysis, this section arranged the data into superordinate themes as well as sub-themes. Superordinate themes are overarching themes which are aimed at capturing the participant's entire experiences. The superordinate themes provide an outline of the participants' experiences of motherhood and postnatal depression. The sub-themes provide a more specific account of the participant's experiences of the phenomenon in question. In this section four superordinate themes were identified as factors that were associated with the development of postnatal depression: adjustment to motherhood, expectations of motherhood, lack of support and understanding from significant relationships and perceived fear of judgement.

The third section consists of the behavioural and emotional consequences of postnatal depression. This includes the behavioural and emotional responses exerted towards their babies during their postnatal depression. The fourth section is dedicated to exploring and understanding how women negotiate their postnatal depression. This section includes women's coping strategies and management of their postnatal depression. The fifth section is an illustration of how these Black mothers' negotiated their way into motherhood. This refers to the ways in which these initially distressed women slowly began the process of re-integrating their new motherhood role with their previous identity.

The sixth and final section is dedicated to the message the courageous Black African women and mothers' have to share with prospective and current mothers as well society at large regarding motherhood and postnatal depression.

4.2. Findings

4.2.1. Difficult beginnings

As previously mentioned, this first theme focuses on these Black African women's initial reactions and transition into motherhood.

4.2.2. Negotiating pregnancy

In the present study, two of the participants, Thembelihle and Ntombenhle, shared views that contradict the idea of a maternal instinct. Thembelihle reported that she had contemplated terminating her pregnancy as she did not want to become a mother. Ntombenhle reported that she came into motherhood at a very young age and as a result her mother assumed all child rearing responsibility. Upon the birth of her second child, Ntombenhle reported that she still did not feel maternal towards her baby and that bonding with her baby proved to be difficult.

According to Thembelihle:

I didn't enjoy it much because I couldn't do anything, I was too heavy. I didn't enjoy pregnancy…it had its perks but overall I didn't enjoy being pregnant. I didn't enjoy not being able to touch my toes.

Based on the quote above it appears that Thembelihle had a negative prenatal experience and that she struggled after her baby was born. Her negative prenatal experiences centred on changes in her body image and the restrictions that being pregnant afforded her such as not being able to touch her toes.

Ntombenhle reported:

Uhm, just the normal pregnancy. During the first six months of my pregnancy my partner was cheating on me but I didn't deal with it properly, like I ignored it. It went as normal. Then after that I got the news that my son was not growing enough so the Dr, they were going to induce me. That gave me so much stress. I went into the hospital they tried to induce me, it didn't work. After that I had to be rushed to a C-section, which was not what I was ready for. I didn't know anything about it because my first daughter, I gave birth naturally. My boyfriend had left by that time. I was all alone in that room. They didn't even explain to me

that I'm not gonna feel my feet after that because I had epidural. So I gave birth and everything was fine with the baby. The thing is, I had pains because of the operation. So the baby was healthy, everything was fine.

Ntombenhle's experiences of pregnancy were also negative and these were further influenced by external circumstances which were beyond her control. Ntombenhle's negative experiences foreshadowed her ability to enjoy her pregnancy. Her limited control in the birthing process further foreshadowed her ability to enjoy her delivery experience. Ntombenhle used the word 'fine' in various places when speaking about her pregnancy and birthing experience. She appears to display a certain degree of ambivalence in recounting her experiences. Even though she had a negative birthing experience, she disregards her experiences in relation to her child and maintains the impression that even though her experiences were negative, at least her child was healthy. It further appears from both these women's accounts that their experiences of childbirth were impacted by the unavailability of family support. A review of the literature illustrates that women feel isolated from others when there is insufficient support during the postnatal period (McVeigh, 1997).

According to Thandekile:

Being a first time mother, you get excited about the pregnancy and then obviously the arrival of the child. The pregnancy went well.

It appears that Thandekile had a positive birthing experience and this is related to the absence of complications during childbirth.

4.2.3. Unexpected births

In the present study, two of the mothers had undergone emergency caesarean sections due to complications.

According to Ntombenhle:

After I got the news that my son was not growing enough, so the Dr, they were going to induce me. That gave me so much stress. When I went into the hospital they tried to induce me, it didn't work. After that I had to be rushed to a C-section which was not what I was

ready for. I don't know anything about it because my first daughter, I gave birth naturally….they didn't explain to me that I'm not going to feel my feet after that because I had an epidural.

The above illustrates that Ntombenhle was not fully informed about the caesarean section she was about to undergo and that more importantly she was not informed of the side effects of the medication which negatively impacted her birthing experience.

Thembelihle shared:

I went to have my check-up and his head was too big so on that day the Dr said we taking this baby out today. I was like; I'm just going for a check-up. I didn't come here to be told that. Go to the hospital and I was like (exaggerated hyperventilating sounds). And I was like I'm not ready for this, I wasn't prepared. I called my husband, he was at work. I made my own way to the hospital.

Later on in the interview she said:

It was just too fast. It happened too fast.

The above illustrates that Thembelihle was not prepared to deliver her baby and that this was an overwhelming experience for her.

A review of the literature illustrates that a traumatic birth experience contributes to women developing postnatal depression (Berggren-Clive, 1996; Oakley, 1980) because women felt undermined and not in control of their bodies during the birthing process. Furthermore women felt they were not appropriately informed about the birthing process. A further factor which contributed towards a traumatic birth experience was the belief that women felt that their bodies had failed them and this sense of failure resulted in feelings of guilt which was associated with the development of postnatal depression (Berggren-Clive, 1996; Miller, 2007; Oakley, 1980).

Cook and Loomis (2012) conducted a study which explored the impact that choice and control have over women's birthing experience. The researchers found that inadequate

provision of information impacted on women's birthing experience. The researchers found that choice during childbirth impacted on women's degree of control in their birthing process (Cook & Loomis, 2012). If women were provided with sufficient information during their birthing process they expressed the ability to maintain control over their birthing process and this resulted in a positive recollection of their birthing experience. The same applied in the inverse and this ultimately contributed to a negative recollection of their birthing experience. Similarly in the study, if women were not adequately informed or orientated to their birthing process, this resulted in a negative birthing experience.

4.2.4. *Difficulty breastfeeding*

A sub-theme identified as a cause of Black mothers' postnatal depression which is related to the women's first experiences of motherhood was breastfeeding. Two of the participant's reported negative experiences in breastfeeding which negatively impacted on their adjustment to motherhood and contributed towards their postnatal depression.

I didn't know that milk doesn't come in the beginning. And it's painful. No one tells you that it's painful; in the beginning it's very painful. When the baby is learning to latch it can be painful. (Thembelihle).

Thembelihle further added:

Everybody has this rosy picture of breastfeeding and pregnancy. I didn't have any of that. It's nice because it's bonding. It's really bonding but this baby is always going to be drinking from you. Every two hours you'll be sitting on your bum. He just drinks and drinks and that's all you do, two hours 24/7 you're breastfeeding your child. That's why a lot of people don't breastfeed.

Thembelihle's narrative indicates that there was an experience of dissonance in her experiences of breastfeeding. Thembelihle's mismatched expectation of breastfeeding is clearly demonstrated through the use of her words "everybody has this rosy picture of breastfeeding and pregnancy". I didn't have any of that'. This "rosy picture" that Thembelihle refers to informed her own expectations of breastfeeding and when she did not experience breastfeeding in the expected way she developed a certain degree of resentment towards breastfeeding her child. She had anticipated breastfeeding to be an easy and

enjoyable process however her reality of breastfeeding differed from the ideal of breastfeeding. Thembelihle further realised the amount of time that goes into breastfeeding. Thembelihle had a positive mental representation of breastfeeding however she had a negative breastfeeding experience.

According to Thandekile:

My breasts were, (physically indicated the growth of her breasts). They went from a size 34 to a size 38DD. It was horrendous, the cabbage leaves never worked, it was huge with veins. That took about three days to go down. All those things just make you hate it. This person's the cause of all of this (Thandekile)

Thandekile's experiences above reflect the physical changes that she underwent as a result of breastfeeding. What may be deduced from the above is that these women were not aware or possibly not informed about what to actually expect around breastfeeding. The women's experiences above illustrate that a culture of silence exists around one's struggles with motherhood; in this case the women's struggle with breastfeeding. Furthermore, the women's struggle with breastfeeding challenges the assumption that a woman's body is biologically wired to mother (Nicolson, 1998).

The historical and still unchallenged message is being reinforced to new mothers that breastfeeding is a natural and easy part of mothering, one that all mothers should practice. This then results in new mothers experiencing a shock when their actual experiences of breastfeeding do not match with their expectations of breastfeeding. Yet again, Thembelihle and Thandekile demonstrate that expectations of breastfeeding were informed by the dominant discourses of the maternal ideal. Thandekile underwent a physical transformation as a result of breastfeeding and this transformation was not documented in what to expect of mothering. As a result of mismatched expectations she also resented motherhood. She passionately uses the word "hate" in reference to breastfeeding.

4.3. Factors that contributed to women developing Postnatal Depression

4.3.1. Expectations of motherhood

4.3.1.1. Mismatched expectations of motherhood

A further superordinate theme which emerged during transcription and was found as influencing women's experiences of postnatal depression were the expectations women had about motherhood. Similar to literature reviewed, women in the present study experienced a mismatch between their expectations of motherhood and their actual experiences of motherhood.

According to Thembelihle:

It's not the picture I had of having my child. I just had the perfect picture of being with my baby, having my baby, picking up my baby. Everything being rosy. I didn't picture being sad, depressed, down, you know, everything, just looking at him. That's not the picture I had, and that made it even worse for me. That okay, now you're depressed, it's something worse.

Thembelihle further reported:

Ya, that I was not being the picture that I painted for myself as well because we have these images of what we want, what we should be like but then when it reality comes, it's never the same.

When asked whether she believes the media also has a role in depicting what motherhood is like, Thembelihle responded:

They painted that it's hard but fun and it's exciting and it's nice. All good things. There was no one that was depressed in these movies and these adverts. Everyone's happy and smiling. No one's ever depressed no one's ever sad. You never see a sad advert like Johnson & Johnson. You never see any mental illness on tv. Nope.

Thandekile reported:

I thought it would be fun, exciting, but not at all. We always think it's going to be something different but then until the baby is born and he's here, it's a completely different experience, but it's exciting. But you get your days where you can't really take it back. It's here it's here.

Thandekile's real experiences of motherhood did not match her expectations of motherhood. This is reflected in her accounts of expecting motherhood to be fun but in reality she soon realised that motherhood was not fun and that at times she wishes she had not been a mother. This is reflected in her honest vocalization where she states that there are days when she cannot "really take it back", "it" in reference to her child. Furthermore Thandekile's expectations of motherhood appear to be a romanticized ideal of motherhood that first time mothers hold as a result of the dominant discourse on motherhood, an ideal that a majority of women appear to buy in to. This was a similar finding in the study by Lewis and Nicolson (1998). In their study on women's experiences of postnatal depression, the researchers' found that women's expectations of motherhood contrasted with their experiences of motherhood and this resulted in women experiencing disappointment in their motherhood role. This study illustrates how postnatal depression occurred as a result of discursive constructions of motherhood. The women in the present study expected motherhood to be a happy and fulfilling experience however this was not what they experienced. This appears to mirror Thandekile's experiences of motherhood as well. She had expected motherhood to be exciting and fun however this was not her reality of motherhood.

In Mauthner's (1998) study on women's experiences of postnatal depression, the researcher found that women experienced a conflict that was related to certain expectations that women had of how they should mother. The women held certain expectations on childbirth, breastfeeding and bonding with one's baby. The women in Mauthner's (1998) study held the expectation that they would know how to breastfeed, that they should be able to cope with motherhood and that they would instantly bond with their baby. However, their experiences contrasted with their expectations. A similar finding was observed in the present study whereby two of the women expressed that before becoming a mother they held certain expectations of motherhood. One participant in particular expressed that she had a 'rosy picture' of motherhood however this was not her reality of motherhood.

When asked how her expectations of motherhood differed from her experiences of motherhood, Thandekile responded:

You go to these mother and baby shows and you see all these things that make you think you can do it. The gadgets would make motherhood fun, no it's not fun. It's just there. You buy all these things, go to baby shows. Because I remember I went to the Barney, I don't know what show but I bought stuff but the reality when the baby's here they make it seem so easy but you're dealing with this child, it's not so easy. Barely sleeping, your expectations are different.

It appears, from the narrative above, that given that she attempted to equip herself with motherhood by attending baby shows, this was still not enough to prepare Thandekile for the reality of motherhood. Frizelle and Hayes (1999) conducted a study which explored mothers experiences of motherhood as well as the impact the maternal ideal had on women's' mothering. The researchers found that as much as mothers need to be prepared for the experiences of motherhood, much of the learning occurs as mothers go through the process of motherhood. It appears that Thandekile had expected that in buying the right baby gadgets in preparation for motherhood that this would make motherhood easy however she soon realised that this in reality was not enough.

Preparation into motherhood was further displayed by Thembelihle, according to her:

Before the baby was born it was just Baby Centre. I just signed up to Baby Centre and just read whatever they sent. My husband got me a baby sleep book. That was two books full on development from birth to two years old. I did a lot of googling, reading, reading books about raising boys.

Thembelihle displays the steps she took in preparation for motherhood such as gathering information from various sources. She displays that she took a vested interest in preparing for motherhood by supplementing her knowledge with multiple sources such as the internet and other written material. However as much as she prepared for motherhood her reality was quite different.

4.3.1.2. Lack of understanding and support from significant relationships

Babatunde and Moreno-Leguizamon (2012) conducted a study on postnatal depression and found that, among other things, a lack of support from their spouses contributed to women

experiencing difficulty coping with motherhood and this factor ultimately contributed towards the development of postnatal depression. This lack of support was also evident in the present study as illustrated by Ntombenhle:

Because some people they expect you to snap out of it but they not even inside your head, so you can't snap out of it because even some will tell you snap out of it, snap out of it, but you can't, it doesn't help.

I remember once my supervisor said I must snap out of it and what not. She wrote me a letter and what not.

Ntombenhle's experiences reflected above suggest the lack of understanding surrounding mental ill-health. People around her, such as her supervisor, expected her to get over her depression and this further suggests that people around her hold the view that her mental health was something that she could control.

According to Thandekile:

The Dads are not always understanding and patient. You have to take control and it's not easy because you tired as well at night and the child's been giving you problems.

Thandekile's use of the word "the dads" and "you" suggests that she is not just talking about herself. She is making reference to an experience shared by other mothers. Thandekile does not use the personal pronoun "I", but rather "you" which suggests insight into the fact that this experience is not just relevant to her but to other mothers as well.

Thandekile's experiences echo those from Mauthner's (1998) study on women's experiences of postnatal depression. Mauthner (1998) found that women experienced their partners and friends to be unsupportive during their postnatal period and this lack of support contributed to women developing postnatal depression. Of further significance in Thandekile's experiences above is the lack of support and lack of understanding provided by her partner. Frizelle and Kell's (2010) study further confirms the reality that male partners do not provide adequate support for mothers as the underlying premise is that motherhood is the responsibility of women.

When Thembelihle first reported about the support she received from her social relationships during her postpartum period, she stated that:

My family was shocked especially my mom and my brother. Basically they were surprised because they didn't expect me to fall pregnant because I was like I'm never having a baby. It was mostly my family wasn't happy about it because my husband is half-Afrikaans so they weren't happy about it. Other people were like, you're going to have a baby, you're going to have a caramel baby.

It appears that Thembelihle's family was unhappy about her motherhood status. The reasons for this appear to be twofold: (1) her family had not expected her to become a mother and (2) her husband was a different race and as a result her child would be of a different race. The focus on race suggests that this was difficult for her family to accept and it further alludes to the rejection that Thembeihle experienced from her family.

Later on Thembelihle added:

It was another thing that was getting me down. That ugh here I'm starting this journey, don't even have my parents support and that just added more weight and I just got deeper and deeper into depression.

Thembelihle's parents were not supportive during her journey into motherhood and their lack of support negatively impacted on her motherhood experience. From the quotes above it appears that Thembelihle's parents had difficulty accepting her motherhood status and accepting her husband. As a result her family withdrew support and this lack of support contributed to Thembelihle's postnatal depression. The association between lack of family support and the onset of postnatal depression was illustrated in Knaak's (2009) study which explored the factors which contribute towards women's postnatal distress. In this qualitative study, the researcher found that women had negative support relationships with family and their partners. The women expected their family to be supportive and their lack of support contributed to their emotional distress in the postnatal period. This mirrors Thembelihle's experiences whose family was generally unsupportive and unaccepting of her motherhood status and her husband and this made motherhood much more difficult for her.

4.3.1.3. Pressure to be perfect mothers

A further sub-theme which emerged under women's expectations of motherhood was the pressure women felt from society to do mothering in a certain way. Two of the participant's reported putting pressure on themselves which resulted in distressed feelings about their mothering abilities.

Uhm, I think again, it came from looking at other people and thinking there's a specific way of doing things and being that it's supposed to be rosy all the time, the pressure came from myself because I had already didn't have such a good upbringing so I wanted to be a good mother. I wanted to give him what I had never had. So I put that pressure on myself to make it work, to make it right (Thembelihle).

Thembelihle's words illustrate that her own relational experiences impacted on her experiences of being a mother. Her mothering came from the pressure from society to be the perfect mother as well as her own negative childhood experiences.

Thandekile reported:

You don't know what to do because you've fed them, you've changed them. What am I doing wrong, is this child unhappy? What am I doing?

From her accounts above, it appears that Thandekile blamed herself for her baby crying despite the possibility that there could be a number of factors beyond her control that caused her child to cry. However she still placed blame on herself. Thandekile's account above further illustrate that in spite of the many steps she took to soothe her crying baby, her child continued to cry and she blamed herself for this, she felt that she was doing something wrong. A similar finding was reported in the study conducted by Jackson and Mannix (2004). In their study on women's experiences of motherhood, the researchers found that women internalized social pressure of perfect mothering and as a result questioned themselves as mothers and placed blame on themselves when their children engaged in deviant behaviour.

Thembelihle further reported:

Becoming a mother added to it because I was always an anxious person. Becoming a mother and having social pressure of what I should and should not do. Social pressure from strangers, my anxiety actually piqued. I'd go to the shop and someone would comment and say something like, 'Don't do that with your baby', 'you're supposed to do that with your baby'.

From Thembelihle's narrative it can be deduced that it is not just people in one's immediate network that pressure mothers, it is even strangers who put pressure on mothers to do mothering in a specific and unrealistic one way.

4.3.2. Adjustment to Motherhood

4.3.2.1. *Multiple losses*:

Multiple researchers have identified loss as a significant finding in relation to how mothers experience their transition into motherhood. Loss was also experienced by the women in the present study.

Thembelihle reported:

Uhm, you have this full identity change, completely, and some people avoid it by carrying on living as normal. But I made a decision to focus on my baby. (Thembelihle)...because now I'm just a mom, I'm just a mother. The me that was there, it felt like that me was gone. Now I have to like get rid of myself. I'm just this person's mother and it's horrible because when you think back, you like (inaudible) but you know you can't be that way anymore. I know some people do it but even with kids. I couldn't do it. I just had to switch from being me to being mom. That switch was quite Depressing because I had to come to terms with no more going out, no more socializing, losing friends because they don't understand that, you know, baby goes to sleep at 7 0' clock and you know 'why don't you leave baby with your husband? They don't understand because they don't have kids.

The above reflects the loss of identity that Thembelihle experienced once she became a mother. Thembelihle now sees herself as 'just a mother' and that her identity is only as a mother. It appears that Thembelihle felt that her previous identity was 'gone' once she became a mother. Furthermore, Thembelihle refers to the loss of friends in reference to the

loss of her social identity once she became a mother. The loss of identity which Thembelihle experienced was also reflected in the study by Lewis and Nicolson (1998). In their study on postnatal depression, the researchers explored the losses that women experience once they become mothers and how this sense of loss results in women being depressed. The researchers found that women were only recognized in relation to their children and that this marked a loss of their previous identity. The loss of her previous identity negatively impacted Thembelihle because she believed that she was reduced to 'just' being a mother.

In the quote above Thembelihle also refers to the losses in her social life and relationships due to the lack of understanding from friends regarding the responsibilities of motherhood. Upon entering motherhood, life as Thembelihle knew it changed drastically. Her previous social life was disrupted when she became a mother. The disruption and loss of former status was further evidenced in Nicolson's (2001) study with women who had postnatal depression. In this study Nicolson (2001) identified that when women become mothers they go through a move which encompasses a disruption and loss of former status. This former status for Thembelihle was her social status and social identity and this disruption appeared to be difficult for her to accept.

Later on in the interview Thembelihle added:

Also I stopped working, so that changed from Monday to Friday getting up early and going to work, coming back, to waking up not doing anything, not going anywhere. That alone is Depressing.

Thembelihle's experience reflected in the above quote illustrates how loss of her occupational status and the loss of her daily routine caused her to become depressed. A similar finding was reported in the study by Bilszta et al. (2005). In this study, which explored women's experiences of postnatal depression, the researchers found that once they became mothers, women mourn the loss of their previous life, a life that existed before the baby was born. This change was particularly significant to the women because the women felt like they had lost control over their lives. This also echoes Thembelihle's experiences of early motherhood as she lost the daily routine that she had grown accustomed to. This serves to illustrate that when women become mothers, there is a change in significant life roles, such as a change in

occupational identity, and this change marks a significant loss. This change in life role was one of the factors which contributed to Thembelihle developing postnatal depression.

In a study conducted by Edhborg, Friberg, Lundh and Widström (2005) the researchers explored Swedish women's experiences of postnatal depression during the first months of motherhood. The researchers found that women struggled with integrating their previous identity with their new identity as mothers. Their struggle with identity emanated from the loss of work during their mandatory maternity leave. A consistent finding emerged from Taylor's (1995) study whereby women experienced a lost sense of self as a result of leaving work once they became mothers. Thembelihle experienced a similar sense of loss.

In the relational perspective to understanding postnatal depression, the second factor associated with women developing postnatal depression was women's conflict with conforming to cultural standards of perfect mothering while simultaneously rejecting these standards (Mauthner, 1998). For example, in Mauthner's (1998) study, the researcher found that women attempted to live up to the cultural standard of engaging in full-time mothering but they also tried to resist this by balancing motherhood with employment however this proved to be difficult. Thembelihle consciously made the decision to end her full-time employment in order to take care of her new born baby, however, she found that this marked a serious loss in her occupational identity and social identity and she saw this loss as one of the factors that lead to her postnatal depression. Thembelihle's narrative illustrates how the role of motherhood has become central and that other parts of her identity have fallen away so that she is now 'just'' a mother. A similar finding was observed in Berggren-Clive's (1998) study. The researcher found that women had difficulty integrating their new identity as a mother with their previous identity and this internal struggle contributed to women developing postnatal depression. This illustrates that Thembelihle experienced an internal conflict in terms of who she became as a mother and this internal conflict may be associated with her developing her postnatal depression.

According to Thandekile:

Your sleeping patterns change, the child is dependent on you. So your time is controlled by the child. So basically you work around them. It's no longer about you, it's them first and then you after.

The above illustration is from the perspective of two women who were first-time mothers. The women's experiences above demonstrate that the transition into motherhood is met with sacrifices and changes that women have to make; occupationally, socially and personally. Thandekile's experiences reflect a loss of independence and having her own time when she became a mother. The loss of independence associated with motherhood was further reflected in the study by Buultjens and Liamputtong (2006). In their study on women's experiences of postnatal depression, the researchers also found that upon their transition into motherhood women experience a loss of independence. These changes include a change of identity status from not being a mother to being a mother, a change in social identity in which opportunities for socializing are limited or not at all possible, a change in professional identity which involves leaving one's occupation in order to mother and ultimately becoming a mother results in putting the needs of the child first.

Thembelihle further added that:

Before I was very outgoing, I spent a lot of time with my friends. I was always happy, joking. I was always the one to go to have a good time. Uhm ya, I was young, I was carefree and obviously I met with my husband and I was slowed down a bit but we didn't settle down. I mean good times together but then when we fell pregnant we realised we had to cut things down a bit. We still have good times at home, we watch movies, go out for drinks but then when our baby came, it became serious. There was no more partying. Just serious. It was just too serious and that "Thembelihle" was all about just being a mother. She was focused on just being a mother and forgot everything else.

Yet again, Thembelihle's words illustrate the extent to which life changed for her when she became a mother. She describes how serious her life became and how much more structured and disciplined she had to become as a mother. Furthermore, her expression also illustrates how her identity had shifted and she identified herself as just a mother. With the assumption being that her identity and life's purpose is reduced to just being a mother. Furthermore Thembelihle refers to herself in the second person and this highlights the extent to which she feels alienated from herself. Staneva and Wittkowski's (2012) study which explored mothers' expectations of motherhood found that women reported that motherhood for them included gains as well as losses. The losses that these women experienced when they became mothers

were the loss of autonomy, sexuality and occupational identity. This serves to demonstrate that women attempt to live up to the ideal of a 'good mother' by engaging in full-time child rearing practices but at the same time, this transition marks a loss in a women's life including her identity, autonomy and independence. This was reflected in Thembelihle's experiences as well.

Nicolson (2001) provided the argument that "depression is the typical response to a loss and bereavement" (p. 12). Nicolson (2001) maintains that depression also accompanies life changes that compare to a loss such as pregnancy, marriage or having a baby (Nicolson, 2001). According to Nicolson (2001) pregnancy and childbirth should be conceptualized within the grief model because just as grief is a reaction to a death, which is a loss, so too is having a baby accompanied by a loss. Furthermore, just as death and divorce accompany emotional lability, so too is having a baby also accompanied by periods of emotional lability. In the above illustration the loss Nicolson (2001) references is sleep, time for one's self, loss of self and change in body image. More importantly Nicolson (1990) further argues that childbirth and early motherhood demands physical and psychological adjustment. Postnatal depression creates a certain paradox (Nicolson, 2001). The paradox is that becoming a mother is expected to be a moment of happiness and celebration however for some, becoming a mother causes emotional pain and suffering (Nicolson, 2001). These conflicting feelings results in feelings of guilt (Nicolson, 2001). Therefore, given that becoming a mother is a process of adjustment and that this adjustment process encompasses a loss of previous identity, loss of previous employment status and in some cases loss of relationships, it should be accepted and expected that some women would become depressed (Nicolson, 1990). These series of losses was clearly reflected by the women in the present study however the difficulty in accepting these losses coupled with how motherhood is socially constructed contributed to women's difficulty in their mothering role.

4.3.2.2. Difficulty coping with motherhood

The third sub-theme identified under the adjustment to motherhood which was associated with the development of postnatal depression in the mothers in this study is the expressed difficulty in coping with motherhood. Taylor's (1995) study on women's experiences of postnatal depression illustrates that one of the factors which causes women to become depressed after childbirth is a sense of being overwhelmed with mothering. This feeling was also expressed by women in the present study. Two of the participants expressed

experiencing a sense of being overwhelmed and difficulty coping with motherhood. A consistent finding was reported by Edhborg et al. (2005) who found that women felt unprepared for motherhood. This manifested as a perceived lack of confidence in caring for their children.

But for me it was just too much. It was overwhelming. It was just too much because I wasn't coping, they baby would cry. I just wasn't coping. Everything was like I was waking up in a nightmare (Ntombenhle)

Ntombenhle's uses the word 'nightmare' to describe her experiences of motherhood suggest that she experienced motherhood to be overbearing.

It felt like too much, like everything was too much. It felt like I had really lost myself. So depressed that the only thing that made sense was to get rid of myself completely (Thembelihle)

Thembelihle was so overwhelmed in her initial experiences of motherhood and caring for her baby that she preferred to escape motherhood by the use of her words "get rid of myself". These women's experiences indicated above suggest the loss of control they experienced in motherhood. In Berggren-Clive's (1998) study on women's experiences motherhood and the onset of postnatal depression, the researcher identified the sub-theme "falling off the edge" to describe the continuum of emotional and behavioural symptoms that women experienced in response to motherhood. The women in this study described urges to either hurt themselves, hurt their babies and/or difficulty functioning on a daily basis. This appeared to be reflected in Ntombenhle's and Thembelihke's experiences as both these women expressed a sense of being so overwhelmed with motherhood that for both motherhood became unbearable.

Thembelihle also reported:

The first time, I ended up at a friend's house. The second time I ended up at my mummy's place. And you know, I understood why some people left their kids because sometimes it feels too much and it feels like the only way is to go.

The above illustration suggests that yet again, motherhood was difficult and unbearable that Thembelihle decided to leave her baby and her husband on two separate occasions. This suggests the sense of helplessness that she experienced in motherhood.

Two of the participants reported feeling unprepared for motherhood and this perceived lack of preparation impacted on their coping abilities.

According to Thandekile

I don't think I was prepared. I don't know if you can be prepared because some people just get it without preparing, they manage okay. Others don't. So I think that we all have this thing, once you have a child, you do this, you do this but when that happens … (Thandekile)

Thandekile further added:

I don't think I was prepared. I don't know if you can be prepared because some people just get it without preparing

Thandekile's illustration suggests that she thinks that there is something wrong with her. This is evident in her belief that some people adjust easily to motherhood whilst she feels that she falls short of this as she is unprepared for motherhood.

Ntombenhle reported:

I remember the last time I was leaving (the hospital), *I cried because I felt like I'm going to be alone with this baby.*

The above quote suggests that Ntombenhle was afraid to be left alone with her new born baby. Her fear was clarified further in the below quote when she added:

I felt like I was just given a child. I've never really been a mother what am I going to do? What am I going to do? When he cries, I would cry with him. Every night I couldn't sleep because of it. I think that stressed me the most.

Ntombenhle's experiences reflected above suggest that she felt helpless as a mother. Her panic can be sensed when she questions herself and this feeling of helplessness impacted on her sleep patterns. Her feelings of helplessness, sense of panic and anxiety was illustrated in the study by Coates, Ayers and de Visser (2014). In their study Coates et al. (2014) explored how women experienced and made sense of their postnatal experiences. Women's experiences of being overwhelmed and uncertain about motherhood were in relation to their inexperience of motherhood. The women in the study had anticipated that pregnancy would prepare them for motherhood however they soon became overwhelmed with motherhood. The researchers argue that a perceived lack of competence in mothering causes women to experience a sense of being overwhelmed, to feel inexperienced and to feel anxious about motherhood and this contributed to women being depressed after childbirth.

Similarly, in a study conducted by Westall and Liamputtong (2011) on women's experiences of postnatal depression the researchers found that most women felt unprepared in assuming the parenting role after the arrival of their baby. As a result of this, women felt anxious and overwhelmed in their new mothering role. Similarly in the present study, these two mothers experienced difficulty coping with motherhood and felt overwhelmed in their motherhood role. Just as the women in Mauthner's (1998) study believed that they should cope single handed with motherhood, so too did the women in the present study also believe that they should be able to cope alone with childrearing. However they soon became overwhelmed and they realised that they needed help. And this realisation was interpreted as a sign of weakness to mother.

Furthermore, later on in the interview, Ntombenhle stated:

It's still a struggle, sometimes you get okay then sometimes you don't.

Ntombenhle's experiences of motherhood illustrates that she experienced difficulty in her mothering role because she did not know how to mother. Furthermore her experiences are in contrast to scholars who have previously argued that because becoming a mother is biological it is therefore easy, natural and instinctual. Ntombenhle's experiences of motherhood are in stark contrast to the attainment of the maternal role which states that motherhood is achieved easily. Ntombenhle's words further signify that motherhood is an ongoing process and one

that engenders continual reflection, renegotiation of self and renegotiation of self in relation to one's child.

Thandekile reported:

Yes they make it seem so easy; I'm like yes I can do it, uh uh. I guess we all different, for me it wasn't fun. I don't think I can manage. I find that they were too much.

Thandekile further added:

It was very hard for me. I used to cry. When the child starts crying I start crying too (P3)

Of significance in Thandekile's narrative is the "they" she refers to in reference to the representation of the maternal ideal. The maternal ideal, as mentioned previously refers to the image of the perfect mother who is able to easily engage in mothering, who is selfless and puts her child's needs before her own (Held & Rutherford, 2012). However, this was not her experience. Thandekile felt helpless and this is evident in her reported bouts of crying when her child cried as well.

4.3.3. Social pressure:

4.3.3.1. Comparing with other mothers
One of the sub-themes which emerged under the superordinate theme social pressure was that women compared themselves to other mothers and subsequently felt inadequate. This sense of inadequacy was associated with the development of their postnatal depression. Two of the participants reported experiences whereby they compared themselves to other mothers and this comparison resulted in feelings of inferiority and of 'not doing mothering right'. The relationship between women comparing themselves with other mothers and postnatal depression was illustrated in Mauthner's (1995) study on women's experiences of postnatal depression. In this study, Mauthner (1995) found that, amongst other factors, women actively compared their mothering experiences with other mothers by checking in with them about their experiences regarding childcare such as feeding, the child's behaviour and their own negative emotions regarding motherhood. When women found that their experiences of motherhood differed from other mothers, this resulted in women withdrawing and isolating

themselves from other mothers. A significant and relevant finding in this study was that women withdrew from their social relationships because they had perceived that they were doing something wrong and that they were bad mothers. Comparing their mothering abilities with other mothers was also observed in the present study.

According to Thembelihle:

I think we watch too much tv. And also when we see other people, even though we don't know what's going on in their lives, they always look happy. They always look like they got things together and they're doing their thing. So if you come and I'm not doing this well, you feel like a loser. Something must be wrong, they're getting it right but why can't I get it right, so…

Thembelihle's use of the word "loser" in the quote above reflects that she compared herself to other mothers and through this comparison she felt like she was doing something wrong. Her words suggest that she experienced herself as a failure as a mother.

According to Ntombenhle:

Everybody thinks they are better mothers than the other mothers.

According to the relational perspective to understanding postnatal depression (Mauthner, 1998), the interpersonal context was associated with women becoming depressed after childbirth. Within the interpersonal context one of the factors associated with women developing postnatal depression arose as a result that women compared their mothering abilities with other mothers. This was because women compared their mothering abilities to other mothers and perceived themselves to be bad mothers when their mothering abilities differed from other mothers. This was also observed in the present study as illustrated by Thembelihle and Ntombenhle's accounts.

4.3.4. Perceived fear of judgement

4.3.4.1. Reluctance to disclose struggles of motherhood:

Although the study conducted by Babatunde and Moreno-Leguizamon's (2012) focused on immigrant women's experiences of postnatal depression, similar patterns of distress were experienced by women in the present study. In the study conducted by Babatunde and Moreno-Leguizamon (2012) women struggled to cope with motherhood and in their difficulty coping they reverted to suffering in silence for fear of judgement and being labelled as mad.

It's embarrassing, you know. I'm speaking from myself but it's embarrassing to tell someone that you're failing because it feels like you failing. (Thembelihle)

Thembelihle was afraid of speaking about her postnatal depression because she perceived that she failed as a mother. Thembelihle further added:

I think you, we, I don't know about any other mothers'. You don't want anyone else to know there's something wrong with you…let's say you're diagnosed with that, you still feel like maybe they made a mistake, maybe it's not true. So there's no way you're going to know until someone shares it with another mother. Something you're embarrassed about or even still trying to understand.

From Thembelihle's narrative above, it appears that she had difficulty accepting her diagnosis of postnatal depression and her way of coping with this was her hope that she was misdiagnosed. Her difficulty in accepting her diagnosis of postnatal depression centred around feelings of embarrassment and believing that she was alone in her diagnosis. According to Thandekile:

No I don't think he understood it as well. So I didn't say anything to him. Instead of talking I just used to leave the child with him.

Thandekile later added:

Because you supposed to be happy. Social pressure about the way you supposed to be, you can't just tell people I've got postnatal depression because they're going to judge you and give you advice that you need help. I didn't tell anyone. And also I had anxiety of people; it just would've made things worse.

Thandekile's experiences reflected above indicate the conflict she experienced with motherhood. This conflict was related to the maternal ideal that motherhood is a happy and joyous experience. Frizelle and Hayes (1999) study explored South African mothers experiences of motherhood and how the maternal ideal impacts on women's mothering. The researchers found that women tried to live up to the maternal ideal and in so doing the women experienced a sense of guilt and inadequacy when they felt that they were not living up to the ideal. "Western romanticized ideologies of motherhood have an enormous impact on how women are stereotyped" (Gross, 1998, cited in Kauppi et al., 2011 p. 58) as they portray images of women as self-sacrificing and put the needs of the family above their own. Given this position, postnatal depression is viewed as a personal defect to which women believe they have to hide their feelings for fear of judgement (Kauppi et al., 2011). Given Thandekile's experiences above, this suggests that because she realised that her experiences of motherhood were not reflected in the dominant discourse of motherhood, she perceived that she would be judged and this contributed to her anxiety.

These two women experienced difficulty in speaking about their struggles in relation to motherhood and as a result chose to remain silent due to perceived fear of being judged. This finding is consistent with literature previously revised which illustrates that women opt to remain silent when they experience difficulty coping with motherhood and this 'suffer in silence' mentality contributes to the development of postnatal depression. The present study illustrates that women engage in an active struggle with themselves, with those around them and their social world (Mauthner, 1998). This struggle included women silencing their voices because their experiences contrasted with what they perceived to be 'good mothering' (Mauthner, 1998). The silence that exists in women's struggles with motherhood was observed in the study by Homewood et al. (2009). The women in the study also struggled with motherhood which led to them being depressed. However, the women remained silent about their struggles because they feared being judged by others. A consistent theme was observed in the study by Edhborg et al. (2005) where the researchers identified three struggles that women encounter in their experiences of motherhood. Women struggled with

themselves as they desired to be perfect mothers. Women struggled with their children in that they felt unprepared for motherhood and women struggled with their partners in that they struggled to have enough time with their partners and they further experienced a strained relationship with their partners. Within their struggles women were reluctant to confide in significant others due to feelings of guilt and shame they experienced in motherhood. The reluctance to speak about their struggles in motherhood is significant to women's experiences of motherhood and was further evidenced in the present study as illustrated by Thembelihle and Thandekile's experiences.

4.4. Women's reactions to being diagnosed with Postnatal Depression

This section serves to provide a background of these courageous women's initial reaction when they were diagnosed with postnatal depression.

According to Thembelihle:

It made me even more depressed. It's not the picture I had after having my baby. I just had the perfect picture of being with my baby, having my baby, picking him up, everything being rosy. I didn't picture being sad, depressed, down. You know, everything just looking blim. That's not the picture I had and that made it even worse for me. That okay, now you're depressed, it's something worse.

Thandekile's quote above suggests that being labelled with postnatal depression did not help her, in fact this label made it worse. Therefore in addition to motherhood not being what she expected she now has to deal with her depression.

I was kinda sad and depressed because sometimes you never think it will happen to you. I was like ah, so when I heard it was that then I'm like okay, it's sad but it happens, it happens.

From the above illustrations, it is apparent that Thembelihle and Thandekile's reactions to their diagnosis was difficult to acknowledge and made them feel even more depressed. The women were evidently sad about being diagnosed with postnatal depression especially since, as demonstrated by Thembelihle, this was neither the image nor the expectation she had of becoming a mother. What can be deduced from these women's reactions is that it was difficult being a mother *and* being diagnosed with postnatal depression. A consistent finding

70

was found in Westall and Liamputtong's (2011) study. In their study on women's reactions to being diagnosed with postnatal depression, the researchers found that women expressed ambivalence and difficulty accepting the label of postnatal depression. On the other hand the researchers also found that some women were more accepting of being diagnosed with postnatal depression and the rationale behind this is that the women were relieved that they would be getting help to improve their emotional well-being and that they would no longer have to pretend to be okay. This was Ntombenhle's rationale to finding out she had postnatal depression. Ntombenhle did not struggle with being diagnosed with postnatal depression. She accepted this diagnosis and was focused simply on getting better. Ntombenhle reported:

I didn't care about being a good mother. I just wanted to get better. I just needed to get better.

Ntombenhle's reactions to being diagnosed with postnatal depression suggest that she was dissociated from this diagnosis. She was focused on just getting better.

4.5. Lack of awareness of postnatal depression in Black African culture:

Given that this study explored Black African women's experiences of postnatal depression, it was deemed necessary and of relevance to include how postnatal depression is perceived in African culture. This section serves to illustrate the perception and understanding of postnatal depression from within the African culture.

People don't really know about Depression, they think I'm bewitched or something. There were a lot of people they were telling me, no maybe it's the epidural because I felt this heat, this intense heat, my head would burn. Then I wouldn't stop sweating, everything. I didn't know what was going with me, it was the first time I heard about this postnatal depression or even Depression for that matter.

According to Thandekile:

I don't think they would understand. Especially in the Black community, when these things happen you don't take them seriously. It's a phase. So we don't think it's a sickness or…So even if you going through this kind of thing, they think it's nothing. Meanwhile it's serious, children actually die.

Thandekile further went on to add that:

….culture plays a big role, especially in the Black community again because they say that every Black women should be capable of raising a child whereas it's not so. You don't have this thing where it comes naturally. It takes a lot.

There appears to be somewhat of a lack of understanding and awareness of postnatal depression in the African culture. This lack of understanding is evident in the fact that it can be interpreted as a sign of bewitchment, as illustrated by Ntombenhle. Furthermore, based on Thandekile's narrative, it appears that motherhood in African culture is thought to be a naturally occurring process. This is similar to the Western discourse on motherhood and the dominant ideology that motherhood is a natural and easy process. However, this was not Thandekile's experience and this unspoken cultural expectation may have further contributed to her postnatal depression. The above quote highlights that the ideal of motherhood that is documented in much of the literature is based in the Western context, is also evident in the stories of these mothers.

We often hear the phrase 'strong Black woman' in reference to the strength that Black women naturally posess in the context of hardships and inadequacy they experience (Beauboeuf-Lafontant, 2009). The 'strong Black woman' is one who is expected to "carry the weight of the world on her sturdy shoulders" (Beauboeuf-Lafontant, 2009, p. 24). The 'strong Black woman' "is the vision of one who is seen as more capable than all men but less incapable than white women" (Beauboeuf-Lafontant, 2009, p. 25). She is one who is "emotionally resilient, physically indomitable and infinitely maternal superwoman" (Beauboeuf-Lafontant, 2009, p. 25).

Strength is a culturally generated term which serves as protection for Black women against adversity and hardship (Beauboeuf-Lafontant, 2009). While the strong Black woman is a prized role, it places Black women at a disadvantage because the strong Black woman metaphor creates the assumption of a Black woman as a maternal figure who is always willing to go the extra mile to help others (Gillespie, 1978, cited in Beauboeuf-Lafontant, 2009). Beauboeuf-Lafontant (2009) argues that the ideal of a 'strong Black woman' places Black women at a pedestal and subjects them to relational and sexual exploitation. This

'strong Black woman' has a dual status whereby on the one hand Black women are strong enough to overcome any adversity and simultaneously Black women have to remain silent in the face of adversity because it is assumed that they can overcome anything and to complain would subject her to scrutiny and ridicule. Beauboeuf-Lafontant (2009) maintains that from a young age girls are socialized into putting the needs of others above their own. This refers to the needs of her husband and her child (Collins, 2000). Black mother is, therefore, an institution (Collins, 2000). However it is a fundamentally contradictory institution (Beauboeuf-Lafontant, 2009). It is because of its rewarding nature and also due to the high personal cost it exacts on Black women (Beauboeuf-Lafontant, 2009).

4.6. Consequences of postnatal depression

4.6.1. Behavioural consequences of postnatal depression

As mentioned previously, this section serves to illustrate the behavioural and emotional consequences of postnatal depression. The behavioural and emotional consequences alluded to is in reference to the degree to which postnatal depression affected these women's ability to interact with and relate to their children and other important areas of functioning such as work.

According to Thembelihle:

It always felt something was going to happen at any moment. For example I would just get angry. I'm angry because now I'm depressed. I'd take it out on my husband and also my environment whenever I'm depressed. I don't have the energy to do any housework, so I would neglect my environment.

Ntombenhle reported:

That time I was on maternity leave and I didn't want the baby next to me. I would cry all the time. Luckily my daughter would even assist me. I would cry all day, not wanting to eat, not wanting to do anything. So when the baby was five months he went to visit his Dad. Still I didn't want to do anything. He had to take over, feed the baby. I would just lie in bed and cry.

....even at work they have to know my quota. It's been a year now; I don't work the full quota because I need to focus.

In addition to this Ntombenhle added:

I didn't want to bath, I didn't want to eat. I'm just doing just to stay alive.

For Thandekile:

....the first few months I didn't like it at all. I didn't want to do it all the time. To the point where I didn't want to have anything to do with the child.

This, Thandekile shared in reference to mothering. A recurrent behavioural consequence demonstrated in the women's experiences was that of crying. Thembelihle cried because she was angry that she was depressed and depression to her signified that she was being perceived as a failure as a mother. Ntombenhle's occupational functioning decreased as a result of her postnatal depression. Ntombenhle and Thandekile did not want to interact or bond with their baby as they appear to recognise that their babies were the source of their distress. From the above illustrations, it can be deduced that these women who developed postnatal depression, negatively affected their ability to interact and bond with their children, their occupational functioning and their daily functioning. Godderis (2010) maintains that women's owns rights are disregarded, women's expression of emotional distress is overlooked and the primary focus is on the child and her family. This illustrates that if we focus too much on the impact of the bond between mother and child then we overlook the social context of mothers and their rights.

4.6.2. *Emotional consequences of Postnatal Depression*
This section serves to demonstrate the emotional impact of postnatal depression that these women experienced.

According to Thandekile:

Exhaustion, being tired. I suppose that goes also with sleeplessness. Just at times I never even wanted to look at the child. Feeding was an issue because I had to play and I didn't want to play.

I just felt inadequate in all areas of my life. It just felt like I was caving in. I can't do any of this. I actually wanted to kill myself one time. My baby would be better without me because I can't do this.

The emotional consequences of postnatal depression were fatigue and insomnia as well as suicidal ideation in relation to perceived sense of inadequacy. In the study conducted by Westall and Liamputtong (2011) the researchers found that women experienced delayed bonding with their babies since either birth or after leaving the hospital. Delayed bonding is characterized as difficulty attaching to the infant. In their study women expressed difficulty bonding with their baby for an average of 3-4 months. In the present study all the women expressed difficulty initially bonding with their baby and only reported that bonding occurred after their babies were a year older. A similar finding was observed in Mauthner's (1998) study. This finding presents a contrast to the maternal ideal and the premise that motherhood and mothering is instinctual and biologically determined behaviour (Nicolson, 1998) and that bonding will happen naturally. What may be deduced from this is that women slowly learn to adjust to motherhood and the mothering role and that bonding is a process too. This further stems to illustrate that mothering is learned behaviour and not something that women naturally acquire.

4.6.3. *Questioning mothering abilities*

A further consequence of postnatal depression is that women question who they are as mothers. This was expressed by two of the participants. Thembelihle noted:

Yes, I always felt like I was a bad mom. I felt bad for my son for having me as a mother because I always felt if he had another person as a mom he'd be happier, he would be better off because I always felt there was something wrong with me.

Thandekile reported:

*Ya I felt bad because I really hated being a mother because I didn't know what I was doing.
There I was thinking I'm doing the best I can but at the time I was not. I thought ey this child
is irritating me what do I do.*

The above narratives suggest that women made negative conclusions about who they were as
mothers based on their difficult experiences in mothering. The above illustrations further
indicate the guilt which is associated with maternal ambivalence, the hate aspect of being a
mother. The illustration from the above is from the perspective of, at that time, first time
mothers. Based on the difficulty these two women experienced in early mothering, they
questioned their worth as mothers and sadly perceived themselves as bad mothers.
Homewood et al. (2009) study further demonstrates the negative self-evaluations that women
make about themselves. Women in the study judged themselves as mothers in the context of
other mothers. Women further questioned their mothering abilities and this contributed to the
women developing postnatal depression.

4.7.   How women negotiate motherhood

In keeping with the study's objectives, this section is dedicated to providing illustrations of
how women eventually manage their postnatal depression and negotiate their difficulties in
motherhood. Three factors were identified from each woman's transcription which illustrates
how women reconcile with their experiences of postnatal depression. Reconciliation in this
study refers to ways in which women navigate their way through motherhood. These factors
are illustrated below.

4.7.1.   *Reintegrating previous identity with new identity as a mother*

During the interview, the women were asked how they have come to balance their current
motherhood identity with their previous identity and this is what Thembelihle had to say:

*I don't know where she is now. It's what I'm trying to figure out with my psychologist. How
to bring her back? Maybe not bring her back, how to make a new one. So she's not there still.*

From the above illustrations, Thembelihle uses the word "she" in reference to her old self. It
appears that Thembelihle is still on her journey to reintegrate her pre-motherhood identity
with her post-motherhood identity. It appears that Thembelihle recognises that perhaps there
is no way of bringing her old self back, that it is about a 'new self' emerging. Thembelihle

uses the words "a new one" in reference to a new Thembelihle and a new identity. This recognition of a new identity demonstrates that the self is constantly being constructed in relation to people's experiences. This further illustrates a social constructionist view on one's identity which is shaped by context and continual interaction with others (Burr, 2003).

Thembelihle also shared that:

My husband, comedy, movies, music, yeah. It's just my husband is the other person that helped and music and dancing…

This illustrates that Thembelihle began to gain a sense of herself through engaging in previously enjoyed activities.

Ntombenhle stated:

I took control of myself. I started to enjoy myself. I started dressing. Doing things I used to do and I felt empowered because I was getting myself back.

From the above illustrations it can be deduced that these women had to find themselves again after they became mothers. These women had to learn to reintegrate their previous identities as individuals in terms of the activities they enjoyed engaging in with their current identity as mothers. In coming to terms with motherhood, a mother therefore needs to recognize the loss and accept that things have changed (Nicolson, 2001). Thereafter a mother needs to work towards re-integrating oneself with the changes that accompany motherhood (Nicolson, 2001). Changes such as change in sleeping pattern, change in alone time, change in identity and change in body image (Nicolson, 2001) accompany motherhood and if women are able to work towards recognizing, accepting and integrating these changes into their new role, this facilitates a healthier adjustment to motherhood. From this perspective, women would not have to blame themselves or feel guilty about their struggles in motherhood. Based on these women's process of negotiation through motherhood, it appears that these Black African women went through a process of reintegrating their previous identity and roles with their new found role of motherhood. Furthermore these Black African women went through the process of adjusting into their role of motherhood. These women further underwent a process of recognizing their negative experiences of motherhood and slowly began a process of these

experiences. The process followed by these women is synonymous with those outlined by Nicolson (2001) and this further strengthens the argument that motherhood is a process of adjustment and that women's experiences should not be labelled nor pathologised.

4.7.2. *Gradual adjustment to the role of motherhood*

This section serves to illustrate these women's journey and transition into motherhood. Ntombenhle notes:

Not easy but hey, every day is a new day. One step at a time, you just don't get there.
Thembelihle explains:

...in terms of motherhood, I've eased up on myself. I'm now at a different stage because he's now at a different stage, older now. So I'm having to deal with different problems but it's different now because he can talk so I can negotiate with him, explain things whereas before, if he's crying, I'd have to figure out why. I'd feel like I'm doing something wrong. So I think it changed as he changed. It didn't just happen because of me. I think it changed as my child grew older.

As mentioned previously, as the child develops, the way in which mothers experiencing mothering changes. Thus when Thembelihle was able to negotiate with her child then mothering becomes easier. Thembelihle's experiences above illustrate that motherhood is a process that requires adjustment and this role changes over time.

Thandekile stated:

Uhm, I won't lie, I thought some days were better than others where some days we okay and then suddenly it just changes. This child's not going anywhere. I'm like you know I've played and now I just want to be alone. But then it's your child, you can't send them anywhere so....other days would be nice bonding session, play, read a book to the child then I'm like I'm tired now can somebody please take this child. I was lucky because my mom used to visit. So she'll take her on weekends. I just have me time.

What can be deduced from the above illustrations is that women grow into the motherhood role and as such the motherhood is a gradual process and mothering is a gradual experience.

These women's honesty in their adjustment to motherhood is significant as it challenges the dominant discourse on motherhood as natural and easy transition which all women are expected to achieve.

4.7.3. *Information seeking behaviours to adjusting to motherhood*

A further approach that helps women adjust to their mothering role is empowering themselves through information seeking. This is important to do however the danger of this is that these kinds of programmes can often reinforce the very ideas that have contributed to their depression initially. Ntomenhle noted:

There's no manual to be a mother you just find your way. But I watch a lot of things like Dr. Phil. I watch a lot of tv.

Thandekile reported:

I just read baby magazines and books.

In Mauthner's (1998) study, the women managed their depression by accepting their difficulties with motherhood and ultimately accepting themselves for who they are. This involved a process of separating their own experiences of motherhood from the dominant discourse of motherhood. Similarly in the present study Thembelihle and Ntombenhle managed their postnatal depression by negotiating through their transition into motherhood by reintegrating their previous identity with their new identity as a mother. Both of these women achieved this by engaging in previously enjoyed activities. The women further gradually adjusted to their role as mothers and this gradual adjustment led to these women gaining a sense of control over their mothering abilities. From the above, it appears that women continue to manage and negotiate the motherhood role through self-empowerment, acceptance and control. Women further negotiated their way into motherhood through information seeking behaviours. Ntombenhle achieved this through the use of the media and Thandekile achieved this through reading.

4.8. How women negotiate postnatal depression

This section details how women negotiate and manage their postnatal depression. Two factors contributed to women coming to terms with their diagnosis and managing their postnatal depression.

4.8.1. Help-seeking behaviours women engaged in

This section illustrates the process that women followed in consulting professionals when they realised that their emotional, cognitive and behavioural functioning was impaired.

According to Ntombenhle:

I learned about SADAG when I was a teenager because I got diagnosed with Depression when I was a teenager and they gave me SADAG's number to contact in case of anything. So I've always known about them. I've never used them until now.

Ntombenhle stated:

Because I'm a talkative person, I speak about something that's troubling me, so I told my mother, she didn't know what to tell me. luckily I have a friend that works for SADAG so I told her what was happening and at that time I couldn't sleep, I couldn't do anything, I would just cry, the whole day cry. Then I phoned, there's a wellness programme at work for free. I phoned the counsellor they told me you might have postnatal depression. I didn't understand it so I went to a psychologist and I paid cash. The psychologist just told me that I need to breathe in, breathe out when I have anxiety. Went home, started breathing exercises but it was worse. So I googled psychologist and psychiatrist and they told me psychiatrist is someone who will medicate you. So I went to the psychiatrist that I googled. He automatically put me on medication for postnatal depression.

I remember I went to the baby's check-up and the Dr asked how I was feeling.

4.8.2. Use of Anti-Depressant Medication:

With regards to medication Thembelihle noted the following:

I just got deeper and deeper into depression. But now I'm on medication. I can just call my psychiatrist, I don't feel good, I need to see you. Make an appointment, go in and iron it out

According to Ntombenhle:

I'm still on anti-depressant medication, I won't get off them. My son is 1, it's still a struggle, sometimes you get okay then sometimes you don't.

It appears that through the use of pharmacological interventions, women begin to negotiate and manage their postnatal depression. While the participants clearly benefitted from the intervention of counsellors and psychiatrists it is interesting that their interventions were behavioural (breathing exercises) and medically focused through the use of pharmacological means. The methods adopted to help these women manage their postnatal depression were in line with the medical model of postnatal depression. Regus (2007) provided an argument about the role of the medicalization of postnatal depression. According to Regus (2007) medical professionals determine what 'normal' behaviour is for mothers and this subsequently sets the stage for the diagnosis of women who do not meet the expectations for normal emotional, cognitive and behavioural functioning. Regus (2007) further maintains that the medicalization of postnatal depression lays the premise for women to be diagnosed and treated for postnatal depression yet the societal expectations that women be perfect mothers is ignored.

According to Regus (2007) women who fail to live up to the maternal ideal become patients of the medical professionals who then offer hope of recovery from postnatal depression. A significant argument Regus (2007) raises is that medicalization of postnatal depression provides a quick fix for women suffering from postnatal depression and it removes the potential for "social change as it locates the problem with the individual" (p. 59). This then maintains and strengthens the medicalization of women's experiences of motherhood as it affirms the belief that there is one way to mother and if women's mothering differs from the 'norm' they are pathologized. This was evident in the present study as all the mothers consulted with health professionals when they realized that their emotive, affective and behavioural functioning was in contrast to what was socially presented. This displays that little or no shift is being undertaken to understanding the reasons that contributed towards women's distress in the postnatal period. This further reinforces the notion that depression

after childbirth symbolises pathology and that there is something wrong with a woman who becomes depressed once she becomes a mother, rather than something with the way in which motherhood is socially constructed.

4.8.3. *Becoming open about Postnatal Depression*

Women further managed their postnatal depression by openly acknowledging it and speaking about it. This is evident to Ntombenhle's narrative:

My world was crushed, it was damaged and I needed to be restored. And luckily I have support. I would tell everybody about what happened. I'm not the kind of person who says I'm going to secretly deal with issues. No! I told even my ex-boyfriends mom. Everybody knew.

From the above narrative, it appears that Ntombenhle's experiences contradicts earlier findings of how mothers did not initially talk about their postnatal depression (Homewood et al., 2009; Lewis & Nicolson, 1998; Mauthner, 1998). This further indicates that in talking about her postnatal depression, Ntombenhle found relief and support.

4.8.4. *Acceptance*

Thandekile said the following about coming to accept her depression:

I was kinda sad and depressed because some things you never think it will happen to you. So when I heard it was that, then I'm like okay, it's sad but it happens it happens.

This demonstrates how this mother reached a degree of acceptance of her postnatal depression and how this acceptance allowed her to continue mothering. The above quote further highlights how Thandekile began to normalise her experiences and by doing so she was able to cope with motherhood.

4.9. Message to other mothers

This section includes the message that these brave women would like to share with new mothers, prospective mothers and other mothers who have postnatal depression.

According to Thembelihle:

They must seek help in any way, whether it's family, a specialist, anyone. They must get help because it just gets worse, it doesn't get better. And the sooner you get help, the sooner you can get better. That's what I would say and not to uhm, feel pressured by social pressure or if someone says just get over it. If someone sees it's a real thing, they must get help.

Ntombenhle stated:

Breathe in, breathe out, it's going to be okay. Take your time and one of the most important thing is, when you feel something don't be ashamed to say; there's something that I'm feeling because had it not been for me speaking about it, maybe I would have killed my child. Maybe I'd be dead. So the moment you feel like something is wrong, something is stressful, don't even bother who will judge you. Just tell the truth, then you'll get help.

Ntombenhle further added:

Teach them before they give birth. Have classes with them to say this is something you might expect because for me nobody told me that. Had I known at the time, I would have gotten help sooner but because I didn't know about it. Maybe it should be part of gynaecologist should give people pamphlets or what not to say you know what, this might occur to you. If ever this occurs to you.

According to Thandekile:

It depends like education, maybe when you go to Clinics or gynaes, have pamphlets that explain maybe the symptoms or maybe have groups where you can have discussions that say; once a baby is born, if you have this kind of feeling or if you feeling this way, talk to this person or do this or drink some camomile tea to calm you down. Maybe something like that. So at least when the child is born, you know, okay, now I'm feeling like this. I can do this, you know, take your mind off what's bothering you or. Also how to deal with the child when the child's crying at night, what's the way of soothing them. Then at least you prepared because I was not.

Ultimately, these women encourage other women to take their time in motherhood and not compare themselves or their experiences, with the experiences of other mothers. These courageous women further encourage other women to speak about their struggles in motherhood. A theme that was deduced from the messages was that all of the messages these women had to share were centered on motherhood and not so much postnatal depression. What can be deduced from this is that if women are able to share in child care responsibilities with significant others and if women learn to ease their way into motherhood and do not put pressure on themselves to be 'perfect mothers' then they will less likely be as distressed with motherhood. I take this point a step further and suggest that perhaps women's adjustment into motherhood should not be labelled.

4.10. Summary of chapter

Findings from the present study strongly confirm that postnatal depression occurs in a relational context which is rooted in the social construction of motherhood as it delineates women's duties as mothers. This social construction is further prescriptive as it marginalizes the experiences of women who fall outside of this. The results confirm what Ussher (2006) argued, that is, that postnatal depression needs to be understood according to women's social, political, economic, gendered and cultural context. The results further confirm that a relational perspective provides a framework for exploring and understanding women's subjective experiences of postnatal depression.

CHAPTER FIVE
CONCLUSION, LIMITATIONS AND IMPLICATIONS FOR FUTURE PRACTICE

5.1. Introduction

In this final chapter, the conclusion and the limitations of the study will be discussed. The chapter ends with the implications for future practice.

5.2. Summary

The social construction of motherhood is rooted in the social construction of womanhood (Hadd, 1990). Motherhood is a socially constructed ideal and this social construction dates back to the 20th century. Industrial Revolution, religion and politics had an impact on the social construction of motherhood. Women, from a young age are conditioned to think and behave in a certain way. This conditioning leads to the maternal ideal where women believe that they should act and behave in specific ways and contradictory behaviour subjects women to much criticism. The maternal ideal presents motherhood as a happy, joyous event. It presents motherhood as easy and natural. The dominant discourse on motherhood rests on the premise that mothering is a women's job and that women should be able to mother. As a result of this, women begin to hold many expectations of themselves as mothers and when they do not live up to the expectations they have bought in to they experience disappointment in themselves as mothers and believe that they have done something wrong. This 'wrong' manifests as postnatal depression, which was the focus of the present study.

The present study aimed at exploring postnatal depression from the perspective of three Black African, South African women because they represent a minority in the realm of postnatal depression research. In this study two of the women expressed loss of previous identity once they became mothers and this loss was one of the factors that contributed to them developing postnatal depression.

The maternal ideal sets the assumption that motherhood is a natural and easy process however once a woman becomes a mother, the reality is different. This finding was observed in the present research. Women in the study expressed that before becoming mothers they had pictured a rosy and happy experience however this was not their experience. In other words women form mental representations of what motherhood should be and these representations are interpreted as good mothering. What this study illustrates is that

motherhood was different to the women's expectations. A further finding in the study is that the transition to motherhood is not easy. All the women expressed difficulty coping with motherhood and that, with the exception of one woman, all child care responsibilities were automatically placed upon them. The study further illustrates that the media also plays a role in depicting the maternal ideal. Two of the women believed that the media played a significant role in depicting motherhood as solely happy and that poor mental health is not something that mothers experience.

A further finding which emerged from this study is that culture also places an expectation on women to naturally know how to mother. Two of the mothers in the study reflected that culturally there is an expectation for Black African women to naturally know how to mother and that this expectation made the women feel like failures when they struggled with motherhood. Earlier on Chodorow (1999) maintained that motherhood is an institution and women, as a result, are confined to certain roles. The institution of motherhood states that women occupy a certain role in society and that all child care duties and responsibilities are subjected to women only. According to Chodorow (1999) mothering is a psychological role which consist of psychological and personal experience of self in relation to child. This means that being a mother is a role that is further impacted on by the child, a bidirectional role, if I may. This was evident in the present study whereby one of the participant's recognized that through her own frustrations in being a mother, her child also became frustrated and this frustration manifested into periods of crying.

A further point of significance is that it appears that postnatal depression only resolves after a little over a year. More significantly, women may experience distress with subsequent children as well, as illustrated by Ntombenhle. And this resolve is largely dependent on the degree of growth and development of the child. All of the participants reported that after their children were a year or older were they able to bond, interact and negotiate with their children. What can be ascertained from this is that as women begin to gain increased control over their mothering abilities, their sense of being overwhelmed and difficulty coping with motherhood decreased. Analysis of the data illustrates that, from the perspective of the participating mothers, wider social expectations of motherhood, adjustment to motherhood, social pressure and perceived fear of judgement contributed to women developing postnatal depression.

Two of the three mothers reported healthy relationships with their mothers and despite this these women still developed postnatal depression. Furthermore all the women in the study were educated even though their level of education differed. Furthermore the women were in employment at the time of their pregnancy at the exclusion of one mother who opted to remain home in order to raise her child. The women in the study were between middle to high socioeconomic status. This serves to demonstrate that despite education, employment status and socioeconomic status women may still develop postnatal depression. Ultimately, this serves to demonstrate that motherhood is a process but not a naturally occurring process. It is a process that requires learning, adjustment and renegotiation of self. In other words, motherhood is experienced as a loss because women feel that they have to give up aspects of themselves in order to fit the ideal. Women were taught that they have to be selfless in the context of their children and the opposite of this is a woman scorned by society and labelled as selfish or non-maternal. Women then put pressure on themselves to be the socially constructed perfect mothers. To label women's experiences as depression is problematic in terms of how such a diagnosis tends to medicalize women's suffering and it overlooks all the other social and contextual factors that mediate experience.

5.3. Limitations of the study

One of the limitations of this study is that a small sample size was used. However, interpretative phenomenological analysis supports a small sample size (Fade, 2004) because it allows for a more detailed interpretive account of the women's experiences with Postnatal Depression (Smith & Osborn, 2007). A further limitation of the study is that in qualitative research transferability is more important than generalizability and as such the results of the present study cannot be generalized to all Black African women. To counter this I have ensured that the study is transferrable and this was achieved through the application of various strategies such as providing a detailed description of the phenomenon as well as the method of analysis. A third limitation of the study was my lack of experience as a researcher in terms of collecting and interpreting the data. As such my inexperience may have influenced my process of analyzing and interpreting of the data.

5.4. Implications for practice

This section refers to the future role that mental health and public health professionals can provide to women during their pre and postnatal period. In attempting to help women better

manage the postnatal period it is deemed beneficial that mental health and public health professionals consistently provide all mothers regardless of their circumstances and demographics with information on motherhood. Such information may be in the form of referrals to support groups or referrals to other health professionals. It is further deemed beneficial that all women should, during prenatal care, receive information on childbirth and labor. If a women is to undergo an emergency cesarean section or if labor is considered a high technology assisted labor (such as the use of forceps) then a consistent pattern of debriefing and orientating the women to this process should be followed. This suggestion is in reference to the participants experiences of their birthing process in which they reported being ill-prepared and frightened. Furthermore previous literature indicates that women who were not informed of their labor process were more susceptible to developing postnatal depression as this resulted in a traumatic birth. Therefore in facilitating an easier transition into the birthing process and simultaneously motherhood, all mothers should be informed about what they may expect in order to mentally prepare themselves for this process and journey respectively.

A further implication for practice is the importance of teaching and educating expectant mothers about the realities of motherhood and perhaps having other mothers share with them so that the myths of motherhood are challenged. Furthermore, the media may play an influential role in documenting and highlighting the real experiences of motherhood in order to demystify myths on motherhood and women's role. In addition to this mental health practitioners may be taught to explore the expectations that expectant mothers hold and to challenge these with mothers so as to demystify the maternal ideal and the doctrine of perfect motherhood. To involve them in a process of conscientisation. Freire (1970) maintains that "conscientisation refers to the process in which "…knowing subjects, achieve a deepening awareness both of the sociocultural reality that shapes their lives and of their capacity to transform that reality" (p. 65). Conscientisation is consciousness raising, it is a reflective process that breeds reflective action (Freire, 1970). According to Freire (1970) "conscientisation is the instrument for ejecting the cultural myths that remain in the people despite their new reality" (Freire, 1970, p. 61). Conscientisation is therefore a mechanism for changing the current reality by being more critical of historical and cultural ideology that informs reality. The present study attempts to engage in a process of conscientisation by creating awareness on how dominant discourses of motherhood and postnatal depression are ineffective in understanding the realities that shapes motherhood. This study challenges a

dominant biomedical model on postnatal depression and it highlights the importance of a feminist and social constructionist analysis of postnatal depression which maintains that it is an experience that is informed by social constructions and ideologies of motherhood. The importance of this study is that it allows for dialogue that explores the experiences of motherhood one that takes into considerations their rights and the contexts that inform women's experiences. In addition to this, workshops may be further held with women to deconstruct the myth of postnatal depression. Furthermore everyone involved with expectant or new mothers can be taught to deal with postnatal depression, including psychiatrists and psychologists. It is also suggested that all postnatal services should continuously provide support to women and should refer all women to local postnatal support groups regardless of whether they may be presenting with symptoms of postnatal depression or not.

Lastly, partner and family physical and emotional support is important to mothers. It is further deemed beneficial that women feel supported during their pre and postnatal period. All of the women in the study reported that they were responsible for a majority of child care and this finding is consistent with previous research. This finding was one of the factors that contributed to women developing postnatal depression. This factor is also related to the social construction of motherhood where the premise is that women are solely responsible for all child care. Providing physical and emotional support to mothers, may facilitate an easier transition into motherhood, debunk the current discourse of motherhood and ultimately reduce the pressure that women consciously and unconsciously place on themselves.

5.5. Conclusion

The above research holds great significance to me personally. As a scholar and prospective mental health professional, it is my hope to continue to be a voice for disadvantaged, underrepresented and misrepresented women. It is also my hope to continue to enrich my knowledge by questioning traditions and re-authoring traditions which subject women to unfair standards. Therefore, it is suggested, as proposed by Nicolson (1998) that this research is used as a tool that allows women to openly acknowledge when and if they struggle with being mothers. Each women's journey in motherhood is different and unique and each women's experience as just as significant. Furthermore women's struggles of motherhood should not be pathologised as this in itself is distressing. Rather women's struggles should be recognized as normal (normally difficult and challenging) as proposed by Nicolson (1990). In Cape Town, South Africa there is the Perinatal Mental Project which is a non-profit

organization whose aim is to provide maternity services to women during their pre and postpartum period. The organization recognises that women experience postnatal distress and the organization aims to provide support to women who are or may be struggling with motherhood. Only three Black African women were interviewed for the study however the knowledge gained from their experiences is quite significant. Based on this, it is suggested that a similar organization is situated in the remaining eight provinces of South Africa. "Becoming a mother is not just a physical event and emotional milestone; it is a time of emotional adjustment and changes the family dynamics. The adjustment to motherhood is powerfully shaped by women's social interactions with others and support is crucial to this adjustment" (Westall & Liamputtong, 2011, p. vii).

References

Abdollahi, F., Sazlina, S, G., Zain, M. A., Zarghami, M., Jafarabadi, M. A., & Lye, M. S (2014). Postpartum depression and psycho-socio-demographic predictors. *Journal of Asia-Pacific Psychiatry*, *6*, 424–434.

Ahmad, M., Butt, M. S., Bilal, U., Arshad, H. S., Ifthikar, N., & Maqsood, U. (2015). Prevalence of postpartum depression in an urban setting. *Biomedical Research*, *26*(4), 765-770.

Almond, B. (2010). *The Monster Within: The Hidden Side of Motherhood*. Berkeley: University of California Press.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders, (5th ed.).* Arlington, VA: American Psychiatric Publishing.

Arendell, T. (2000). Conceiving and investigating motherhood: The decade's scholarship. *Journal of Marriage and Family*, *62*(4), 1192-1207.

Babatunde, T., & Moreno-Leguizamon, C. J. (2012). Daily and cultural issues of postnatal depression in African women immigrants in South East London: Tips for health professionals. *Nursing Research and Practice. Retrieved on 28 February 2018 from* *www.downloads.hindawi.com*.

Barclay, L., Everitt, L., Rogan, F., Schmied, V., & Wyllie, A. (1997). Becoming a mother— an analysis of women's experience of early motherhood. *Journal of Advanced Nursing*, *25*(4), 719-728.

Bashiri, N., & Spielvogel, A. M. (1999). Postpartum depression: A cross-cultural perspective. *Primary Care Update for OB/GYNS*, *6*(3), 82–87.

Beauboeuf-Lafontant, T. (2009). *Behind the mask of the strong Black woman: Voice and the embodiment of a costly performance*. Philadelphia: Temple University Press.

Beck, C. T. (1998). The effects of postpartum depression on child development: A meta-analysis. *Archives of Psychiatric Nursing*, *12*(1), 12-20.

Beck, C. T. (1999). Postpartum Depression: Stopping the thief that steals motherhood. *Journal of Nursing for Women's Health*, *3*(4), 41-44.

Beck, C. T. (2001). Predictors of Postpartum Depression: An update. *Nursing Research*, *50* (5), 275–285.

Biernacki, P., & Waldorf, D. (1981). Snowball sampling: Problems and techniques of chain referral sampling. *Sociological Methods & Research*, *10*(2), 141–163.

Bilszta, J., Buist, A., & Milgrom, J. (2006). Women's experience of Postnatal depression-beliefs and attitudes as barriers to care. *Australian Journal of Advanced Nursing*, *27*(3), 44–54.

Burr, V. (2003). *Social Constructionism*. (2nd Ed.). New York: Routledge.

Buuitjens, M., & Liamputtong, P. (2007). When giving life starts to take the life out of you: Women's experiences of depression after childbirth. *Midwifery*, *23*(1), 77-91.

Card, C. (1996). Against marriage and motherhood. *Hypatia*, *11*(3), 1-23

Chinawa, J. M. Odetunde, O. I., Ndu, I. K., Ezugwu, E. C., Aniwada, E. C., Chinawa, A. T., & Ezenyirioha, U. (2016). Postpartum depression among mothers as seen in hospitals in Enugu, South-East Nigeria: An undocumented issue. *Pan African Medical Journal*, *23*(1), 1-6.

Chodorow, N. J. (1999). *The reproduction of mothering: Psychoanalysis and the Sociology of Gender*. Berkeley: University of California Press.

Choi, P., Henshaw, C., Baker, S., & Tree, J. (2005). Supermum, superwife, supereverything: Performing femininity in the transition to motherhood. *Journal of Reproductive and Infant Psychology*, *23*(2), 167-180.

Chrisler, J. C., & Johnston-Robledo, I. (2002). Raging hormones?: Feminist perspectives on premenstrual syndrome and postpartum depression. In M. Ballou, & L. S. Brown (Eds.), *Rethinking mental health and disorder: Feminist Perspectives* (pp. 174–197). New York: Guilford Press.

Coates, R., Ayers, S., & de Visser, R. (2014). Women's experiences of postnatal distress: A qualitative study. *BMC Pregnancy and Childbirth*, *14*(1), 359-373.

Collins, P. H. (2002). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*. New York: Routledge.

Cook, K., & Loomis, C. (2012). The impact of choice and control on women's childbirth experiences. *The Journal of Perinatal Education*, *21*(3), 158.

Cooper, P. J., & Murray, L. (1998). Fortnightly Review: Postnatal depression. *British Medical Journal*, *316* (7148), 1884-1890.

Cooper P. J., Tomlinson, M., Swartz L., Woolgar, M., Murray, L., & Molteno, C. (1999). Postpartum depression and the mother-infant relationship in a South African peri-urban settlement. *British Journal of Psychiatry, 175*(6), 554-558.

Cox, J. (1986). *Postnatal Depression*. Edinburgh: Churchill Livingstone.

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

Cox, J., Murray, D., & Chapman, G. (1993). A controlled study of the onset, duration and prevalence of postnatal depression. *British Journal of Psychiatry*, *163(1)*, 27–32.

Dalton, K. (1980). *Depression after Childbirth. How to recognize and treat postnatal illness*. USA: Oxford University Press.

Damaske, S. (2013). Work, family and accounts of mothers' lives using discourse to navigate intensive mothering ideals. *Sociology Compass*, *7*(6), 436-444.

De Tychey, C., Spitz, E., Briancon, S., Lighezzolo, J., Girvan, F., Rosati, A., Thockler, A., & Vincent, S. (2005). Pre- and postnatal depression and coping: A comparative approach. *Journal of Affective Disorders*, *85*(3), 323-326.

Doucet , S. A., Letourneau, N. L., & Stoppard, J. M. (2010). Contemporary Paradigms for Research Related to Women's Mental Health. *Health Care for Women International*, *31*(4), 296-312.

Eatough, V. and Smith J.A. (2008) 'Interpretative phenomenological analysis'. In C. Willig and W. S. Rogers (Eds.) (pp. 179-194), *Handbook of Qualitative Psychology*. London: Sage.

Edhborg, M., Friberg, M., Lundh, W., & Widström, A. M. (2005). ``Struggling with life'': Narratives from women with signs of postpartum depression. *Scandinavian Journal of Social Medicine*, *33*(4), 261-267.

Fade, S. (2004). Using interpretive phenomenological analysis for public health nutrition and dietetic research: A practical guide. *Proceedings of Nutrition Society*, *63*(4), 647–653.

Forman, D. N., Videbech, P., Hedegaard, M., Salvig, J. D., & Secher, N. J. (2000). Postpartum depression: Identification of women at risk. *British Journal of Obstetrics and Gynaecology*, *107*, 1210–1217.

Fowles, E. R. (1998). The relationship between maternal role attainment and postpartum depression. *Health Care for Women International*. *19*(1), 83-94.

Freire, P. (1970). Cultural action and conscientization. *Harvard Educational Review*, *40*(3), 452-477.

Frizelle, K., & Hayes, G. (1999). Experiences of motherhood: Challenging ideals. *Psychology in Society*, *25*(1), 17-36.

Frizelle, K., & Kell, G. (2010). A contextual account of motherhood. *Psychology in Society*, (39), 26-44.

Godderis, R. (2010). Precarious beginnings: Gendered risk discourses in psychiatric research literature about postpartum depression. *Health*, *14*(5), 451 – 466.

Gorman, K. A., & Fritzsche, B. A. (2002). The good-mother stereotype: Stay at home (or wish that you did!). *Journal of Applied Social Psychology*, *32*(10), 2190-2201.

Gross, E. (1998). Motherhood in feminist theory. *Afflia Journal of Women and Social Work*, 1*3*(3), 269-272

Hadd, W. (1990). *The Good Enough Mother: The Social Construction of Motherhood*. Unpublished Doctoral Dissertation, Concordia University: Canada.

Hanley, J., & Long, B. (2006). A study of Welsh mothers' experiences of postnatal depression. *Midwifery*, *22*(2), 147-157.

Harris, S.R. (2010). *What is constructionism? Navigating its use in sociology*. Boulder, CO: Lynne Rienner Publications.

Hollway, W., & Featherstone, B. (Eds.). (1997). *Mothering and ambivalence*. London: Routledge.

Homewood, E., Tweed, A., Cree, M., & Crossley, J. (2009). Becoming Occluded: The Transition to Motherhood of Women with Postnatal depression. *Qualitative Research in Psychology*, 6 (4), 313-329.

Kathree, T., & Petersen, I. (2012). South African Indian women screened for postpartum depression: A multiple case study of postpartum experiences. *South African Journal of Psychology*, *42*(1), 37–50.

Kauppi, C., Montgomery, P., Shaikh, A., & White, T. (2012). Postnatal Depression: when reality does not match expectations. InTechOpen. Retrieved 10 May, 2017, from http://rspace.uwaterloo.ca/xmlui/handle/20.500.11895/292.

Klainin, P., & Arthur, D. G. (2009). Postpartum Depression in Asian Cultures: A literature review. *International Journal of Nursing Studies*, *46*, 1355–1373.

Knaak, S. (2009). Having a tough time: Towards an understanding of the psycho-social causes of postpartum emotional distress. *Journal of Motherhood Initiative for Research and Community Involvement*, *11*(1), 80-94.

Knaak, S. J. (2010). Contextualising risk, constructing choice: Breastfeeding and good mothering in risk society. *Health, Risk & Society*, *12*(4), 345-355.

Kruckman, L., & Smith, S. (2000). "An Introduction to Postpartum Illness."*Postpartum Support International*. Retrieved 20 April 2018 from www.postpartum.net/in-depth.html.

Lawrie, T, A., Hofmeyr, G, J., de Jager, M., & Berk, M. (1998). Validation of the Edinburgh Postnatal Depression Scale on a cohort of South African women. *South African Medical Journal*, *88*(10), 1340–1344.

Lazarre, J. (1976). *The Mother Knot.* Durham: Duke University Press.

Lazarus, K., & Rossouw, P. (2015). Mothers' expectations of parenthood: The impact of prenatal expectations on self-esteem, depression, anxiety, and stress post birth. *International Journal of Neuropsychotherapy*, *3*(2), 102-123.

Lewis, S. E., & Nicolson, P. (1998). Talking about early motherhood: Recognizing loss and reconstructing depression. *Journal of Reproductive and Infant Psychology*, *16*(2-3), 177-197.

Liamputtong, P., & Naksook, C. (2003). Perceptions and experiences of motherhood, health and the husband's role among Thai women in Australia. *Midwifery, 19*(1), 27–36.

Littlewood, J., & McHugh, N. (1997). *Maternal Distress and Postnatal Depression: The myth of Madonna*. Basinstoke: MacMillian.

Lonia, M., Katowa-Mukwato, P., Dixey, R., & Maimbolwa, M. (2014). A sweet and sour taste: Motherhood as an ambivalent experience in Zambia. *International Journal of Counselling Psychology, 6*(8), 99–106.

Malekpour, M. (2007). Effects of attachment on early and later development. *The British Journal of Developmental Studies*, *53*(105), 81–95.

Mallikarjun, P. K., & Oyebode, F. (2005). Prevention of postnatal depression. *The Journal of the Royal Society for the Promotion of Health, 125*(5), 221–226.

Mauthner, N. S. (1993). "Feeling low and feeling and about feeling low": Women's experiences of motherhood and postpartum depression. *Canadian Journal*, *40*(2), 143–161.

Mauthner, N. S. (1995, May). Postnatal Depression: The significance of social contacts between mothers. In *Women's studies international forum*, *18*(3), 311-323.

Mauthner, N. S. (1998). It's a woman's cry for help': A relational perspective on Postnatal Depression. *Feminism & Psychology*, *8*(3), 325-355.

Mauthner, N. S. (2010). ''I Wasn't Being True to Myself'': Women's narratives of Postpartum Depression. In D. C. Jack., & A. Ali (Eds.), *Silencing the Self Across Cultures* (pp. 459-484). Oxford: Oxford University Press

McIntosh, J. (1993). Postpartum depression; Women's help-seeking behaviour and perceptions of cause. *Journal of Advanced Nursing*, *18*(2), 178–184.

Mercer, T. R. (2004). Becoming a Mother versus Maternal Role Attainment. *Journal of Nursing Scholarship*, *36*(3) 226-232.

Miller, T. (2007). "Is this what motherhood is all about?" Weaving experiences and discourse through transition to first-time motherhood. *Gender & Society*, *21*(3), 337-358.

Mills, E. O., Finchillescu, G., & Lea, S. J. (1995). Postnatal depression – an examination of psychosocial factors. *South African Medical Journal*, *85*(2), 99-104.

Murray, L. (1992). The impact of postnatal depression on infant development. *Journal of Child Psychology and Psychiatry*, *33*(3), 543-561.

Murray, L., & Cooper, P. J. (1997). Postpartum depression and child development. *Psychological Medicine*, *27* (2), 253-260.

Murray, L., Cooper, P., & Hipwell, A. (2003). Mental health of parents caring for infants. *Archives of Women's Mental Health*, *6*, s71-s77.

Nahas, V., & Amasheh, N. (1999). Culture care meanings and experiences of postpartum depression among Jordanian Australian women: A Transcultural Study. *Journal of Transcultural Nursing*, *10*(1), 37–45.

Nakku, J. E. M., Nakasi, J., & Mirembe, F. (2006). Postpartum major depression at six weeks in primary health care: prevalence and associated factors. *African Health Science*, *6*, 207-214.

Nicolson, P. (1998). *Post-natal depression: Psychology, science, and the transition to motherhood*. London: Routledge.

Nicolson, P. (1998). Loss, Happiness and postpartum depression: The ultimate paradox. *Canadian Journal of Psychology*, *40*(2), 162.

Oakley, A. (1980). *Women confined: Toward a sociology of childbirth*. New York: Schocken Books.

Oates, M. R., Cox, J. L., Neema, S., Asten, P., Glangeaud-Freudenthal, N., Figueiredo, B., & Klier, C. M. (2004). Postnatal depression across countries and cultures: A qualitative study. *The British Journal of Psychiatry*, *184* (46), s10-s16.

Ong, S. F., Chan, S. W. C., Chong, Y. S., Shorey, S., & He, H. G. (2012). First-time mothers' postnatal experiences and support needs in Singapore: A descriptive qualitative study *Midwifery*, *30*(6), 772 – 778.

O'Reilly, A. (2004). *From motherhood to mothering: The legacy of Adrienne Rich's Of Woman Born*. Albany: State University of New York Press.

Parker, R. (2005). *Torn in two: The experience of maternal ambivalence*. New York: Virago.

Parry, C. D. (2008) "We Wanted a Birth Experience, not a Medical Experience": Exploring Canadian Women's Use of Midwifery. *Health Care for Women International*, *29*(8-9), 784-806.

Peltzer, K., & Shikwane, M. E. (2011). Prevalence of postnatal depression and associated factors among HIV-positive women in primary care in Nkangala district, South Africa. *Southern African Journal of HIV Medicine*, *12*(4), 24-28.

Phoenix, A., Woollett, A., & Lloyd, E. (1991). *Motherhood: Meanings, practices and ideologies*. London: Sage Publications

Radoš, S. N., Tadinac, M., & Herman, R. (2013). Prevalence of depression during pregnancy and Postpartum in a sample of Croatian women. *Journal of Clinical Psychology*, *1*(2), 79-93.

Ramchandani, P. G., Richter, L. M., Stein, A., & Norris, S. A. (2009). Predictors of postnatal depression in an urban South African cohort. *Journal of Affective Disorders*, *113*(3), 279–284.

Regus, P. (2007). *The Emerging Medicalization of Postpartum Depression: Tightening the Boundaries of Motherhood*. Unpublished Master's thesis. Georgia State University, Atlanta.

Rich, A. (1995). *Of Woman Born: Motherhood as experience and institution*. New York: WW Norton & Company.

Robertson, E., Grace, S. T., Wallington, T., & Stewart, D. E. (2004). Antenatal risk factors for postpartum depression: A synthesis of recent literature. *General Hospital Psychiatry, 26(4)*, 289-295.

Romito, P. (1990). Postpartum depression and the experience of motherhood. *Acta Obstetricia et Gynecologica Scandinavica*, *69* (154), 1-37.

Romito, P., Saurel-Cubizolles, M, J., & Lelong, N. (1999). What makes new mothers unhappy: Psychological distress one year after birth in Italy and France. *Journal of Social Science and Medicine*, *49(12)*, 1651 – 1661.

Shaikh, A., & Kauppi, C. (2015) Postpartum Depression: Deconstructing the label through a Social Constructionist Lens. *Social Work in Mental Health*, *13*(5), 459-480.

Smith, J. A., Jarman, M., & Osborn, M. (2007). Doing interpretative phenomenological analysis. In D. M. Murray., & K. Chamberlain (Eds.), *Qualitative Psychology: Theories and Methods* (pp. 218–240). Los Angeles: Sage Publications

St. Pierre, C. M., & Lynn, C. E. (2007). The Taboo of Motherhood: Postpartum Depression. *International Journal of Human Caring*, *11*(2), 22–31.

Staneva, A., & Wittkowski, A. (2013). Exploring beliefs and expectations about motherhood in Bulgarian mothers: A qualitative study. *Midwifery*, *29*(3), 260-267.

Stellenberg, E.L., & Abrahams, J. M. (2015). Prevalence of and factors influencing postnatal depression in a rural community in South Africa. *African Journal of Primary Health Care Family*, *7*(1), 1–8.

Stewart, D. E., Robertson, E., Dennis, C. L., Grace, S. L., & Wallington, T. (2003). Postpartum depression: Literature review of risk factors and interventions. Retrieved 6 July 2016, from www.who.int/mental_health/prevention/suicide/lit_review_postpartum_depression.pdf.

Sulyman, D., Ayanda, K. A., Dattijo, L. M., & Aminu, B. M. (2016). Postnatal depression and its associated factors in Northeastern Nigeria. *Annals of Public Medicine and Public Health*, *9*(3), 184-190.

Sword, W., Busser, D., Ganann, R., McMillan, T., & Swinton, M. (2008). Women's care-seeking experiences after referral for postpartum depression. *Qualitative Health Research*, *18*(9), 1161–1173.

Takševa, T. (2017). Mother love, maternal ambivalence, and the possibility of empowered mothering. *Hypatia*, *32*(1), 152-168.

Thornton, R., & Nardi, P.M. (1975). The dynamics of role acquisition. *American Journal of Sociology*, *80(4)*, 870-885.

Thurer, S. (1994). *The myths of motherhood: How culture reinvents the good mother*. Boston: Penguin Books.

Ugarriza, D. N. (2002). Postpartum depressed women's explanation of depression. *Journal of Nursing Scholarship*, *34*(3), 227-233.

Warner, J. (2005). *Perfect Madness: Motherhood in the Age of Anxiety*. New York: Riverhead Books.

Westall, C., & Liamputtong, P. (2011). *Motherhood and Postnatal depression: Narratives of Women and their Partners*. Dordrecht: Springer.

Willig, C. (2008). *Introducing Qualitative Research in Psychology*. (2nd ed). Milton Keynes: Open University Press.

Winnicott, D. (1960). The theory of the parent infant relationship. *International Journal of Psycho-Analysis*, *41*, 585-595.

Wisner, K. L., Parry, B. L., & Piontek, C. M. (2002). Postpartum depression. *New England Journal of Medicine*, *347*(3), 194-199.

Zinga, D., Phillips, S. D., & Born, L. (2005). Postpartum depression: We know the risks, can it be prevented? *Revista Brasileira de Psiquiatria*, *27* (suppl 2), s56-64.

Appendix A   **Participant Informed Consent Form**

Dear Participant

My name is Marineesa Majola. I am a Masters in Counselling Psychology student studying at the University of KwaZulu-Natal, Howard College Campus, South Africa.

I am conducting a study which explores women's lived experiences of Postnatal depression, by exploring the following factors:

1. How mothers' perceive motherhood
2. The factors that women perceive as contributing towards their Postnatal depression
3. How mothers' negotiate their Postnatal depression, and
4. How mothers' cope with their Postnatal depression

As a result, I would like to ask you questions based on this.

Please note that as a participant to this study:

1. Your identity will remain confidential and there will be no information used in the study to identify you.
2. The duration of the interview will be between 1 ½ - 2 hours.
3. There may be more than one interview and the interviews will be split according to your availability.
4. Information will be clarified with you before being included in the final document.
5. Any information you provide will be used for purposes of this research only.
6. The interviews will be recorded with a tape recorder which will be stored in a safe place at all times.
7. Data will be stored in secure storage and destroyed after 5 years.
8. You have a choice to participate, not participate or stop participating in the research. You will not be penalized for taking such an action.
9. Your involvement is purely for academic purposes only, and there are no financial benefits involved.
10. If you are willing to be interviewed, please indicate (by ticking as applicable) whether or not you are willing to allow the interview to be recorded by the following equipment:

	Willing	Not willing
Audio equipment		
Photographic equipment		
Video equipment		

I can be contacted at:

Email: marineesamajola@gmail.com

Cell: +27833310625

My supervisor is: Ms. Kerry Frizelle

Contact details: email: frizellek1@ukzn.ac.za   Phone number: +27 312603261

Thank you for your contribution to this research.

DECLARATION

I _____(full names of
participant) hereby confirm that I understand the contents of this document and the nature of
the research study. I hereby consent to participating in the research study. I understand that I
am at liberty to withdraw from the study at any time, should I so desire.

I hereby consent to participating in the research study.

SIGNATURE OF PARTICIPANT   DATE

_____   _____

Appendix B: **Semi-Structured Interview Schedule**

Mothers' lived experiences of postnatal depression Interview Guide

Participant Demographic Information

1. Name   :

2. Age   :

3. Date of Birth   :

4. Race   :

5. Marital Status   :

6. Highest Education Level :

7. Occupation   :

8. No of children   :

9. Physical Address   :

10. Place of Interview   :

11. Language used during Interview:

Theme 1: Pregnancy and birth related questions

1. Was this a planned/unplanned pregnancy?

If unplanned, how did you feel when you found out you were going to have a baby?

2. How would you describe your birthing experience?

Possible follow up: Were you prepared for the birth of your baby?

Possible follow up: Were your experiences of birth different from what you had anticipated? If yes, please explain how?

3. Were there any traditions, customs you had to follow after the birth of your child?

4. What was your experience with the hospital staff after the birth of your baby?

5. Did you have social support at the time of your birth?

Theme 2: Questions related to Experiences of Motherhood

1. Are there any cultural/religious beliefs/practices that inform your duties as a mother?

2. How did you first cope/adjust/to being a mother?

 Possible alternative: How would you describe the way you first coped with being a mother?

3. Were your experiences of being a mother different from what you had expected?

Follow up question: Can you please describe how?

 Alternate question: What did you think motherhood would be like?

Follow up: Is there anything you wish you were told about being a mother, before you
became a mother?

4. How did your life change once you became a mother?

5. Did becoming a mother have an impact on your identity? If so, how?

6. What are some of the challenges you have experienced as a mother?

Follow up: Were you able to speak to anyone about the difficulties you experienced with
motherhood? If so, who? If not, why did you feel you could not speak to anyone about the
difficulties you were experiencing?

Theme 3: Postnatal depression related questions

1. Can you please tell me when were you diagnosed with Postnatal depression?
   Follow up: How were you diagnosed?

2. What did you understand about your diagnosis?

Follow up: Had you heard of Postnatal depression before you were diagnosed? If so, what
were your previous perceptions about Postnatal depression?

Follow up: How did these perceptions impact you?

3. How did you make sense of your diagnosis?
   Follow up: Did you read up about your diagnosis/consult with a Doctor in order to
   know more about your diagnosis?

4. How did you begin to reconcile with your diagnosis?

5. Can you please tell me what do you think contributed towards you being depressed
   after your child was born?

6. What impact, if any, did being diagnosed with Postnatal depression have on your self-
   esteem?

7. How did you cope with being a mother and being diagnosed with Postnatal
   depression?

8. What impact did being diagnosed with Postnatal depression have on your ability to
   mother your child?

9. How long after the birth of your child did you seek help?

Possible follow up: What was that experience like for you?

10. How did you feel about opening up and talking about your Postnatal depression?

11. Did you have any social support during this period?

12. What helped you to deal with Postnatal depression?

13. How did you find it building a relationship with your baby?

Alternate question: Were you able to immediately bond with your child?

14. What message would you like to give to other mothers who may be going through Postnatal depression?

Alternate question: What message would you like to give to women who are about to become mothers?

Appendix C: **Participant Information Sheet**

1. Participant 1:   Thembelihle*

   Age: 27 years old

   Marital Status: Married

   Level of Education: Grade 12

   Employment Status: Selectively Unemployed

   Number of children at time of diagnosis: 1

   Diagnosed by: Psychiatrist

2. Participant 2:   Ntombenhle*

   Age: 34 years old

   Marital Status: Single

   Level of Education: Bachelors' Degree

   Employment Status: Selectively Employed

   Number of children at time of diagnosis: 2

   Diagnosed by: Psychiatrist

3. Participant 3:   Thandekile*

   Age: 38 years old

   Marital Status: Separated

   Level of Education: National Diploma

   Employment Status: Selectively Employed

   Number of Children at time of diagnosis: 1

   Diagnosed by: Psychiatrist

Appendix D: Ethical Clearance Form

KWAZULU-NATAL

INYUVESI
YAKWAZULU-NATALI

17 October 2016

Ms Marineesa Majola 207507932
School of Applied Human Sciences-Psychology
Howard College Campus

Dear Ms Majola

Protocol reference number: HSS/1669/016M
Project title: A qualitative exploration of three mothers' lived experiences of Post Natal Depression

Full Approval – Expedited Application

In response to your application received 5 October 2016, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

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

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

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

Yours faithfully

....
Dr Shamila Naidoo (Deputy Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

cc Supervisor: Kerry Frizelle
cc. Academic Leader Research: Dr Jean Steyn
cc. School Administrator: Ms Ayanda Ntuli