Mothers' perceptions of the effects of the Babies in Mind programme on maternal mental health and mother-infant attachment: A South African narrative study

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Mothers' perceptions of the effects of the Babies in Mind programme on maternal mental health and mother-infant attachment: A South African narrative study

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Declaration

I hereby declare that the work in this thesis is my own, except for the quotations and summaries, which have been duly acknowledged. It is submitted for the degree of Doctor of Philosophy at the Nelson Mandela University. It has not been submitted for any other degree or examination at any other university.

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Abstract

The focus of this study is on mothers, motherhood and the Babies in Mind programme as an early intervention strategy for mothers in South Africa. The rate of maternal mental ill health in our country is alarming. Research consistently confirms that maternal mental health directly affects infant and child mental health. One of the major determinants of mental health is mother-infant attachment. Studies have indicated the range of deleterious effects that maternal mental ill health and mother-infant attachment issues have on offspring from infancy to adulthood. This has implications for the mental health of future generations and society at large. Researchers have called for evidence-based interventions that address maternal mental health and mother-infant attachment, especially in developing countries. South Africa has no national prevention or treatment programme to address these needs. This study investigated the Babies in Mind programme as an early intervention option to address the gap in promoting maternal mental health and mother-infant attachment.

A social constructionist, narrative study was employed to meet the objectives of the study. The aim was to explore mothers' perceptions of the impact of the Babies in Mind programme, with particular reference to their mental health and their relationships to their infants. Focus was placed on understanding the social constructions of motherhood at the community level and how these constructions were reconstructed through the programme. Purposive sampling was employed and focus groups were conducted to collect the relevant data. The data was analysed using thematic analysis. The findings indicated that mothers' experiences of the Babies in Mind programme were positive and there were improvements in their mental health and relationships to their infants. A relationship model for mothers was developed based on the themes that emerged from the data analysis. A platform for continued support and discussion was organised via a social media (Whatsapp) support group. Twelve

guidelines were suggested for the implementation of intervention programmes such as the Babies in Mind programme at the community level.

Key words: mothers, motherhood, *Babies in Mind*, intervention programmes, maternal mental health, mother-infant attachment, social constructionism, South Africa

Table of Contents

List of Diagrams

List of Tables

List of Boxes

Chapter 1

Introduction and Overview

"It is easier to build strong children than to repair broken men."

Frederick Douglass

Introduction

Through the lens of a psychologist, it is possible to see the truth and the appeal in the above statement by the social reformer, Frederick Douglass (1855). Though Douglass in his writings describes experiences of slavery and hardships unlike those experienced by the average twenty first century individual, the principle highlighted in his statement is still applicable to our society: rather build strong children than have the difficulty of repairing broken adults.

The significant responsibility of building strong children falls to the adults who do the work of producing and raising them. A mother, in particular, does the ground work in this regard. Donald Winnicott (1960) argued that "there is no such thing as an infant, meaning that whenever one finds an infant one finds maternal care, and without maternal care there would be no infant" (p. 39). A mother is the first person a child will attach to and she will become a significant role model for many years thereafter. Bowlby (1969) placed emphasis on the first year of life as a critical time in the relationship between a mother and her infant. When a mother is able to sufficiently care for her infant, the infant has the best possible chance of developing a healthy psyche. However, if a mother does not have the capacity to care sufficiently for her infant, the effects are detrimental for the growing individual. The awareness of this critical link has inspired many mother-infant intervention programmes

around the world. In South Africa several programmes have been implemented, however, the focus has mostly been the health and welfare of the infant. The Babies in Mind programme which is featured in the present study was designed with the infant and the mother in mind. The workshops were designed to be educational, supportive and empowering for mothers, and for that effect to positively impact on their infants.

In psychology the development and experience of infants and children have received much attention, however, little is understood about a mother's own experience through and of her child's development. Raising children is a considerable task, and being a mother requires the ability to fulfil multiple roles and regular demands. Motherhood is often perceived as being central to the development of children and not always understood for what it is (Dale, 2012). According to Long (2009) motherhood has often been "constructed as a function rather than an experience: the subject of motherhood is the child receiving mothering, rather than the mother herself" (p. 55).

Recently there has been a shift in the literature on motherhood. Researchers in psychology have been moving away from solely focusing on the effects of motherhood on children to focusing on the experiential nature of motherhood for the mother herself. In other words, mothers are no longer simply being seen as mere objects in the lives of their children, rather the focus has shifted to the subjective experience of mothers in raising their children. This shift can more aptly be described as being a move from a quantitative to a qualitative exploration of motherhood. A number of researchers have attempted to explore the subjective experiences of South African mothers (Frizelle & Hayes, 1999; Kruger, 2003; Mamabolo, 2009; van Doorene, 2009; Walker, 1995), however, research in this area is still limited, particularly at the community level. This research, as a result, adds to the growing body of knowledge on motherhood in the South African context.

Psychotherapy provides psychologists with a glimpse into the experiences of men and women who struggle with deep emotional and psychological wounds; often stemming from difficulties in infancy and early childhood. As a psychologist, I am afforded the privilege of assisting adults and parents, including mothers, to build strong children, specifically through therapeutic interventions. I count it as a privilege for two reasons: (1) it empowers them with tools and strategies to raise their children in a manner which equips them emotionally and psychologically to deal with life's challenges, and (2) it is an effort to prevent the brokenness of the future generation of men and women who, without early intervention, will need painstaking 'repairing' later in life. That being said, there is another reason for my passion for assisting mothers as they raise their children, and that is that I am a mother myself. My own story is part of the lens that I use to understand other mothers' stories. It is part of who I am as a therapist and it is what allows me to relate to the intricacies of the experience. It is therefore appropriate in the context of this study that I give an account of my own story of being a mother, my perceptions of motherhood, and my experience of the Babies in Mind programme as it formed an integral part of my life. It is worth noting that the use of the personal pronoun "I" in this study is deliberate as I have sought to embed my story within the stories of other mothers, and in so doing, relinquish the voice of the "distant narrator" (Bal, 1193, p.296).

Babies in Mind on my Mind

I first came across the Babies in Mind programme when I was pregnant with my second child in 2012. The significance of the programme to me at that time will only make sense in the light of my experience with my first child in 2010, which was an emotional roller-coaster to say the least. The day I came home from the hospital with my first child I

was overcome with emotions akin to grief and loss. It had hit me that my life would never be the same again. There was a helpless baby that was completely and utterly dependent on me. I could not go to the toilet, or take a break, or eat a full meal without the constant appendage. It was overwhelming. But, as mothers do, I got used to it. With time I coped better, however, I often felt disconnected from the 'outside world'. I recall feeling as if I was in a cocoon with my baby. It was just me and her. Nothing else seemed to matter. I was completely enveloped in the experience which was rich with the interaction and events between us. I memorised her every expression and gesture and I mastered her different cries. I attended to her every need and waited on her hands and feet. My experiences in the world around me began to change. I started doing strange things like staring at the furniture in my house, wondering if it was a hazard or not. I remember becoming angry at random motorists driving past if they hooted or played loud music. At times I could not even tolerate them driving past in the first place. Another significant change was that my handbag became a suitcase. It was filled with all kinds of baby essentials (I had two of everything, one for home and one for the baby bag), just in case I needed something like an extra set of clothing for her, or an extra set of clothing for me (if she vomited) or a towel or a nail care set or something as mundane as a packet. To further illustrate my penchant for making my environment more convenient and myself more available to my baby, I cut my much loved long hair into a very, very short bob. Shorter hair meant less time in the shower, less time with the blow dryer and less time doing my hair up every day, which essentially meant less time away from my baby.

This preoccupation with my baby and my role as mother meant that I was often emotionally isolated from my husband, my family and my friends. I recall craving adult company during those long days alone with my baby. I found myself scrolling through motherhood websites and chat groups on social media, trying to engage with adults who

understood my experiences. I craved support, and felt that no one else, beside a mother could give me the kind of support I needed.

I experienced many challenges with my baby, from struggling with breastfeeding and the guilt of moving onto bottle-feeding, to conflict about where my baby should sleep (in the cot, or in my bed), to whether or not to give her certain medications, and to the struggle with her health (she suffered from severe reflux and constipation). Our biggest struggle was with sleep. For two years my baby woke up every two to three hours, and some nights every hour. It became my obsession to find the 'right method' to get her to sleep better. The problem was that there were so many voices out there regarding what the 'right method' was. I read books, I watched television programmes, I followed the advice shared on the motherhood groups on social media, I researched and researched and tried and tried. But nothing worked. All that I achieved was that I became anxious about it and so did my baby.

I look back at that time now and realise that my baby eventually grew out of her sleeplessness because I got tired of trying. I eventually just gave her what she wanted (I later realised that it was exactly what she needed) which was to sleep next to me through the night without disruption (like moving her over to the cot). Even though I was a fully qualified psychologist, helping people everyday, I could not help myself. I did not have the knowledge or the wisdom to make the 'right' decisions for myself and my baby at the time. In the end, my help came through trial and error and (what I thought was) 'giving in' to my baby.

That little baby is now nine years old and a happy, healthy child but the journey of raising her as an infant and a young toddler was strewn with challenges. By the time I was pregnant with my second child, I had learnt many lessons, and was ready to do things differently. It was around that time that I met Jenny Perkel and found out that she was involved in infant mental health. I was overjoyed at the prospect of meeting someone who

had the knowledge that I was looking for. She had written a book called *Babies in Mind* in 2007 and was just about to launch the Babies in Mind programme which she had developed based on the book. She was looking for practitioners to affiliate with and who could run the programme with mothers (and if need be, fathers) of infants. After a short deliberation (I really did not need long to think about it), I signed up as a Babies in Mind practitioner. A colleague had joined me at the time. We read the Babies in Mind book and the manuals, we did our own research on mother-infant mental health, and without further ado we dived straight into implementation of the programme. The experience was positive and empowering for the participants and for us.

The greatest benefit of being part of the Babies in Mind programme for me was the personal impact in my own life. Later that year I had given birth to my second child and I was considerably more relaxed. The theoretical principles upon which the Babies in Mind programme rested gave me the knowledge to make healthier decision for my baby. I did not allow myself to become inundated with voices and messages about infant health and mental health care. The loudest voice was my baby's voice. My focus was on building a strong attachment to my baby, and allowing her to guide me in that. She was a better feeder (even though I struggled with breastfeeding once again) and she was a better sleeper and she was a calmer baby than my first. It can be argued that her temperament may have been different, or her health better, which is valid, but I know for sure that I felt calmer with her and both of us benefitted from that.

The Babies in Mind programme was a significant factor in my sense of success as a mother the second time around. I became an advocate for the programme, and before long, I aspired to conduct research on the the programme and that was what gave birth to this study.

Motivation for the Study: The Call for Intervention for Mothers

Researchers have implored scholars to investigate evidence-based interventions for maternal mental health issues like postnatal depression to prevent its detrimental effects on mothers and offspring (Baron et al., 2016; Milgrom & Holt, 2014; Rathod et al., 2017). It has also been highlighted that it is crucial to develop guidelines for practical implementation of interventions and programmes for maternal mental health (Surjaningrum, Minas, Jorm & Kukuma, 2018). In the last decade an increasing amount of research has been conducted on social and therapeutic interventions for mothers (Atif et al., 2016; Atif et al., 2017; Bennett, et al., 2013; Beyond Blue, 2008; Denis, Michaux & Callahan, 2012; Glavin, 2012; Goldvarg & Kissen, 2011; Griffiths & Barker-Collo, 2008); however, most of the research has been conducted in the so-called developed countries. Tomlinson, Bornstein, Marlow and Swartz (2014) have found that only 2.3% of articles published on mother-infant mental health included data from low and middle income countries where 90% of the world's infants live. In South Africa (a middle income country), it was noted that there is still limited exploration in the area of mother and infant mental health. However, available research indicates that urgent intervention is needed in this area. Krauss (2010) found that a semi-structured group intervention for mothers with postnatal depression, at a community health centre in Cape Town, was beneficial in reducing symptoms of postnatal depression. Krauss (2010) intended that the South African Department of Health would have access to the information garnered in her research. It is unknown whether this did happen, but it is still evident that screening and treatment of maternal mental health at the primary health care level remains mostly overlooked. Krauss (2010) has recommended more rigorous investigation in this area, especially in South Africa where mental health concerns are considerable. Krauss (2010)

suggest that intervention should be identified which the South African government can adopt and implement nationwide to address maternal and infant mental health.

The South African government has committed to providing adequate mental health care for its citizens. In 2002, the Mental Health Care Act (No 17 of 2002) was promulgated. It enshrined the human rights of individuals with mental disorders, and provided mechanisms for the protection and promotion of those rights. In 2007, South Africa became a signatory of the United Nations Convention on the Rights of Persons with Disabilities and its Optional Protocol (United Nations, n.d.). Through this action, the South African government committed to a global drive toward achieving the full rights of persons with disabilities (Burns, 2011). In 2012, the Department of Health developed the National Mental Health Policy Framework and Strategic Plan 2013 – 2020 (Department of Health, n.d.). The document proposes a new mental health system based on primary health care (PHC) principles. It identifies key activities that are considered pertinent to transforming mental health services in South Africa. It ensures that mental health services are accessible, equitable, comprehensive and integrated at all levels of the health system, and in line with World Health Organization recommendations (Department of Health, n.d.).

In 2015 the Department of Health published a White Paper on National Health Insurance (NHI) which the Department aimed to roll out over 14 years (South African Government, 2018). The concept behind NHI is to universalise health care coverage for all South Africans by pooling funds obtained through taxes to provide free quality health care at state institutions, including clinics and hospitals (South African Government, 2018).

Also in 2015, the Department of Health launched Operation Phakisa which promotes the concept of the Ideal Clinic (Department of Health, 2015). Currently the PHC system in South Africa is faced with many challenges and the quality of health care is not adequate

(Department of Health, 2015). Operation Phakisa aspired to ensure that by the end of 2019 each of the 3,507 PHC facilities in South Africa will display the characteristics of an Ideal Clinic (Department of Health, 2015). One of the characteristics that relates closely to this study is that an Ideal Clinic should provide "community-based health promotion and disease prevention programmes in collaboration with the community" (Department of Health, 2015, p. 10). This concept reflects the emphasis in literature on early intervention for mental health concerns (Baron et al., 2016; Denis, Michaux & Callahan, 2012).

The notion of 'prevention is better than cure' is not new to our society. Many programmes in various fields have been developed to promote wellness and prevent disease. Though, when it comes to mental health, there is a lack of advocacy and health promotion on a large scale at the ground level in South Africa (Burns, 2011). Regarding maternal mental health; as previously mentioned, prevention of illness and promotion of health is advocated and emphasised in many parts of the world (Alfredsson, Sebastian & Jeghannathan, 2017; Atif et al, 2016; Atif et al., 2017; Denis, Michaux & Callahan, 2012; Husain et al., 2006; Johnson et al., 2015; Jones & Ernestina, 2013), however, in South Africa, despite our high mental health burden, no programmes to promote or treat maternal mental health have been introduced in a systematic manner within the public health sector (Baron et al., 2016; Lund et al., 2014; Rathod et al., 2017). The current study speaks to this gap in mental health care through the implementation of the Babies in Mind programme.

Problem Statement

In order to develop a healthy society in South Africa, we need healthy individuals. Theory and research have emphasised that the early experiences of infants affect their functioning along the trajectory of development. If an infant is securely attached to its

mother, it lays the foundations for positive mental health (Bowlby, 1988). If an infant is insecurely attached to its mother, a range of negative consequences ensue (Allen-Mearns, Blazevski, Bybee & Oyserman, 2010; Murray & Cooper, 2003; Spence, Najman, Bor, O'Callaghan & Williams, 2002; Stein, Malmberg, Sylva & Barnes, 2008; Weissman, 1997; Weissman, Wickramaratne, Nomura, Warner, Pilowsky, & Verdeli, 2006). The early attachment between a mother and infant is thus extremely important to the development of healthy individuals. In order to promote secure attachment, a focus needs to be placed on the experience of motherhood and maternal mental health. Postnatal depression and other maternal mental health concerns negatively affect a mother's experience of motherhood and her ability to care adequately for her infant as maternal sensitivity becomes impaired (Cooper, et al., 1999; Diener, Nievar & Wright, 2003). This leads to negative effects on the attachment between mother and infant. In South Africa, with our alarming rates of postnatal depression (Cooper et al., 1999), urgent intervention is needed to promote maternal mental health, prevent maternal mental ill health, and facilitate secure mother-infant attachment.

Most of the literature on maternal mental health and motherhood focuses on mothers as delivery vehicles for provision for infants (Long, 2009). Some literature focuses on the sociology and politics of motherhood, most often from the feminist perspective (Seelhott, 2006; Tucker, 2006; Visintin & Aiello-Vaisberg, 2017; Walker, 1995). Psychological theories tend to objectify mothers and any discussion on motherhood is usually limited to its function and quality from the perspective of infant development (Bowlby, 1969; Freud, 1905; Winnicott, 1960). Recently there has been a shift towards understanding the *experience* of mothers as they raise their infants and cope with life. There is an interest in the way mothers' construct meaning through their process of mothering. This being said, there is still, however, a lack of theory on the *psychology* of motherhood. This study endeavours to contribute to this

new theoretical body of knowledge on motherhood, whilst at the same time addressing the importance of mother-infant mental health programmes to practically support and empower mothers, especially in the South African context. This will be achieved through an exploration of mothers' experiences of the Babies in Mind programme.

Research Question

Do mothers in a South African context experience the Babies in Mind programme to be beneficial in improving maternal mental health and mother-infant attachment?

Research Aim

The research question above underscores the aim of this study which is to explore and describe the effects of the Babies in Mind programme on maternal mental health and mother-infant attachment through exploring the perceptions and experiences of mothers who attended the programme in the South African context.

It is important to note that while the practical benefit of the Babies in Mind programme is being attended to in this study, the programme is also seen as a *vehicle* to understanding and influencing the perceptions and experiences of mothers with regard to their mental health and their attachment to their infants. Therefore, in this study, equal focus is placed on the Babies in Mind programme as an intervention strategy, and the perceptions and experiences of mothers about motherhood and their narratives of mothering an infant.

Research Objectives

There were three objectives which needed to be met in order to answer the research question and achieve the aim of this study. The three objectives were:

1. to explore and describe mothers' experiences of participation in the Babies in Mind programme,
2. to explore and describe the perceived benefit of the Babies in Mind programme in improving maternal mental health and mother-infant attachment, and
3. to explore and describe the barriers and facilitators in implementing an intervention programme such as the Babies in Mind programme with mothers in a South African context.

Overview of Chapters

Chapter one serves as an introduction and overview of the present study. The chapter presents a personal narrative account of the motivation for the study. The problem statement, the research aims and the objectives of the study were also outlined.

Chapter two presents the theoretical underpinnings of this study which is postmodernism, social constructionism and the narrative approach. The chapter aims to theoretically contextualise the voice of the participants in this study.

Chapter three explores the concept of motherhood. Maternal mental health is discussed; particularly in the South African context. The chapter discusses the impact of maternal mental health issues on mother-infant attachment, with a focus on maternal sensitivity as a mediating factor. The chapter also highlights intervention programmes for mothers and introduces the Babies in Mind programme.

Chapter four outlines the research design and methodology used in the study. The sampling procedure, data collection techniques, and data analysis procedure is described. Narrative inquiry which was employed in this study is discussed and ethical considerations are also highlighted in this chapter.

Chapter five presents the findings of the study. Four major themes were identified. Sub-themes, additional themes and further themes were also identified and discussed in relation to the literature and theoretical frameworks highlighted in chapters two and three.

Chapter six provides conclusions and limitations of the study based on the results presented in chapter five. This chapter also highlights recommendations for future research.

Summary

In this chapter a brief overview of the study was presented. The motivation for this study was presented through my personal narrative account of mothering infants. The chapter also discussed the problem statement, the aim and the objectives of this study. The chapter concluded with a delineation of the format of the study. Chapter two provides a discussion of the theoretical frameworks which underpin this study.

Chapter 2

Postmodernism, Social Constructionism and the Narrative Paradigm

"Before I got married, I had six theories about bringing up children.
Now I have six children and no theories. "

John Wilmot

Introduction

In chapter one I provided a narrative account of my journey into motherhood. The account was specially shaped and moulded to give you, the reader, a window into the world of my experiences. Specific language was used, particular tone was employed and emotion was conveyed. Yet still, the meaning I have shared with you will be changed the instant you (with your unique history, sociology, psychology and biology) see and process the words on those pages. Events and experiences do not have predetermined meaning, rather they take on meaning in the context of social interaction (like you reading the text) and through the language that is used to describe them (the language I have used and the language that you will use to interpret the information). The ontological starting point of all experiences is that they are socially constructed (Gergen, 2005). Therefore, the construct and experience of 'motherhood' is socially constructed. Mothers from different cultures, economic statuses, in different locations with different historical backgrounds, all experience motherhood differently. Conversely, there are also similarities in the experience of motherhood. These are arguably the dominant discourses that infiltrate through the gates and walls, into the homes of mothers as they care for and raise their infants and children. For example, in South African

urban settings there could be dominant ‘Western’ discourses and in rural settings there could be dominant ‘African’ discourses. Mothers who move away from rural areas to urban settings find that they have to straddle Western and African discourses in order to satisfy the socio-cultural expectations imposed on them from both settings (Magwaza, 2003; Naidoo, 2010).

Given the above, in this study which explores mothers’ perceptions of the impact of the Babies in Mind programme, it is necessary to account for the socially-constructed stories and expressions that emerge. The theoretical framework that seemed best to provide a lens to arrive at a coherent conceptualisation of mothers’ experiences, taking into account the socially-constructed nature of their realities, was a social-constructionist, narrative paradigm. This paradigm and the school of thought (postmodernism) from which it derives is discussed in this chapter.

Postmodernism

Brann (1992) posed the question: “What is Postmodernism?” Elaati (2016) pointed out that ‘postmodernism’ as a construct is viewed as ambiguous and that many scholars and critics have debated the meaning of it. Brann (1992) argued that postmodernism is not about an ‘object of thought’, but about ‘what a number of people are thinking’ (Brann, 1992). It is an “intellectual movement” (Burr, 2000, p. 12).

In order to describe postmodernism, Brann (1992) provided a tripartite deconstruction of the term. The three elements of the term include ‘post’, ‘modern’ and ‘ism’.

- The element ‘ism’, or the personal form, ‘ist’, is a Greek and Latin suffix, connoting the adoption of the habits of a group. Brann (1992) described it as “running in droves” (p. 4). In other words, a community of like-minded thinkers.

- The element, ‘modern’, is a coinage of the sixth century AD, rooted in the Latin word *modo* meaning ‘just now’ or ‘this moment’. It implies being on the cutting edge of time (Brann, 1992). According to Webster and Mertova (2007) modernism upholds objectivity and scientific knowledge, claiming that there is only one measurable truth. Brann (1992) highlights that there have been many modernisms: theological, national, aesthetic, literary, architectural.

- The element ‘post’ does not simply mean ‘after’. According to Brann (1992), ‘post’ intends the Greek preposition ‘ana’ which, as a prefix, can mean ‘back again’, as in ‘anamnesis’ or a recollection. And here, ‘recollection’ is not mere ‘recall’ either, but effective re-appropriation of memory. This means that a postmodern work is not composed in accordance with any previous universal rule/s or meta-narrative (Brann, 1992). It has no precursor or set of conditions, in a sense, it creates its own.

Taking the above into account, Brann (1992) postulated that postmodernism is a “set of sophisticated revealing texts to be gotten to when all that preceded them have been properly studied (p. 6)”. She goes on to say that it is the “sawing through of the perch we sit on” (p. 6). In other words, postmodernism completely undermines the intellectual structures we usually rely on. It destroys the central arguments that have dominated ancient and Western thought around constructs such as language, identity, origin, voice and mind (Elaati, 2016). It treats the past as a “flea market” where “we can easily acquire old functionless things” to use as “pieces of decoration” (Brann, 1992, p. 6). It departs from rationality and coherence of the modern world (Terre Blanche et al., 2006).

Pioneers of postmodern thinking were Jean Baudrillard, Jacqeus Derrida, Jean-Franois Lyotard, Michel Foucault and Gilles Deleuze (Elaati, 2016). Postmodern thinkers view reality as constantly changing, making the quest for one essential truth impossible (Sim,

2001). They believe that individuals are limited in their ability to measure and describe the universe in any precise, absolute, and universally applicable way (Freedman & Combs, 1996). They therefore uphold the notion of subjective truths and reject the notion of ultimate truth (Burr, 2000).

Consequently, postmodernism opposes the notion that thought, theory and language is a direct reflection of reality. Rather, they are mediated by historical and cultural factors (Best & Keller, 1991). Freedman and Combs (1996) view postmodernism as resting on four basic premises: (1) realities are socially constructed, (2) realities are constructed through language, (3) realities are organised and maintained through stories, (4) there are no essential truths.

In addition, postmodernism rejects what Burr (2000) refers to as "grand theories" (p. 13) and what Brann (1992) refers to as "meta-narratives" (p. 5) which are dominant discourses in the world relating to ontology and epistemology. Alternatively, postmodernism suggests that perceptions of the world are based on social processes (Gergen, 1992). Therefore, there are various ways of understanding the world and they are all valid within their social contexts.

The principles of postmodernism have inspired the work of theorists who advocated for understanding human nature and the social world through the notion of social constructionism. The following section briefly explores the theory of social constructionism. The discussion then leads to an unpacking of the narrative paradigm which lends a frame for this study.

Social Constructionism

Social constructionism is concerned with ontology, that is, the nature of reality. It is a paradigm shift away from the physical sciences which focus on empirical measurement of

objects and phenomena. Social constructionism can be defined as a perspective which holds that a great deal of human life exists as it does due to social and interpersonal influences (Gergen, 1985). It therefore asserts that phenomena and their meanings are continually being accomplished by individuals who are seen as 'social actors' in their worlds (Bryman, 2016). Therefore, not only are phenomena produced through social interaction, they are also in a constant state of change and revision as individuals impact the world around them. Consequently, there can be no 'ultimate' definition of phenomena or experiences. Individuals impact and are impacted upon by those around them, while at the same time, others are impacted by them, and in turn impact them. In this way, reality is co-created or co-constructed by individuals in a particular context. Social constructionism is therefore in complete alignment with postmodern thought regarding ontology, in that the 'real' is only applicable in a particular social context.

Social constructionism is also concerned with epistemology, in that it makes assertions about the ways we can come to know reality. As a theory, it involves challenging our common-sense knowledge of ourselves and the world (Galbin, 2014). It does not just offer a new analysis of topics such as 'personality' or 'attitudes' which can be slotted into existing frameworks of understanding (Galbin, 2014), rather it asserts that the very frameworks themselves need to change, and with it our understanding of every aspect of social and psychological life (Burr, 1995). The assumption that individuals have the capacity to construct their own understanding of the world leads to the notion that individuals are able to construct reality through mental and linguistic processes (Galbin, 2014). Therefore, in order to 'know reality', individuals can only 'know' that which is co-constructed by a community. In other words, knowledge and systems are inherently dependent upon communities of shared intelligibility and vice versa (Gergen, 1985).

In essence, social constructionism argues that the content of consciousness and the mode of relating between individuals is taught by culture and society, that is, all the metaphysical quantities that we take for granted are actually learned from others (Owen, 1995). Gergen (1985) argued that we are therefore forced to resign our cherished positions as 'knowers' and our assumptions that there are 'facts' that we can come to know. These 'facts', along with other ideas and assumptions, are simply social constructions, artefacts of socially mediated discourse (Gergen, 1985). Furthermore, these 'facts' are governed by normative rules that are historically and culturally situated. Therefore, a social constructionist perspective "locates meaning in an understanding of how ideas and attitudes are developed over time within a social context" (Dickerson & Zimmerman, 1996, p. 80).

The basic principles of social constructionism.

The example of 'Hannah' (an imaginary character) is presented for the purpose of illustrating the basic principles of social constructionism, which are (Galbin, 2014): (1) realities are socially constructed, (2) realities are constituted through language, (3) knowledge is sustained by social processes, and (4) reflexivity in human beings is emphasised. Hannah is a 30 year old woman, living in a metropolitan city in South Africa. She recently gave birth to her baby, Noah, who is now two months old. Hannah's pregnancy was emotionally challenging. She had had a miscarriage a few months before she fell pregnant with Noah. Her husband, Joel, was supportive during that time, however, he was not able to relate to her intense sadness. Hannah was still grieving for Jonah when she fell pregnant with Noah. Although overjoyed about her pregnancy, she struggled to feel close to Noah. She did all the 'right things' in her pregnancy such as attending antenatal classes, visiting her doctor every month, exercising, eating healthy meals and taking the recommended supplements. She was

determined to make a success of the pregnancy. Despite her attempts to ‘do’ her pregnancy correctly, Hannah continued to struggle to bond with Noah. She thought that it would be better when he was born.

As her pregnancy progressed, Hannah felt increasingly uncomfortable. Her body felt unlike her own. She experienced shortness of breath, frequent urination and had swollen feet and ankles. She decided to ignore her discomfort as much as possible and focus her attention on her upcoming baby showers and maternity leave. She also distracted herself by purchasing pregnancy fashion online. She felt happy that she was able to pull off the perfect ‘pregnant mama’ look. As the time for the birth neared, Hannah became fearful. The uncertainty surrounding the birth process was overwhelming. She had read up about the importance of having a birth plan so that her wishes for the birth process could be adhered to. She was adamant that she did not want to use pain medication and she wanted to give natural birth as her mother had once told her that mothers who give birth via caesarean section are not real mothers.

Soon it was time for Noah to be born. Hannah went into labour during the night. She remained at home and counted her contractions. In the morning Joel took her to the hospital. Hannah was giddy with excitement and fear. Her contractions grew stronger and more frequent but the nurses told her that she was not dilating enough and that they needed medical intervention. Hannah started to panic. This was not how she had planned her baby’s birth. Her pain had become excruciating but she still refused to use pain medication, as she felt that that was at least something could control. The doctor and nurses become concerned and they told her that they needed to operate and ‘take the baby out’ as soon as possible as he was becoming distressed. Hannah was devastated but too afraid to argue. She was wheeled into theatre and given an epidural. Minutes later she heard her baby cry in the distance. She was

exhausted and overwhelmed and did not feel the sense of awe that she had read about and anticipated. The nurses took her baby away and she was ‘stitched up’ and taken to a ward. She fell asleep and did not see her baby for several hours. When the nurses brought her baby to her, she felt detached from him. This was Noah, her long awaited for baby, but she felt nothing, except exhaustion and disappointment. Hannah felt that the birth process was a disaster and that she was not a real mother as she did not give natural birth.

Hannah struggled with breastfeeding and gave it up within days. She was not motivated to try for long. Days became weeks as Hannah took care of Noah. Her days consisted of feeding Noah, changing his nappy, bathing him and sleeping whenever she could. Joel came home to a messy house every day as Hannah was not washing the baby’s bottles or cleaning or cooking. She was not herself, and clearly not coping with her role as mother.

Hannah felt like a failure. She could not get her mother’s voice out of her head, saying: “you are not a real mother”. She cared for Noah but she felt distant from him, as though she was caring for someone else’s child. She felt resentful whenever Noah woke up at night because all she wanted to do was sleep. She knew this was not right. She did not feel good. She disliked her reflection in the mirror as she had gone from being a glowing pregnant mama to an overweight, exhausted frump. She could not understand how the mothers in the magazines looked so amazing with their new born babies and their perfect post-pregnancy figures. Joel urgently called the doctor one afternoon as he had come home to find Hannah sitting on the floor, with a tub of ice-cream on her hand and a dazed look on her face as she listed to a screaming Noah laying in his crib.

The first principle of social constructionism is that realities are socially constructed. Social constructionism is interested in how human behaviour and experience is inextricably

linked with its social context, and how it in fact frequently emerges from that context. In Hannah's case, her social construction of motherhood was influenced greatly by her social environment. The magazines that Hannah read portrayed motherhood as an ideal time in a woman's life. The young models used on the covers and in the advertisements in pregnancy magazines are attractive and give the impression that looking shapely and glowing in pregnancy is normal. The beautiful and contented mothers looking lovingly into the eyes of their smiling plump babies are designed to illustrate the 'fairy tale' of motherhood. Society sells the dominant discourse, that is, the image of the 'ideal mother' and Hannah bought into it. She compensated for her grief over her miscarriage by channeling her energy into 'looking the part' in her pregnancy with Noah. She focused on the material aspects of motherhood, as is evident in her interest in pregnancy fashion and her time spent on planning her baby shower parties.

The critical voice of her mother played a role in influencing Hannah's expectations of the birth process. Her mother told her that a real mother gives natural birth, implying that other forms of birth retract from the essence of motherhood. Unfortunately Hannah had a traumatic birth experience which led to her feeling intense disappointed as her plan did not go as expected. Hannah's emotions were largely impacted by her thoughts and expectations of motherhood, which were ultimately influenced by social norms around her.

The second principle of social constructionism is that realities are constituted through language. Social constructionism emphasises that the greatest influence in individuals lives is not what 'exists' but how it is conceptualised and internalised. Therefore, language plays plays an important role in constructing 'reality'. This point is best illustrated by Hannah's mother's comment about 'real mothers' giving natural birth. Hannah's notion of motherhood was influenced by this as she believed her mother's words to be 'true'. As a result she

believed that since she was incapable of giving natural birth that she was not a real mother. She felt she was a ‘failure’. She possibly thought of herself as ‘a fake’, or as ‘inadequate’. The words by which she defined herself impacted her reality. She became increasingly demotivated and depressed and she struggled to attach to Noah as she did not feel like a mother.

The third principle of social constructionism is that knowledge is sustained by social processes. Knowledge that is accepted as ‘reality’ in a particular context, for example, scientific, cultural or social, is considered a social process. Knowledge is therefore seen as a particular expression of a social context. What is considered to be ‘obviously true’ or ‘real’ is produced and sustained by social processes, for example, the difference between genders is different in different contexts, depending on historical, cultural and religious factors. In Hannah’s case her knowledge of motherhood is socially shaped through conversations that she has had with her mother, and pictures and articles that she has read in magazines and on websites. A mother in a different context might not have experienced the same feelings that Hannah felt, as they might not have interpreted having a caesarean section, or being overweight and exhausted as impacting their competence or right to be a mother.

The fourth principle of social constructionism is that reflexivity in human beings is emphasised. Reflexivity is has to do with individual’s ability to discuss or examine themselves. It is an interest in ‘how’ knowledge is created and not merely ‘what’ knowledge is created. Hannah’s husband, Joel, had started her therapeutic process when he called the doctor on the day he found her sitting on the floor while Noah was crying. The doctor was likely to refer her to therapy where she would unpack and examine her thoughts and feelings about motherhood. Part of that process would be understanding how her understandings of motherhood developed with time. This process would speak to the process of reflexivity and

would give Hannah the opportunity to socially re-construct the unhelpful notions of motherhood that have affected her experiences.

The principles unpacked above and the illustration of Hannah's story of motherhood emphasises that the way in which individuals understand the world and the phenomena or constructs that they deem to be 'true' are actively constructed between people as they go about their daily lives and interact with each other. The ways of knowing, therefore, are all part of an on-going social process.

The use of social constructionism in research.

With regard to research, there are five features of social constructionism that make it a unique and helpful approach (McLeod, 1997). The features are discussed below in relation to the current study.

1. *Social constructionism rejects the traditional positivistic approach to knowledge.* In the current study this point is appreciated as mothers' experiences cannot be objectively measured or studied. The very nature of mothering and motherhood calls for subjective understanding, as illustrated in Hannah's story.

2. *Social constructionism takes a critical stance in relation to taken-for-granted assumptions about the social world which are seen as reinforcing the interests of dominant social groups.* Although the current study aims to explore and describe mothers' experiences and is not so much concerned with critically challenging dominant discourses, it does acknowledge that they exist and they need to be accounted for.

3. *Social constructionism upholds the belief that the way we understand the world is a product of the historical process of interaction and negotiation between groups of people.* This is a central concept in this study as it aims to explore experiences of mothers within a

particularly socio-cultural context. Social constructionism invites the study of experiences which are embedded within social, cultural and economic contexts.

4. *Social constructionism maintains that the goal of research and scholarship is not to produce knowledge that is fixed and universally valid, but to open up an appreciation of what is possible in different settings.* Motherhood is not homogenous. The study of it can go on forever if there is an acknowledgement of this point. There are innumerable variations in the experiences of motherhood which need to be explored and understood in order to better cater to the needs of mothers.

5. *Social constructionism represents a movement toward redefining psychological constructs, such as the 'mind', 'self', 'emotion', as socially constructed processes that are not intrinsic to the individual but produced by social discourse.* Within psychology there are dominant discourses around motherhood (discussed in chapter three) which favour biological, unconscious processes. These discourses are challenged through the notion that our 'psychology' is to a large extent located in our social experiences.

Due to its bold claims about the nature of reality, social constructionism has received much criticism from scholars (Misra & Prakash, 2012). Nevertheless, as a theory, it provides positive contributions to research and practice that cannot be overlooked. Firstly, it respects the plurality and diversity of our social world. Instead of a singular or hegemonic view of reality, constructionism entertains multiple realities, and it therefore offers innovative ways of appreciating and shaping reality (Gergen, 1996). Misra and Prakash (2012) rightly point out that recognising others on their terms builds trust and encourages dialogue. Social constructionism allows for this. The move from objective reality to reality as co-constructed opens the scope for interchange, collaboration and sharing (Misra & Prakash, 2012). Secondly, social constructionism reconfigures human discourses in non-reductionist ways

(Misra & Prakash, 2012). That is that it provides a platform for discussion about phenomena that does not reduce it to mere physiology (Gergen, 1973). It regards individuals as intertwined with cultural, political and historical evolution, in specific times and places, and so re-situates psychological processes cross-culturally, in social and temporal contexts (Galbin, 2014). This suggests that, apart from the inherited and developmental aspects of humanity, social constructionism hypothesises that all other aspects of humanity are created, maintained and destroyed by our interactions with others through time.

The present study aimed to explore mothers' constructions of their experiences of participating in the Babies in Mind programme within the community context. As the researcher, I was interested in the construction of meaning and knowledge regarding the impact of the programme on mothers' mental health and attachment to their babies. As mentioned, social constructionism was therefore a good fit for this study as it created the opportunity for critical engagement with the mothers and made room for the co-construction of meaning and knowledge between the participants and myself as the researcher.

Given the above, it is worthwhile to re-emphasise that language plays an important role in the construction of knowledge. This is one of the key principles of social constructionism, as stated above. Terre Blanche, Durrheim and Painter (2006) make a distinction between *linguistics* which is a study of the technical aspect of language use and structure, and *language* which encodes patterns of social meaning in the world. Social constructionism is concerned with the latter. Through language, a single experience can be explained in several different ways, resulting in different perceptions and experiences, none of which are necessarily accurate or inaccurate (Gergen & Gergen, 2003; Willig, 2013). As previously mentioned, social constructionism asserts that language is a means of co-creating or co-constructing reality rather than a reflection of the individual mind (Gergen & Gergen,

1991; Owen, 1995). In other words, we can come to know reality through language, but that knowledge does not necessarily equate to an understanding of the 'human mind' as a universal concept.

Gergen and Gergen (1991) suggested that in research, the researcher, being part of the realm of shared language, becomes a co-creator of reality alongside participants. In that way, they have a window into the world of the participants, however, it is not separate from the views out of the windows of their own worlds. They refer to this process as 'relational reflexivity' in that both the researcher and participants share the power to construct meaning in a particular time and space (Gergen & Gergen, 1991). The meaning is not objective, but completely subjective and bound to a particular context.

The Narrative Paradigm

This section provides an overview of the narrative paradigm. Narrative inquiry, which flows out of the narrative paradigm as a specific research lens used in the social sciences, will be discussed in chapter four (methodology chapter). Morgan (2000) stated that the narrative paradigm is respectful, non-judgmental and positions individuals as experts in their own lives. The approach embodies a social constructionist view of reality in that experiences can never be objectively known, only subjectively interpreted (Freedman & Combs, 1996).

Polkinghorne (1988) suggested that the narrative paradigm tries to find connections between events and experiences, as opposed to finding universal truths about situations, as with the modern positivistic paradigms. Therefore, the material or data that is most relevant in narrative research is the stories that people tell of their experiences and their subjective interpretations of those experiences.

Stories and storytelling.

Individuals both live their stories in an on-going experiential text and tell their stories in words as they reflect upon life (Connelly & Clandinin, 1990). An individual is, all at once, engaged in living, telling, retelling and reliving their stories (Connelly & Clandinin, 1990). Stories are told so that individuals can identify themselves as themselves to themselves, and to others (White, 2000). The way in which individuals structure and tell their stories creates particular meaning and allows them to make a particular kind of sense of their experiences (White, 2000). Stories function as lessons in which individuals learn something essentially human about life (Connelly & Clandinin, 1990). As Corey (2005) put it: stories ultimately determine the reality of the storyteller.

For the participants in this research study, their experiences were expressed through the stories they shared about themselves and their infants. During the Babies in Mind programme the participants shared stories with each other each week. I also shared stories about my journey as a mother, and together we learnt about each other and from each other. It was through our mutual storytelling that learning and empowerment relating to motherhood was constructed.

Meaning through storytelling.

As mentioned above, individuals purposefully select aspects of their experiences that they want to focus on and put them together in particular ways to form stories (Webster & Mertova, 2007). Cultural beliefs and symbols are often added to deepen the meaning in stories (Chinn, 2002). Experiences are therefore made meaningful by the particular stories individuals choose to tell about them. The story I shared in this chapter illustrates this point.

Reismann (1993) argued that individuals tend to have certain motives for telling stories in particular ways as their stories ultimately portray a particular version of their self-identity. Narrative researchers aim to uncover the meanings in stories through creating written accounts, or narratives, of the stories told. They analyse elements of the stories such as the way individuals position themselves within their stories and the verbal constructions that are used to tell the stories. A narrative is therefore not an objective retelling of a story, rather it is a version of how the story has been interpreted by the researcher. Again, the idea is not to arrive at a universal truth or objective understanding of an experience or a story, it is about creatively reconstructing a story that allows meaning to emerge about individuals' experiences (Chinn, 2002). With reference to the present study, during the conducting of the Babies in Mind programme and the research process I collected stories of the mothers in the field. The stories were later written up as narratives and analysed to uncover meanings from them which gave me an aperture into the world of their experiences.

Untold stories.

Kermode (1981) referred to untold stories as 'narrative secrets'. White and Epston (1990) suggested that individuals have rich lived experiences but only small portions of that is reflected in the stories that they choose to tell. Often the stories told fall within the realm of dominant discourses in society or in a particular community. This compliance to the norm is usually done out of self-preservation. Going against the norm often earns an individual disdain and reproach from others. Many stories are left untold because of this. These untold stories are of particular interest to narrative researchers. In order to make room for alternative discourses, dominant discourses are often deconstructed (Freedman & Combs, 2002). In other words, the ideas, practices and beliefs of social context are unpacked and analysed.

Narrative research allows for an in-depth study of experiences (Nelson, McClintock, Perez-Ferguson, Shwaver, & Thompson, 2008) and allows the researcher to consider an individual as a whole rather than simply focus only on the constructs under investigation (Carson & Fairburn, 2002). The narrative approach is concerned with externalising problems, in other words, problems are considered to be something separate from the individual rather than inherently part of them (Freedman & Combs, 2002). In the present study the Babies in Mind programme was considered as a vehicle for externalising mothers' experiences about their mental health and attachment to their infants. The programme made it possible for me to access mothers' perceptions about their experiences in a non-threatening manner.

The narrative paradigm and social-constructionist theory equipped me with the theoretical lens through which I could approach the research process, engage with the participants in the field and conduct the construction of this research study. This study emphasised the importance of adopting a coherent worldview when conceptualising information about individuals and the world, without which the information will likely be misunderstood and compromised.

Summary

This chapter provided a brief but, 'applicable to this study's context', overview of postmodernism, social-constructionism and the narrative paradigm. These theoretical positions underpin the research question being posed (discussed in chapter one). The theoretical position also allowed for the co-construction of meaning with the research participants regarding their experiences of the Babies in Mind programme. By taking a firm theoretical position I was able to answer the research question (discussed in chapter one) through co-constructing meaning with the research participants of their experiences of the

Babies in Mind programme. It also gave me a framework for understanding the available literature on motherhood and intervention programmes for mothers in the South Africa context. The next chapter provides a review of the literature on mothers, motherhood and maternal mental health in South Africa. This then provides a further understanding of the context of this study.

Chapter 3

Mothers, Motherhood and Maternal Mental Health in South Africa

"Mothers are the most instinctive philosophers."

Harriet Beecher Stowe

Introduction

Motherhood is a common experience. Stats SA (2017) revealed that a total of 969 415 live births were recorded in South Africa in 2016. This means that 969 415 women became mothers that year, not taking into account twin-births. The South African Demographic and Health Survey (2016) indicated that the average South African mother has 2.6 children in her life-time. Apart from all the consequences and connotations of motherhood, it is evident just from the frequency of the event, that the transition into and experience of motherhood requires attention by practitioners and researchers.

In this chapter, light is shed on the concept and experience of motherhood. A definition of motherhood will be provided. Special attention will be afforded to motherhood in the period of infancy since that is pertinent to the study. Contextual factors impacting South African mothers will be considered, and further into the chapter the concepts of maternal mental health and maternal sensitivity will be unpacked.

Being a mother is often seen as one of the most important life events for women universally (Kruger, 2003). This includes biological mothers and social mothers (i.e. caregivers, grandmothers and adoptive mothers) alike. The term 'mother' is used in this study to denote biological mothers as well as women directly and intensely involved in the role of mothering an infant. It is necessary to point out that a discussion on motherhood from the

perspective of men who ‘mother’ children in the absence of a female mother or of homosexual male ‘mothers’ (single homosexual males or homosexual couples who have children) falls outside the scope of this study, however, it is acknowledged that the construct of motherhood is often applicable with these populations and that further research which includes these aspects is supported.

The experience of becoming a mother is momentous and life changing (Kruger, 2003). The process begins at conception. A mother carries a growing foetus for approximately 40 weeks; bearing the discomfort and strain that comes with the process. She must then give birth (a gruelling event on its own) to a helpless infant who for months thereafter will be completely dependent on her. The first year is often the most difficult for this reason. An infant is incapable of meeting any of its own needs and so is completely reliant on its mother to provide food, shelter, comfort (physical and emotional) and safety.

As an infant grows it gains greater independence, usually corresponding with its age. This brings with it various challenges through life. A mother is required to constantly adapt to a child’s changing needs and consistently develop the ability to meet them. The journey is long and arduous and inspires some of the best and some of the worst moments in a woman’s life. Social blogger, Jessica James (2016) stated that motherhood is:

“…a connection that is unmatched and insurmountable in any form or other relationship. It’s a love that grows continually, a love that always wants more and better. It’s being terrified that you can’t prevent pain, injustice, heartbreak and at times even death. It’s laughing at jokes that aren’t even funny, but the way they say it makes it hilarious. It’s listening to stories that go on and on without a point. It’s always being available for the “Mommy, watch me!” yells and “Mommy, I need you” please. It’s drowning out the word MOM repeated over and over in attempts to get your attention. It’s songs sung out of tune and

settling squabbles with siblings. It's being mean, and teaching hard lessons, that hurt you inside so deep you want to cry, but you must stand strong with resolve. It's being strong for them when you are weak. It's smiling when you want to cry, and crying when you're smiling with pride."

James (2016) speaks of motherhood as a deeply emotional and highly involved undertaking. The relationship between a mother and her child generates numerous emotions including love and joy, sadness and terror. These emotions can be experienced at separate times or all at once. Motherhood thus requires patience, wisdom, flexibility and humour. It has the power to draw out of a woman an inner strength; enough for herself and that of her child.

Defining Motherhood

Theorists in various fields have attempted to define the concept of motherhood, however an explicit definition does not seem to exist. Walker (1995) conducted a landmark study on the conceptualisations of motherhood in South Africa in the twentieth century. Although the study was conducted over twenty years ago, many of her findings are still applicable today. For instance, she pointed out that there appears to be a powerful assumption at work that motherhood is "so familiar an institution and experience" that in the literature it has not been rigorously defined (Walker, 1995, p. 424). She argued that this indicates the "powerful normative authority of the term and the implicit universalism toward which our common-sense understandings and experiences of motherhood so readily propel us despite our most earnest theoretical scruples" (Walker, 1995, p. 424). This finding is applicable to the current study since the literature on motherhood appeared to either fall into the category of agreeing with the dominant discourses of motherhood (the universal construct that Walker

(1995) referred to), or challenging the dominant discourses of motherhood (mostly from a feminist perspective).

Akujobi (2014) stated that motherhood can be referred to as "an automatic set of feelings and behaviours that is switched on by pregnancy and the birth of a child (p. 371)." It is seen as a "moral transformation whereby a woman comes to terms with being different in that she ceases to be an autonomous individual because she is one way or the other attached to another – her child" (p. 371). The phrases "switched on" and "transformation" used by Akujobi (2014) suggest that in this view motherhood is an experience that has a beginning and cannot be experienced without an onset, that is, the begetting of a child. Furthermore, Akujobi's (2014) term "different" implies that women who have children experience themselves in a distinctly unique way compared to women who do not have children. Motherhood is thus seen as an experience that is intricately entwined with the arrival of an infant and fundamentally impacted by the notion of being attached to it. This definition would fall into the category of the 'dominant discourses' of motherhood as it argues that motherhood is biological, and that mothers raise their children themselves and are forever changed by the experience.

As mentioned above, there is debate around the nature of the experience of motherhood. Some theorists attested to the above-mentioned universality of the motherhood experience and yet others have identified differences in the experience of motherhood based on culture, race and other factors (Berg et al., 2018; du Toit, 2017; Ichou, 2006; Walker, 1995). What can be granted though is that generally motherhood brings with it enduring changes in a woman's life and necessitates that women manage their role as mother along with various other roles. It requires of women significant physical, psychological and socioeconomic adjustments. And it necessitates prior preparation, the acquisition of

knowledge and a sense of capability (Javadifar, Majlesi, Nikbakht, Nedjat & Montazeri, 2016).

To provide a more holistic definition for the term ‘motherhood’, particularly in a South African context, Walker (1995) argued that motherhood embraces at least three intricately entwined dimensions. They are (1) the practice of motherhood, (2) the discourse of motherhood, and (3) the social identity of motherhood. Major elements of the practice of motherhood include: childbirth (taking into account that biological motherhood does not necessarily lead to social motherhood, and social motherhood is not strictly dependent on biological motherhood), physical care, emotional care and involvement and socialisation (Walker, 1995). A mother may be responsible for all or only some of the above tasks.

With regards to the discourse of motherhood, Walker (1995) pointed out that there are differences in the discourses of motherhood between the various social groupings in South Africa. The dominant discourse for white and middle class women is that of ‘the good mother’ (Walker, 1995). This refers to a mother who cares for her child physically and emotionally (Walker, 1995). In black and working-class communities, there is less emphasis on a mother’s involvement in the day-to-day care of her children and more emphasis on her responsibility to provide financial support and discipline (Moodley & Slijper, 2016; Walker, 1995). While acknowledging the impact of these political discourses on motherhood, Walker (1995) also highlighted that most South African research in the area has been preoccupied with the analysis of discourse and neglected to focus on the meanings that mothers create in negotiating their daily lives. She emphasised that “neither mothers’ practice nor their self-image can simply be ‘read off’ from political rhetoric” (Walker, 1995, p. 426). Since Walker (1995) made the above assertion, a few studies on the experiences of mothers in the South African context have been conducted (Dale, 2012; du Toit, 2017; Frizelle & Kell, 2010;

Kruger, 2003; Mjwara & Maharaj, 2017), however, it is agreed that most of the literature on motherhood in South Africa is 'political' in nature. As previously mentioned, the present study is valuable in that it adds to the body of knowledge around the subjective *experiences* of mothers in the South African context.

Regarding the social identity of motherhood, Walker (1995) argued that considering this dimension allows researchers to address mothers as agents who think and feel about their lives and their role as mothers. Outside of motherhood, mothers have other identities, often including 'woman', 'wife', 'employee', 'student', 'Black', 'White', 'Coloured' etc. These co-existing identities interact and influence each other, and at times they may restrict or refashion the expectations, attitudes and behaviours associated with being a mother (Kruger, 2003; Pillay, 2012; Walker, 1995). Women's identities as mothers are influenced by conscious and unconscious activity. Psychoanalytic feminists have paid attention to the unconscious influences that cause women to be mothers through the analysis of the psychic structuring of children's gender identities and through their experiences of being mothered themselves (Sanyal & Gupta, 2017; Walker, 1995). More relevant though, is the issue of conscious awareness of identity. This notion that identity is created and sustained through self-reflection and not unconsciously manifested in an individual is important in allowing for the possibility of agency and change (Walker, 1995). Walker (1995) argued for researchers to move away from seeing mothers as passive recipients of ideology or discourse or driven solely by unconscious motives and desires, but to see them as social actors who actively construct their identities.

Walker (1995) found that in South Africa, despite the challenges that mothers face, motherhood is often viewed as an empowering identity for women. This is corroborated by other studies on motherhood conducted in South Africa (Ichou, 2006; Kruger, 2003; Naidoo,

2010) In some instances, motherhood even allows women to have a stronger sense of self-worth from which to challenge various forms of oppression, and in the process, develop new strengths and capabilities (Ichou, 2006; Naidoo, 2010; Walker, 1995).

Allomothering.

In South Africa, motherhood at the community level is different to western cultures. Walker (1995) pointed out that in black and working-class South African communities, there was less emphasis on a mother's involvement in the day-to-day care of her children and more emphasis on her responsibility to provide financial support and discipline. Over time it has become normal for women to be employed and be away from home for many hours of the day. Many mothers also work away from their home towns and so children are often raised by other individuals in their absence (e.g. grandmothers, older siblings and other family or community members) (Berg, Lachman & Voges, 2018). This concept of children being raised by other individuals is called allomothering or allomaternal care (Meehan, 2009). Allomaternal care has long been recognised as commonplace in under-developed societies (Tronick, Morelli & Ivey, 1992). But apart from the changes in the socio-economic tapestry of our society requiring women to work, allomothering has been widely accepted as a unique cultural trait of non-western societies, especially in Africa (Berg, Lachman & Voges, 2018). Meehan (2009) pointed out that allomaternal care provides a wide range of benefits for infants, including improved cognitive development and increased survival (Meehan, 2009). Allomothering is thus clearly a positive cultural adaptation. Infants are thought of as belonging to the community and the well-being of children is considered a collective responsibility (Tomlinson, et al., 2005). This philosophy is depicted by the African proverb 'it takes a village to raise a child' (Mooya, Sichimba & Bakermans-Kranenburg, 2016), and

driven by the notion of *Ubuntu*, meaning 'a person is a person because of another person' (Berg, 2003).

A few recent South African studies have explored mothers' experiences of motherhood, but none have focused on the experiences of other individuals who play the role of mother to infants and children. This lack of exploration of the experiences of allomothers appears to be a significant gap in South African research. Therefore, the present study includes, as participants, grandmothers and caregivers, who were given the opportunity to attend the Babies in Mind programme and share their stories. As has been emphasised, motherhood cannot be homogenised (du Toit, 2017). Adding to this, Kruger (2006) stressed that motherhood in South Africa is cased within a unique socio-political history, characterised by race, culture, class and socio-economic status, having a significant impact on mothering.

Theories of Motherhoood

In art and literature motherhood has largely been idealised. Specifically, in cinema and visual art, motherhood is most often romanticised and portrayed within the conventional family structure (nuclear family). In literature, the notion of the 'ideal mother' is promoted. Skott (2016) published a book called *Motherhood Mystique* which illustrated this idealised view of motherhood. The motherhood mystique supposes that women *want* to be mothers; that they are uniquely suited to raise children, and that motherhood is the ultimate fulfilment of a woman's life (Sanyal & Gupta, 2017; Skott, 2016), as illustrated in the example of Hannah in chapter two. Incidentally, these idealised and dominant discourses of motherhood are currently being criticised. The prominent criticism holds that these representations and images of motherhood do not depict the evolving, complex and often difficult role of motherhood in our society. Researchers are calling for artists and writers to bring life to the

complexity of motherhood as it is subjectively experienced (Hafferman & Wilgus, 2018). The sociological, political and psychological approaches found in the literature shed light on specific theoretical conceptualisations of motherhood. These approaches are discussed below.

Sociological and Political Approaches.

Within the fields of sociology and politics, the concept of motherhood has long been debated on account of its impact on the identity and value of women. The discourses around motherhood have been scrutinised from every angle. Feminist theorists and activists seek to protect mothers from discrimination based on stereotypes. For example, Seelhoff (2006) fervently pointed out that mothers are less likely to be hired than women without children and are paid lower starting salaries than similarly qualified men or women without children. In a Brazilian study conducted by Visintin and Aiello-Vaisberg (2017) mothers spoke out against society's demand for complete dedication to the care of their children and the relinquishing of other aspirations. Mothers claimed that society's heavy demands on them promoted emotional suffering (Visintin & Aiello-Vaisberg, 2017). Other studies have confirmed these results and shown that mothers (including South African mothers) suffer emotionally under societal expectations (Elliot, Powell & Brenton, 2015; Pillay, 2012; Walls, Helms & Grzywacz, 2016).

Radical feminism has gone so far in protecting women's rights as mothers that they have rebelled against the very concept of motherhood itself; claiming that it is an imposed societal institution (Seelhott, 2006; Tucker, 2006). Walker (1995) argued against the reduction of motherhood to an institution, and the activity of mothering to a role imposed by others. She emphasised that feminists make the mistake of paying too much attention to discourse, in the form of dominant ideologies, and not enough to the authentic meanings

mothers attach to their experiences and how these meanings intrinsically shape their identities and behaviours apart from political attitudes (Walker, 1995).

Psychological Theories.

In the field of psychology, the *mother* has primarily been examined within the context of her relationship with her infant. Freud (1905) argued that a child's first love object is the mother's breast. He referred to the early suckling relationship as the prototype of all later love relations (1905). Since Freud's insight at the beginning of the twentieth century, other theorists have adapted and expanded on his views. Psychodynamic theories such as object relations theory (Melanie Klein, Donald Winnicott, Harold Guntrip), ego-psychology (Anna Freud, Heinz Hartmann, David Rapaport), self-psychology (Heinz Kohut) and attachment theory (John Bowlby and Mary Ainsworth) all agree that a mothers' attunement to her infant is essential to its survival. Of the above-mentioned theories, attachment theory occupies a central place in psychodynamic theory and provides substantial empirical evidence of the tenets of the mother-infant relationship (Levy, Meehan, Temes & Yeomans, 2012). Attachment theory has been used extensively in research and practice and in the development of many intervention programmes (Levy et al., 2012).

Bowlby's (1969) theory emphasised that women are programmed to care for babies and children. As previously mentioned, the notion that women are biologically wired for motherhood is currently being criticised in political, literary and artistic domains. Nevertheless, attachment theory is one of psychology's significant contributions to the understanding of motherhood and its implication for infants and children. Bowlby's theory has had an impact on policy design internationally (Berlin, Zeanah & Lieberman, 2008). His theory has made an impact regarding policies on hospitalisation and institutionalisation of

children and parental visitation rights (Karen, 1998). Another area of influence has been in social work practices, for example, foster care placements (Goldsmith, Oppenheim & Wanlass, 2004). Pertinent to this study is the fact that Bowlby focused on early intervention and preventative treatment (Berlin, Zeanah & Lieberman, 2008)). He emphasised that change needed to come in the form of mothers internal working models, parenting behaviour and parents' relationship with therapeutic intervenors (Berlin, Zeanah & Lieberman, 2008). According to Berlin, Zeanah and Lieberman (2008), ongoing research using Bowlby's theory has led to the development of many interventions and programmes.

Another major contributor to the psychological perspectives on motherhood is Donald Winnicott (1960). He was a renowned paediatrician and psychoanalyst who suggested that mothers do not have to be perfect; they simply have to be 'good enough'. Winnicott's softer approach to mothering created a wave of relief and was considered progressive in a time during which the societal expectations of parenting were stringent and harsh (Tisdall, 2016). As mentioned, due to society's ideals about motherhood, mothers often strive to meet the expectations and standards that they perceive society to hold, and as a consequence, struggle greatly with self acceptance in the process. The concept of being a good enough mother is permissive, allowing a mother to be herself and parent her infant/child intuitively. The concept reduces the pressure that mothers place on themselves and it increases a mother's sense of confidence and self efficacy in her parenting. However, that being said, even when there is a healthy sense of confidence and self efficacy, mothers are still required to possess a few essential skills in order to be a competent parent. There is a plethora of books, research and literature about competent mothering and parenting. In fact, there are so many voices out there that mothers and parents often struggle to make sense of what is advisable and good for

their infant and/or children (Perkel, 2007). This was illustrated in my personal account of motherhood in chapter one.

In order to provide a general framework for the kind of requirements for competent mothering as perceived within the context of this study, Robert Epstein's (2010) list of competencies have been summarised. These competencies are seen to predict good parenting outcomes, parent-child bonds and child happiness, health and success. It is a general approach, does not promote any particular theory and can be applied to motherhood. Below is a paraphrased summary of the competencies:

- Provide love and affection: mothers should support and accept their children, be physically affectionate and spend quality one-to-one time with them.
- Manage stress: mothers should take steps to manage their stress and their children's stress, practice relaxation and promote positive interpretations of events.
- Relationship skills: mothers should maintain positive relationships with their partners, and model effective relationship skills to others.
- Autonomy and independence: mothers should treat their children with respect and encourage autonomy age-appropriately.
- Education and learning: mothers should promote and encourage learning and provide their children with opportunities for learning.
- Life skills: mothers should be able to provide for their children's needs, have a steady income and plan for their children's future.
- Behaviour management: mothers should regulate their own behaviour and their children's behaviour and use positive reinforcement.
- Health: mothers should model a healthy lifestyle and promote good habits, such as exercise and proper nutrition.

- Religion: mothers should support spiritual and religious development.
- Safety: mothers should take precautions to protect their children and maintain awareness of children's activities and friends.

Ideally, mothers should aim to obtain the above competencies. Of course, with the right amount of support and resources, that is quite possible. Unfortunately, many mothers do not receive sufficient support and live in resources-limited contexts that influence the quality of their parenting. In South Africa, there are many factors that influence motherhood, internally and externally. The next section will unpack a few of these factors. Since 'motherhood' does not belong to any particular field, the researcher, in attempting to provide theoretical perspectives on the construct, has drawn on ideas from various disciplines. The literature highlights the acceptance of certain aspects of motherhood (a mother's relationship with her child), and the challenge toward other aspects of it (e.g. societal pressures, discrimination, oppression, etc.). Ultimately, motherhood is a complex construct, receiving interest from different disciplines in the attempt to comprehend and represent it.

Contextual Factors Affecting Motherhood in South Africa

Motherhood does not occur in a vacuum. As previously mentioned, mothers raise their children in variable contexts which fundamentally influence their experience of motherhood. South Africa, being a multi-cultural, developing country with a traumatic history presents mothers with a context unlike anywhere else in the world. In this section the contextual factors affecting motherhood in South Africa will be discussed.

Culture.

South Africa is home to a population rich in culture and ethnic diversity. The country has 11 official languages and a wide range of religions and cultures. The population can be divided into racial categories: African (79.2%), Coloured and White (8.9%) and Indian and Asian (2.5%) (Brand South Africa, 2017). Within these groupings there is diversity of cultures and customs. Culture can be described as socially shared beliefs, values, norms and expectations practiced by a group of individuals, community or even society at large (Ung, 2015). It includes the unspoken rules of conduct and acceptable standards within a group (Ung, 2015). Culture has the power to influence the individual's thoughts, feelings and behaviours.

Mothers' experiences of motherhood are deeply influenced by their culture. Sudarkasa (2004) explored the notions of natural motherhood and cultural motherhood and explained that the biological aspect of being able to conceive and give birth derives from nature, however, in human societies the rules and expectations of mothers are culturally determined. Practices and experiences of motherhood therefore differ from culture to culture as they are socially constructed. Research has generated evidence regarding the impact of culture on motherhood. For example Naidoo (2010) highlighted that in South Africa, black mothers, especially those of the older generation, placed high value on fertility. The bearing of children affords women a level of power in the home albeit subject to the patriarchal hierarchy within these communities (Naidoo, 2010; Walker, 1995). Within black communities there has also been an "uncoupling of marriage and motherhood" (Walker, 1995, p. 431). South Africa has seen a rise of female headed households. Interestingly, the stigma around single motherhood has continued to decline in African communities as an increasing number of young women are avoiding marriage but not relinquishing motherhood (Moodley & Slijper, 2016; Rabe &

Naidoo, 2015; Walker, 1995). Mamabolo (2009) and Van Doorene (2009) both conducted studies into the experiences of mothers in South Africa. Both researchers found that black working mothers felt that the ultimate expression of womanhood is motherhood. Women are seen as having the inherent capacity to be mothers because of their gender and the also still remain the primary caregivers for their children, despite also working (Mamabolo, 2009; Van Doorene, 2009).

Walker (1995) commented on the historical constructions of motherhood among white South Africans. In the early twentieth century, white South African women moved away from the drawing-room ideal of Victorian domesticity and embraced a lifestyle and motherhood based on "domestic competence, resilience and engagement with the survival of the family and community" (Walker, 1995, p. 433). This was especially true for Afrikaner white women who veered away from "passivity and delicacy" to participate (physically and politically) in the fight against British colonial power and in other instances, to participate in the economic upkeep of the home by engaging in employment outside of the home (Walker, 1995, p. 433). In modern times the picture has changed even more as the role of motherhood among white South Africans is shared with their roles in social and the working world (Pillay, 2012).

Ntarangwi (2012) discussed culture's influence on parenting in the black African context. It was emphasised that in rural contexts, children are raised in a community setting where parenting extends beyond the home. Mkhize (2004) pointed out that in collectivist cultures in Africa individuals are defined in relation to others and understand the self as interdependent with others. The previously mentioned notion of *Ubuntu*, represents this cultural norm. Berg et al. (2018) explored some of the indigenous African mothering practices found in South African communities today. For example; back carrying and unlimited breastfeeding are commonly practiced by mothers in these communities. Physical

closeness is maintained as an infant is carried on a mother or caregivers' back from approximately 6 weeks to 2 years of age (Graham, Manara, Chokotho & Harrison, 2015). Back carrying is the primary mode of transportation of babies and toddlers and allows the mother to keep her children safe (Graham et al., 2015). With regards to breastfeeding, not only is the breast presented for feeding, but in these settings mothers ensure that infants have unlimited access to the breast and maintain constant physical oneness with their infants in this way (Maiello, 2003).

The above mentioned practices and norms are unique to specific communities in South Africa. Mothers living in cities experience motherhood differently. For example, westernised mothers in urban settings raise their infants independently (Wardrop & Popadiuk, 2013). The individualistic culture of the West promotes independence, autonomy and priority of individual needs (Darwish & Huber, 2003). Urbanisation and acculturation have led to changes in the experience of motherhood. Traditional practices are being increasingly diluted by western practices and methods (Du Toit, 2017; Naidoo, 2010). The younger generation black mothers are focused on self empowerment, financial independence and career aspirations (Moodley & Slijper, 2016; Naidoo, 2010).

Magwaza (2003) conducted research about the contrasting experience of motherhood for black and white mothers. She reflected on her own experiences as a mother and explained that the mothers in her community played an active role in her children's care. She pointed out that in black communities it was common practice for neighbours to collect children from school and care for them until their mothers would return from work (Magwaza, 2003). This illustrated the collective responsibility that black mothers feel towards raising children. She contrasted this with her experience of living in a predominantly white suburb where she was encouraged to work less and employ a domestic worker in order for her to spend more time

with her children (Magwaza, 2003). The two different approaches to motherhood practices reflect not only how culture plays a role in mothering but also how a mother's socio-economic situation may impact on the type of resources they draw upon in raising children. Magwaza (2003) explained that black mothers generally have more social support than white mothers due to communal mothering practices, however, this is slowly changing for middle class mothers who are living in integrated, multiracial areas. Motherhood in South Africa is a complex and changing landscape of experiences. As time has progressed, cultural expressions of motherhood have evolved, even within racial groups (Du Toit, 2017).

Socioeconomic status.

According to the American Psychological Association (2018), socioeconomic status refers to the social standing or class of an individual or group of individuals. It is commonly measured as the combination of education, income and occupation (APA, 2018). Socioeconomic status affects quality of life. For mothers, socioeconomic status is a factor that directly impacts the experience of raising children. Being able to afford basic supplies such as clothing, nappies, toiletries, formula milk where necessary and appropriate foods is a responsibility that every mother carries.

In South Africa, a denoted developing country, the prominent issue around socioeconomic status is poverty. According to Stats SA (2017b) in 2015, more than half of South Africa's population lived below the upper boundary of the poverty line (R992 per person per month). This translated into over 30.4 million South Africans living in poverty. That same year, the Eastern Cape, where the current study is being conducted, had the highest prevalence rates at 72.9 % of the province's population living in poverty (Africa Check,

2018). Bain (2014) stated that the black population in South Africa is disproportionately affected by poverty.

When a mother lives in poverty, it makes providing for her infants and children an everyday challenge. Housing, schooling and health care become significant concerns. Incidentally, in South Africa, the burden of ill health is greater in lower than higher socioeconomic groups (Ataguba, Akazili & McIntyre, 2011). Poverty is a known risk factor for postnatal depression (Aneshensel, 2009; Tomlinson, et al., 2004). According to Tomlinson et al. (2004), mothers raising children alone without financial support from fathers is also a risk factor for postnatal depression. Very often for mothers living in poverty, accessing good health care to treat illness is a rare privilege (Ataguba, Akazili & McIntyre, 2011). Mothers living in poverty must navigate the journey of motherhood whilst jumping socioeconomic hurdles every day. Mothers are therefore faced with a double burden of having to provide care and finances required to care for their children (Moodley & Slijper, 2016). In these instances mothers become dependent on relatives for emotional and financial support, however this source of support is difficult in South Africa as family life has been disrupted due to the legacy of apartheid and the history of migrant labour (Moodley & Slijper, 2016). Due to the HIV and AIDS pandemic, there has been a rise in grandparent and child-headed households (Moodley & Slijper, 2016). This means that relatives are often over-burdened with their own difficulties and mothers are left to cope on their own with the challenges of raising infants and children. The Child Support Grant does provide some financial relief but it is not enough to prevent mothers from struggling emotionally (Moodley & Slijper, 2016; Orderson, 2011). Mothers are often not emotionally or psychologically equipped to cope with the task of raising infants and children. Moodley and Slijper (2016) highlight the need for supportive and educational programmes for mothers. This study attends to that need.

Family structure.

In our modern society there have been changes in the pattern of family structure from the previous commonly held notion of the nuclear family. The variety of family household structures is especially striking in South Africa. Common trends include the absence of fathers (but sometimes presence of other male figures), low fertility rate (of white and Indian South Africans), and the postponement of marriage (especially among black South Africans) (Rabe & Naidoo, 2015). Ichou (2006) pointed out that many black South African women feel that childbearing is not dependent on marriage. There are other such nuances in the family systems in South Africa that influence the context in which mothers raise children. Mechanisms to address diverse families' needs have been implemented in South Africa (Sevenhuijesn et al. 2003). The White Paper on Families (Department of Social Development, 2012), was a milestone in South African policy history where the diversity of family structures was recognized (Makiwane & Berry, 2013).

Ntshongwana, Wright, Barnes and Noble (2015) have investigated the concept of lone motherhood, which is also known as single mothering, in South Africa. They emphasised that mothers who care for children without a spouse or partner experience unique difficulties and are more deprived than their counterparts who live with a spouse or partner. Clarke and Hamplova (2013) highlighted that the two primary ways in which women become lone mothers is through (1) giving birth outside of marriage, or (2) experiencing a union dissolution through divorce or widowhood while having at least one dependent child. Lone motherhood in South Africa is notoriously difficult to investigate because of the complexity in the process of union formation in this context. Where marriage is concerned, marriages are often informal and formal marriages are often an elongated process due, in some cultures, to the incremental transfer of bride wealth. Demographic studies have often gathered limited

data about lone motherhood because the question of 'marital status' is complex. South African literature has thus tended to focus more on female-headed households. While this concept is broader and easier to measure, it does not necessarily provide information about lone motherhood because many female-headed households consist of married women with migrant husbands. The result of this is that there are no systematic estimates of the rates of lone motherhood in South Africa. However relevant indicators suggest that lone motherhood is widespread and common in most sub-Saharan African countries (Clarke & Hamplova, 2013).

Challenges of Motherhood

Domestic violence and unwanted pregnancies.

The rate of intimate domestic violence in South Africa is among the highest in the world (Tsai, Tomlinson, Comulada & Rotheram-Borus, 2014). According to Stellenberg and Abrahams (2015), partner abuse is found in nearly one in three women in rural South Africa. The South African Domestic Violence Act of 1998 defines domestic violence as any act, such as sexual abuse, physical abuse, assault, emotional abuse, verbal abuse, damage to property, stalking, economic abuse, or threats which endanger an individual's health, safety or wellbeing, and are acted out by someone with whom an individual currently or previously engaged in a domestic relationship (Vetten, 2000).

In abusive relationships, women struggle to escape as they are often dependent on their partners either financially and/or emotionally (Kathree, et. al. 2014). The patriarchal social system in South Africa still protects men even when they display lack of commitment and little interest in fulfilling financial and parental obligations and/or fidelity in their relationships (Kathree, et. al. 2014). Lapierre (2010), found, in a study conducted in

England, that women who were exposed to domestic violence strove to be good mothers who put their children first. Their unwillingness or inability to leave their abusive contexts did not impair their endeavour to protect and care for their children (Lapierre, 2010). A South African study by Rodrigues (2014) found the mothers who remained in abusive relationships felt guilty about their situations. They felt that they needed to leave their partners for the sake of their children.

Women in abusive relationships more often have unplanned pregnancies due to rape or coersion (Slavic & Gostecnik, 2015). Having an unwanted pregnancy, especially from a traumatic experience (domestic violence or sexual assault) can significantly impact a woman's experience of being a mother. There appears to be limited South African research on the experiences of motherhood after rape. Slavic and Gostecnik (2015) conducted a study on the experience of pregnancy, childbirth and motherhood in women with a history of sexual abuse in Slovenia. They found that mothers experienced flashbacks of sexual abuse during pregnancy and childbirth, and their mothering practices were affected by unconscious sequelae of their childhood trauma. For example, breastfeeding was experienced as "dirty" as their breasts were "dirtied" by the perpetrators during abuse in the past (Slavic & Gostecnik, 2015, p. 131). Mothers seemed to express negative attitudes toward their children if a history of sexual abuse was present.

Adolescent motherhood.

Another significant factor that affects motherhood is age. South Africa has experienced an increase in the rate of adolescent motherhood. According to Riva Crugnola et al. (2014) the number of adolescent mothers is increasing so much that early motherhood in adolescence is currently a major health challenge in most countries. A World Health

Organization report indicated that each year 16 million adolescents become mothers (Bhandari & Joshi, 2017). According to the South African Demographic and Health Survey (2016), the rate of adolescent motherhood in South Africa is 71 births per 1000 women aged 15 – 19. Children born to adolescent mothers are at increased risk of sickness and death (South African Demographic and Health Survey, 2016). Adolescent mothers themselves experience increased risk of negative health outcomes during pregnancy as well as negative long term physical, emotional and socioeconomic outcomes (Mangeli, Rayyani, Cheraghi & Tirgari (2018). Mangeli et al. (2018) found in their study on Iranian adolescent motherhood that the participants experienced the heavy burden of adulthood on their small shoulders. They experienced numerous practical difficulties, threats to their physical and mental health, threats to their children's health and they missed opportunities to develop themselves socially and occupationally. They stressed the importance of high-quality prenatal, perinatal and postnatal care services for adolescent mothers to support them and their children.

Apart from the above mentioned factors that influence motherhood, it is necessary for the purpose of this study to highlight that motherhood is experienced differently through the various phases of a child's life. Motherhood in the first year of life is qualitatively different to motherhood at any other time. This point will be discussed in the next section.

Mothering an Infant

An infant has very basic needs at the beginning of life, that is, to feed, to sleep, to be clean and comfortable and to feel secure. It is a mother's responsibility to constantly and consistently ensure that these needs are met. Very often, everything in a mother's life comes to a standstill to make time and space, and free up energy for an infant. Mothers often describe this time in their lives as overwhelming (Wardrop & Popadiuk, 2013).

In the first few months the relationship between a mother and her infant is centred on the feeding experience (Freud, 1905). A healthy breastfeeding experience strengthens an infant's developing psyche (Perkel, 2007). Unfortunately many mothers encounter challenges with feeding, for example, latching difficulties, problems with milk supply, breast physiology challenges etc. (Perkel, 2007). For both the mother and the child, the feeding experience can be pleasant or severely traumatic, depending on how it unfolds. Perkel (2007) described that breastfeeding can be likened to a dance between a mother and her infant. Sometimes the rhythm will flow, and other times there will be stepping on toes and outbursts by both (Perkel, 2007).

Another challenge during infancy is an infant's need for sleep most of the day. The trouble for mothers is that infants sleep in short spells. When an infant is awake, a mother is required to be completely engaged in feeding, cleaning, comforting and interacting with her infant. While the infant is sleeping, a mother often tries to use the time to complete other chores or tasks, or care for the needs of older children and her family (Perkel, 2007).

Infants communicate through crying. Mothers usually learn to recognise their infant's crying and the variations in crying which signals specific needs (Soltis, 2004). A mother is required to attend to her infant's need as soon as possible. Often an infant simply needs to be soothed and a mother must have the emotional capacity and physical strength to do so each time. It is essential for an infant to be in close proximity to its mother (Bowlby, 1969). This is a biological and psychological function and ensures the survival of the infant. Attachment is a critical building block of the human psyche. Mothers and infants instinctively attach to one another (Bowlby, 1969). Sometimes, however, there is an interruption in this attachment process, often caused by mental or physical health issues in the mother. The process of attachment will be unpacked in the next chapter and maternal mental health will be discussed

in more detail in the next section. Ultimately, the challenge is for a mother to maintain her capacity to sufficiently care for her infant because its survival and well-being depends on it.

These constant demands on a mother make motherhood strenuous in the first year life. This is physically, mentally and emotionally draining. The burden on a mother is exacerbated significantly if she experiences any additional challenges such as a sickly infant, relationship difficulties and/or domestic violence, financial concerns, lack of support, and especially if a mother herself develops a sickness or disorder (Lewis, 2002).

Mother-Infant attachment.

Mother-infant attachment is a catalyst for good infant mental health and promotes mental health throughout the course of development. Attachment theory was originally developed by John Bowlby and expanded on by Mary Ainsworth (Ainsworth & Bowlby, 1991). Bowlby's attachment theory is authoritative in psychology. According to Bretherton (1992) Bowlby's theory revolutionised the world's perspective on an infant's attachment to its mother and the disruption thereof through separation, deprivation and bereavement. Ainsworth's innovative methodology made it possible to test Bowlby's ideas empirically and expand the theory (Bretherton, 1992).

Bowlby (1988) postulated that infants were born with a repertoire of behaviours that were designed to ensure proximity to supportive others, for example, mothers. Being in close proximity to a mother ensures protection from physical and psychological threats, and the provision of basic needs. Although this adaptive behavioural system (attachment behavioural system) is very important in infancy, it does continue to be active throughout life (Bowlby, 1988). Bowlby (1988) stated that the activation of attachment behaviour is universal and should be considered the norm in relationships. He developed this idea by explaining that as

much as attachment seeking behaviour is, to some degree, pre-programmed within the infant, so too, parenting behaviour is evident in the mother, for example, a mother's urge to cradle an infant (Bowlby, 1988). The mother-infant dyad is thus characterised by mutual attachment which is emotionally gratifying to both mother and infant (Bowlby, 1988). Maternal mental health issues are problematic to mother-infant attachment because they interfere with the natural maternal sensitivity that is required to facilitate secure attachment (Diener, Nievar & Wright, 2003). Maternal sensitivity refers to a mother's ability to be emotionally and psychologically sensitive to her infant, that is, to sense its emotions and needs (Arteche et al., 2011; Gil, Droit-Volet, Laval & Teissedre, 2012; Hwa-Froelich, Loveland Cook & Flick, 2008; Tomlinson et al., 2004). Since the current study centres on the experience of mothers, it is helpful to point out that a stressed child negatively impacts the coping of a mother, which in turn negatively impacts the quality of the mother-infant attachment (Diener, Nievar & Wright, 2003). This then becomes a vicious cycle in which maternal mental health issues negatively impact mother-infant attachment, which negatively impacts infant mental health, and in turn this exacerbates maternal distress which further affects maternal mental health.

Maternal mental health.

Maternal mental health generally refers to a mother's mental health in the period commencing within 6 weeks after the delivery of her infant (Jones & Ernestina, 2013). The World Health Organization defines maternal mental health as a state of well-being in which a mother realizes her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her community (Herrman, Saxena & Moodie, 2006). Naturally, when these areas of functioning are impaired, a mother

will experience distress which may lead to disorder. The range of disorders that afflict new mothers fall into different categories and these disorders are expressed differently in literature. Andrews-Fike (1999) highlighted three categories of maternal mental health disorders:

- Postnatal blues: 60% – 80 % of women experience postnatal blues, starting 3 to 4 days after delivery and ending 2 weeks later (Manjunath, Venkatesh & Rajanna. 2011). Manifestations include: crying, insomnia, fatigue, low mood, anxiety and poor concentration. Postnatal blues rarely requires medication and usually subsides with support and education (Manjunath, Venkatesh & Rajanna, 2011).
- Postnatal depression: this is a disorder that is more severe than postnatal blues, manifesting similar symptoms, but indicates more severely depressed mood and irritability. Ten to 15% of women worldwide are affected by this disorder (Sawyer, Ayers & Smith, 2010). Brockington (2004) suggested that postnatal depression can also be considered an umbrella term that encompasses several disorders during the postnatal period.
- Postnatal psychosis: this is a rare disorder (0.89 – 2.6 cases per 1000 deliveries) with symptoms of mania, severe depression and psychotic features (VanderKruik et al., 2017).

Of the three categories, postnatal depression has received increasing attention in the last few decades, not only because of its impact on maternal health but also because of its tremendous negative effect on attachment and consequently, the impact on infant mental health and child development. Postnatal blues is mild and transitory and postnatal psychosis is acute and uncommon; whereas, postnatal depression is highly prevalent, often enduring,

and as previously mentioned, has tremendous long term effects for the mother and child (Russell, Lang, Clinton, Adams & Lamb, 2013). Globally, in women of childbearing age, depression accounts for the highest burden of mental health (Prince et al., 2007; Vos et al., 2012). Suicide and infanticide is linked to severe cases of postnatal depression and psychosis (Almond, 2009; Clarke, Skouteris & Wertheim, 2009).

In South Africa, a statistic for postnatal depression was established by Cooper et al. (1999) where the prevalence rate in a peri-urban settlement in Cape Town, was found to be 34.7%. A more recent statistic was established by Stellenberg and Abrahams (2015), where the prevalence of postnatal depression in women living in rural Witzenberg was found to be 50.3%. This rate is high compared to other countries, for example, in the USA, postnatal depression rates are between 12% and 13% (United Health Foundation, 2018), in Australia, 15.5% (Eastwood, Jalaludin, Kemp, Phung, & Barnett, 2012), in Pakistan, 28% (Husain et al., 2006) and in India, 45.5% (Johnson et al., 2015).

A statistic for antenatal depression in South Africa was established by Kathree, Selohilwe, Bhana and Petersen (2014), where they found the rate to be 47% in rural Kwa Zulu Natal. Antenatal depression is accepted as one of the leading risk factors for the development of postnatal depression (Kathree, et. al. 2014).

In the Witzenberg study mentioned above, Stellenberg and Abrahams (2015) found that on a Beck Depression Inventory analysis, 28.8% of the mothers had severe depression, 48.8% had moderate depression, and 22.5% had mild depression. Factors that influenced the development of postnatal depression for these mothers were: being unmarried (63.5%), being unemployed (61.3%), and having a pre-existing psychiatric illness (53.8%). Significant associations were also found between postnatal depression and unplanned pregnancies and the quality of partner relationships.

Internationally, risk factors for postnatal depression include: dimensions of poverty such as low levels of education, poor housing and low income (Patel & Kleinman, 2003); food insecurity and hardship (Coast, Leone, Hirose & Jones, 2012); unplanned or unwanted pregnancies (Fisher et al., 2012); inadequate support, history of depression, low self-esteem and poor relationships with partners (Fischer et al., 2012; Stewart et al., 2003). Many South African mothers are parenting in adverse conditions with the additional burden of high levels of medical illness, illiteracy and violence and crime. Some studies have found that in South Africa up to 40% of children are exposed to community violence (Lockhat & Van Niekerk, 2000). Tomlinson et al. (2005) have raised concerns about the type of parenting that is possible under pervasive adversity and the impact on the development of children growing up in these conditions.

Beck's (1979) cognitive theory of depression and mental illness holds that problems results when individuals develop erroneous ideas about themselves and the world. If an individual, in dealing with a situation, perceives the event in a distorted way, that perception becomes recorded and it is used to frame other similar or dissimilar situations (Beck, 1979). The individual then becomes plagued with these distorted and destructive beliefs about themselves. Beck (1979) stated that when such irrational beliefs, assumptions and thoughts are challenged, the individual can develop healthier ways of thinking and viewing situations and find relief. For instance, if a mother thinks: "I must be adept at everything, or else I will be a failure", she will feel depressed when she perceives a failure in her coping or behaviour. If she is assisted to view the situation in a healthier way, she will develop more rational and helpful thoughts, for example: "It is normal to make mistakes and it does not mean I am a failure."

Lewis (2002) investigated the specific situations and psychological triggers involved in mothers developing negative thoughts, assumptions and beliefs that lead to postnatal depression. Some of these triggers include: difficulty in accepting their role as a mother, disappointment in the expectation of motherhood, the loss of a previous life, before motherhood, difficulty in their relationship with their partner, difficulty in their relationship with their mother, feelings of being isolated and alone, a sense of loss of control, trauma, especially unexpected crises during the postnatal period, losses before pregnancy, especially miscarriage or the loss of a child. According to Perkel (2007), the research on postnatal depression does not point to one specific cause of the disorder. There are different contributory factors and each woman's experience is unique.

Wardrop and Popadiuk (2013) pointed out that there is a high co-morbidity between postnatal depression and postnatal anxiety. Postnatal anxiety constitutes the same symptoms as generalized anxiety, that is, restlessness, racing heart, ruminating, sense of dread, worry, panic attacks, fears and phobias, irritability, sleep disturbance (Wardrop & Popadiuk, 2013). There is limited research available on postnatal anxiety. Wardrop and Popadiuk (2013) stated further that in the current literature contradictions are found in the results due to variability in research methods, tools used and perspectives employed. Some studies have shown that there is no difference in prevalence rates of anxiety between mothers and non-childbearing women and other studies have shown marked increased in anxiety during the postnatal period (Wardrop & Popadiuk, 2013). Britton (2005) found that 24.9 % of mothers have moderate anxiety and 1 % of mothers have severe anxiety. This statistic shows that postnatal anxiety is a common problem for many mothers. Kaitz et al. (2010) found that anxious mothers showed exaggerated behaviour during free play and teaching with their infants. They also exhibited typical hyper-arousal behaviour that is characteristic of most anxiety disorders. These

mothers suffer tremendously with physical, emotional and cognitive symptoms that impair their quality of life (Wardrop & Popadiuk, 2013).

Mothers with postnatal anxiety worry about every aspect of mothering an infant. In the study conducted by Wardrop and Popadiuk (2013), mothers worried about their babies having high demand needs (e.g. colic or having some or other medical issues) and especially whether they would be able to tolerate it. Self-efficacy often becomes an issue for mothers who battle with anxiety. Baron, Berg and Czajkowski (2011) stated that self-efficacy refers to the speculation and judgment of whether an individual is capable of completing an action. It is seen as the self-belief in the competence of the individual in their own actions and motivations (Baron et al., 2011). Mothers often worry about their ability to cope with the demands of the infants and the expectations of motherhood. Mothers also worried about other issues, for example, their health, their appearance and others' expectations and thoughts of them, especially their own mothers, sisters and friends (Wardrop & Popadiuk, 2013). Mothers with postnatal anxiety described disappointment in the limited support from their partners and expressed feelings of isolation and lack of support (Wardrop & Popadiuk, 2013). These thoughts and feelings are similar to the feelings expressed by mothers with postnatal depression and reflect Beck's (1979) suggestions that negative thoughts lead to negative experiences.

According to du Toit (2017), scholars have begun to criticise the existing classification of maternal distress, questioning the significance of diagnostic categories such as postnatal depression. It has been argued that existing psychiatric classifications yield an incomplete picture of maternal distress (Matthey & Ross-Hamid, 2011). du Toit (2017) suggested that this hinders further inquiry into the diversified and multidimensional nature of motherhood, especially in South Africa. Unfortunately, despite this plausible argument,

outside of the clinical diagnostic classifications for maternal mental health issues, there are currently no other available classification structures. The researcher therefore has found it acceptable to use the existing frameworks for classifying maternal mental health conditions.

The above mentioned conditions and their alarming prevalence rates and risk factors suggest that maternal mental health issues are a serious public health concern. Untreated postnatal depression and anxiety is a human rights issue as it compromises social justice for children who receive inferior maternal care, and it compromises the quality of life for women (Wachs, Black, & Engle, 2009). Maternal mental health is a relevant subject for attention in South Africa. The health of mothers determines the health of infants, and infants grow up to be the adults of the future. As Douglass (1855) implored 'it is easier to build healthy children than fix broken men'. Mothers have great influence in the process of building infants and children. The next section unpacks maternal sensitivity, the mechanism through which maternal mental health influences and affects infants and children.

The Impact of Maternal Mental Health on Maternal Sensitivity.

As previously mentioned, a prominent attachment theorist, Mary Ainsworth, theorised that a sensitive and responsive mother is crucial to the development of secure attachments during infancy (Ainsworth, Blehar, Waters & Wall, 1978). Maternal mental health is an important factor of mental ill-health as it interferes with the natural maternal sensitivity that is required to care adequately for infants (Cooper, et al., 1999; Diener, Nievar & Wright, 2003). Depressed mothers have been found to be significantly less sensitive in interactions with their infants than non-depressed mothers (Arteche et al., 2011; Gil, Droit-Volet, Laval & Teissedre, 2012; Hwa-Froelich, Loveland Cook & Flick, 2008; Tomlinson et al., 2004). It has long been established that mothers suffering with depression show flat affect, provide less stimulation

and respond less to their infants than non-depressed mothers (Field, 1984). These mothers also struggle to attune to their infants' emotional state and are not able to sustain social interaction (Cox et al., 1987b). In a study conducted by Murray, Kempton, Woolgar and Hooper (1993) it was found that mothers with depression focused less on their infants' experiences and more on their own issues which often went beyond their immediate context. When depressed mothers were able to focus on their infants, they tended to be more critical and hostile and referred to their infants as intentional agents who were causing their suffering (Murray et al., 1993). Recent studies have confirmed these interactional dynamics during postnatal depression (Gil et al., 2012; Hwa-Froelich et al., 2008).

Kaitz et al. (2010) found that mothers with postnatal anxiety also showed differences in their interactions with their infants. Mothers with postnatal anxiety seemed to have difficulty regulating emotion and thus their responses toward their infants were often exaggerated (Kaitz et al., 2010). Interestingly, mothers with postnatal anxiety did not show impairment in maternal sensitivity toward their infants (Kaitz et al., 2010). When it comes to maternal mental health, it appears that maternal sensitivity is affected by postnatal depression than postnatal anxiety.

An infant's first social construction of their world and their reality of the world is in relation to their mother. It is therefore true to say that their mother is the first influencer of the social world that they will grow and develop in. It is for this reason that a mother's mental health is an important contributor to the manner in which that relationship is experienced and perceived. This emphasises the importance of maternal mental health and ill-health considerations in attachment.

The Implications of Maternal Mental Health and Mother-Infant Attachment Issues

Bowlby (1988) emphasised that the attachment between a mother and an infant is of utmost importance in the first year of life. A secure attachment minimises infant stress and develops a good foundation for future mental health (Bowlby, 1988; Miller & Commons, 2010). Studies have confirmed that maternal mental health challenges negatively affects the attachment between a mother and her infant (Cooper, Murray & Stein, 1993; Leverton, 1991; Martins & Gaffan, 2000).

The link between maternal mental health challenges and mental illness in offspring is well documented. Studies have found that some of the effects manifesting in childhood and adolescence include: language development delays (Stein, Malmberg, Sylva & Barnes, 2008), cognitive delays (Murray & Cooper, 2003), negative academic outcomes (Allen-Mearns, Blazevski, Bybee & Oyserman, 2010), and the occurrence of adolescent anxiety and depression (Spence, Najman, Bor, O'Callaghan & Williams, 2002). Furthermore, longitudinal studies have found that adolescent and adult children of depressed mothers constitute a higher risk for mental and medical problems and are more likely to have lower levels of functioning at home, work and in relationships as compared to adult children of psychologically healthy mothers (Weissman, 1997; Weissman et al., 2006).

Poor cognitive development impedes long-term human capital growth that is essential for socio-economic development particularly in low and middle income countries (Wachs, Black, & Engle, 2009). The result is long-ranging negative developmental, social and economic costs for the country. Due to the deleterious outcomes of maternal mental health challenges on offspring mental health, and the long-ranging effects on society at large; it is important to identify and address maternal mental health concerns as early as possible. Early intervention for maternal mental health is advocated in literature (Alfredsson, Sebastian &

Jeghannathan, 2017; Atif, et al., 2016; Atif et al., 2017; Baron et al., 2016; Bennett, Barlow, Huband, Smailagie, & Roloff, 2013; Denis, Michaux & Callahan, 2012; Dennis, 2005; Nakku et al., 2016; Rathod et al., 2017). As stated previously, postnatal depression is the most prominent mental health concern for mothers in the months after giving birth (Atif et al., 2016; Baron et al., 2016; Prince et al., 2007; Vos et al., 2012). It is emphasised that social support in the postnatal period is linked with lower rates of postnatal depression (Krauss, 2010; McKenzie, Patel & Araya, 2004; Tomlinson, Cooper & Murray, 2005).

Intervention Programmes for Mothers

In scarce-resource contexts, like South Africa, the response to mental health promotion and prevention has often been based on a programmatic response, especially since one-to-one interventions have been rejected as unsustainable in these contexts. A programme can be defined as "any group related, complementary activities that are implemented together in order to achieve specific, pre-determined outcomes" (Bhana & Govender, 2010, p. 61). Programmes are constantly being implemented to intervene in different areas of health and mental health care. It is emphasised that the effects of programmes need to be studied so that their effectiveness and impact on target populations can be evaluated. The evaluation of programmes ensures accountability, makes room for improvement, and allows for comparison with other similar services (Van Marris & King, 2006). It is essential to establish if a programme is being used optimally and if it meets the needs of its participants (Van Marris & King, 2006). The current study presents the Babies in Mind programme as an intervention option to meet the gap for maternal mental health promotion and prevention services at the community level.

Research has identified several barriers and special considerations regarding the general treatment of mental health in the South African context. These points will be described in order to contextualise the need for mother-infant programmes that address maternal mental health and mother-infant attachment.

Special considerations in the South African context.

The treatment gap.

The first major barrier to intervention in South Africa is that most individuals do not have access to quality health care. Most individuals will access health care at local clinics. Unfortunately the gap between the number of people who require treatment at these facilities and those who actually receive it (also known as the treatment gap) is substantial and was estimated to be about 75% in South Africa (WHO, 2011). In 2010 there was approximately one psychiatrist to two million people, one nurse working in mental health care per 164, 000 people and one psychologist per 2.5 million people in Africa (WHO, 2011). Although these are not recent statistics, the picture in South Africa has not changed drastically so these statistics give a sufficient idea of the treatment gap in our country. Therefore several factors underpin the large treatment gap in South Africa, including the critical shortage of specialist mental health workers, and the centralisation of services (WHO, 2010). Geographical inequities, the historical legacy of colonial and apartheid health systems, and shortage of mental health specialists have created the back drop for this crisis (Lund, Kleintjes, Kakuma & Flisher, 2010). In the absence of a properly functioning health system it is difficult to provide programmes on a large scale. In South Africa, most programmes are implemented on a small and local scale (Swartz, 2010), leaving many individuals without access to these interventions.

Idiosycratic factors.

When there are mental health programmes and treatments available at local clinics, very often, individuals do not access them. There are several idiosyncratic factors which contribute to this problem. Researchers have found that issues of stigma and discrimination are significant barriers which prevent people from accessing mental health services when they are available (Atif et al., 2016; Baron et al., 2015; Rahman et al., 2013). Other barriers include practical issues such as work commitments and lack of alternatives for childcare, lack of awareness, negative attitudes, cultural beliefs and language barriers (Seedat et al., 2009). A South African study indicated that the barriers for individuals with depression in low income communities are often attitudinal, rather than structural (Bruwer et al., 2011). The study showed that individuals do not see depression as a mental illness, but rather as a result of adverse life circumstances such as poverty or lack of support. In low and middle income countries there is widespread evidence to show that socio-demographic factors and high exposure to stressful lifestyles, and social support are strong determinants for the development of depression and contribute to high levels of postnatal depression (Fisher, et al. 2012). Baron et al. (2015) highlight the challenge in that the very factors that contribute to the need for treatment are often also the factors that hinder the accessing of it. According to Baron et al. (2015) the more risk factors a participant experiences, the less likely the participant is to access treatment. They also mentioned the possibility that the participants may not have perceived psychosocial intervention to be the appropriate means to deal with their stressors. They suggested that there is a need to improve mental health literacy among women to raise awareness around depression, life stressors and the benefits of psychosocial interventions.

Cultural and contextual issues.

Researchers argue that there is a need for interventions to be culturally and contextually appropriate (Atif et al., 2016; Atif et al., 2017; Kathree et al., 2014; Minde et al., 2006; Nakku et al., 2016; Surjaningrum et al., 2018). Rahman et al. (2013) emphasize that in low and middle income countries where women live in multigenerational households, it is important for members of the extended family to be engaged in the intervention at the household level to reduce reticence and encourage long term behaviour change (Rahman, et al. 2013). Clarke et al. (2013) found that in communities where there are strong gender inequalities, it is difficult for women to negotiate change in their lives and it may be unrealistic for health workers to expect women to be empowered enough to change their circumstances. In these situations, involving the family can mitigate risk factors for depression such as intimate partner coercion and violence, lack of financial autonomy and poor sense of personal agency (Rahman, et al. 2013).

Cost effectiveness.

In a meta-analysis done by Clarke et al. (2013), it was found that group based interventions were beneficial for women in low and middle income countries because it reduced the sense of stigmatisation compared to individual sessions with a health professional. Group interventions are also cost-effective and appropriate in resource constrained settings.

Integration of mental health into local clinics and task sharing have been suggested by the World Health Organization and the South African Department of Health as effective mechanisms to increase access to mental health care in South Africa and other low and middle income countries (Department of Psychiatry and Mental Health, University of Cape

Town, 2007; WHO, 2008). The strategy of task sharing was proposed as an alternative to specialised health care. Its objective is to devolve tasks traditionally provided by specialists to non-specialist health workers to reduce pressure on specialists and enable packages of mental health care to be delivered to larger numbers of people at lower costs (Lund et al., 2014; Fulton et al., 2011; Rathod et al., 2017). It has been highlighted that in high income countries, home visits by nurses are favoured in situations of postnatal depression, however in low and middle income countries with resource constraints, community health workers are more feasible (Kathree et al., 2014). The challenge is to source suitable community health workers and to fund the training, development and supervision of these individuals. Ward and Wessels (2013) argue that there is evidence in high-income countries that investment in parenting programmes reap significant dividends in children's healthy development. This demonstrates that a parenting programme could be a cost-effective use and investment of South African public funds in that it will reap significant benefit.

The above mentioned factors lend a fresh perspective to the context within which practitioners can treat maternal mental health concerns in South Africa. A study done by Kathree et al. (2014) showed that interventions for maternal mental health require a multilevel approach. At the clinic level, routine screening for depression should be conducted at all antenatal and postnatal visits up to a year after birth. In addition to this, referrals for medication and psychological treatment need to be made to promote social support and empower women to manage their symptoms. Baron et al. (2015) also emphasise that understanding the profile of women who are less likely to use mental health services may help adapt the services for optimal use and accessibility.

Examples of South African intervention programmes.

Over the past decade, several effective and promising programmes have been developed in South Africa to address maternal mental health. Cape Town has a well-established parent-infant mental health service within the Red Cross Children's Hospital. At Khayelitsha Clinic, under the auspices of the University of Cape Town, a home visitor's programme has been established. In Johannesburg, the 'Baby Mat' project was introduced at the Alexandra Clinic and mother-infant psychotherapy services are provided at Rahima Moosa Mother and Child Hospital, under the auspices of Ububele (a non-governmental organization) (Bain, 2014). It has been argued that although these programmes are effective; they are resource-intensive, time-consuming and only focused on individual mother-infant dyads (Bain, 2014). There is a need to provide mental health programmes for mother-infant dyads that are cost and time effective and suited to the South African community setting. Below are a few examples of intervention programmes focused on mothers with infants. Although the studies conducted on the programmes are quantitative in nature, the findings indicate the type of intervention hoped for through these programmes.

The Social Baby (adapted) - Khayelitsha.

Cooper et al. (2009) conducted an intervention programme for the improvement of mother-infant attachment in Khayelitsha. The content of the intervention was based on a programme developed by health visitors in Britain, which itself followed closely on the principles of an intervention called 'The Social Baby'.

The intervention was delivered from late pregnancy to six months postpartum. Women were visited in their homes by trained lay community workers who provided support and guidance in parenting, focusing on maternal sensitivity and the establishment of mother-

infant attachment. The quality of mother-infant attachment was measured at six months and 12 months, and infant attachment security at 18 months. A secondary measurement of maternal depression was conducted at six months and twelve months.

The results of the study showed that the intervention was associated with a significant benefit to the mother-infant relationship. At both six months and 12 months, mothers in the intervention group were statistically more sensitive and less intrusive in their interactions with their infants. Higher rates of secure infant attachment was noted at 18 months. The intervention also had a benefit on the mood of mothers at six months, as measured on the Edinburgh depression scale, however no improvement in the prevalence of depression was established. According to Cooper et al. (2009), the magnitude of the improvement in parenting was on the same level as reported in the developing world of interventions that focused on maternal sensitivity. The limited effect of the intervention on postnatal depression is consistent with other research that indicates that interventions focused primarily on the mother-infant relationship do not necessarily bring about improvements in maternal mood (Nylen, Moran, Franklin & O'Hara, 2006).

New Beginnings – Johannesburg.

Another study conducted done by Bain (2014), investigated the effects of the 'New Beginnings' psychotherapy program conducted with high-risk mother-infant dyads at two shelters for the homeless in Johannesburg. The aim of the programme was to improve mother-infant attachment. At pretesting, infants exhibited delays in a number of developmental areas and mothers showed high levels of depression. After the 12 week programme was conducted, significant improvements in infants' speech abilities and in the mothers' abilities to structure their interactions with their infants was noted. Mothers became

more sensitized to their infants and communication between mother and infant improved. According to Bain (2014), the level of improvement correlated with the number of sessions the mothers-infant dyads attended.

Maternal depression and anxiety levels were screened for in order to provide the researcher with a broader sense of the mothers' distress. All participants in the study reported moderate to severe levels of anxiety and depression (Bain, 2014). While the programme was not aimed to alleviate maternal depression, the researcher noted that levels of depression and anxiety appeared to increase slightly, with 72% of mothers reporting slightly higher symptom levels at post-testing (Bain, 2014).

Mother Mentor Programme – Eastern Cape and Western Cape.

The Mother Mentor Programme is run and funded by the Philani Maternal, Child Health and Nutrition Program (a non-governmental organization). The organization has been running maternal, child health and nutrition programmes in informal settlements around Cape Town since 1979 (Philani, 2014). The programmes focus on family health, support of pregnant mothers, prevention of child malnutrition and the rehabilitation of underweight children (Philani, 2014).

The idea of the Mother Mentor Programme is to engage capable women in helping to improve the lives of families in their communities (Philani, 2014). The Philani organization has developed an effective community health worker model adapted from home visiting programmes in the US and Brazil (le Roux et al., 2015). The philosophy is that even in very poor communities, some women develop coping mechanisms that enable them to raise healthy children (Philani, 2014). Women are selected to be mother mentors based on a positive deviant model. The premise of the positive deviant model is to utilise the knowledge

and coping skills of successful mothers in the community to build role models of independence and problem-solving for struggling mothers (le Roux et al., 2015).

Mentor mothers do home visitations to each house in their community, providing guidance and support to mothers and families. In some areas mentor mothers do up to 5000 home visits per month (le Roux et al., 2015). Mentor mothers are trained and supervised throughout their time of working in the community. Specific outcomes are assessed by supervisors (le Roux et al., 2015). A significant focus is on improving health status (birth weights, developmental milestones), healthcare utilisation and health monitoring, HIV-related preventive behaviours (e.g. condom use), mental health (depression) and social support (Rotheram-Borus et al., 2011). The effectiveness of the Mother Mentor Programme was recently investigated in South Africa via a randomised controlled trial. The researchers have found that that mothers and infants in the intervention group had better overall maternal and infant well-being over the first 6 months post-birth compared to mothers and infants in the control group (who received standard primary health care) (le Roux et al., 2013). Maternal depression was assessed using the Edinburgh Postnatal Depression Scale and found to be similar in both conditions (le Roux et al., 2013).

The above-mentioned studies have yielded positive results in specific outcomes, indicating that intervention programmes can be effective in South Africa. Rahman et al. (2013) highlighted several guidelines designed to make policy makers, planners and politicians aware of the need to scale up services for maternal and child mental health. Six guidelines are listed below:

1. Develop ways to integrate screening of mental health into routine primary health care (e.g. clinic visits)
2. Establish effective referral mechanisms in clinics

3. Develop ways for non-specialists (for example, community health workers with minimal training) to facilitate effective interventions
4. Address stigma related to mental illness that could impede the integration of mental health into mother and child health programmes
5. Develop sustainable models to train and increase the number of culturally and ethnically diverse lay and specialist providers to deliver evidence-based services
6. Incorporate a mental health component into international mother and child health aid and development programmes

Identifying a programme that caters to the needs of both mother and infant is an important task in addressing maternal mental health and mother-infant attachment concurrently. An overview of South African interventions has been provided, including findings on their efficacy in treating maternal mental health and/or mother-infant attachment. In this study, the impact of the Babies in Mind programme is being investigated from a qualitative perspective. The Babies in Mind programme offers a unique emphasis on both maternal mental health and mother-infant attachment in one package. The programme is described below as a means to enhance the reader's understanding of the research study undertaken.

The Babies in Mind programme.

The Babies in Mind programme was developed in 2012 by a South African clinical psychologist and trained midwife, Jenny Perkel. Perkel has decades of experience in maternal and infant mental health and has held several positions on professional boards and associations (Perkel, 2016).

Initially Perkel (2007) wrote the book *Babies in Mind* to inform and empower new parents (and/or caregivers) on issues related to infant emotional and psychological health. A significant focus was on early intervention for maternal mental health concerns. A few years after the book was published, Perkel developed and launched the Babies in Mind programme.

Practitioners (psychologists and other health care workers) from around South Africa were invited to obtain a licence to conduct the programme in their cities. The researcher obtained a licence in 2012 and began conducting workshops and private consultations with participants in Port Elizabeth. Perkel's vision for Babies in Mind has been for midwives or CHW to be trained to run the programme, and for the programme to be rolled out at the PHC level.

The Babies in Mind programme consists of 10 workshops covering various topics related to maternal mental health, mother-infant attachment and infant mental health. The following topics are included in the programme: "getting to know your baby", "stressed out mother", "facilitators versus regulators", "sleep problems", "attachment and separation", "high need babies", "the importance of fathers", "when your baby cries", "the feeding dance" and "the importance of trust". The workshops are designed to be informative and interactive and have several objectives, which are:

1. To build participants' confidence and self-esteem as a parent
2. To provide participants with an opportunity to connect with new parents and feel understood
3. To screen the mental health of participants and refer for treatment if mental illness is suspected
4. To provide a better understanding of babies' psychological needs
5. To advocate secure attachment between participants and their infants

The Babies in Mind programme is grounded in psychoanalysis and supported by neuroscience (Perkel, 2007). Psychoanalysis emphasises that if a mother is not emotionally attuned and available to her infant, attachment will be impaired, and the infant's ability to develop and integrate positive mental representations of their mother and of themselves will be impeded (Steele, Steele, & Johansson, 2002). This dynamic may lead to insecure attachment (Arteche, et al., 2011; Martins & Gaffan, 2000). As previously mentioned, attachment difficulties contribute to the emergence of socio-emotional difficulties and psychopathology in infants which continue along the trajectory of development (Allen-Mearns, Blazevski, Bybee & Oyserman, 2010; Murray & Cooper, 2003; Spence, Najman, Bor, O'Callaghan & Williams, 2002; Stein, Malmberg, Sylva & Barnes, 2008; Weissman, 1997; Weissman, Wickramaratne, Nomura, Warner, Pilowsky, & Verdeli, 2006). The Babies in Mind programme intervenes at an early stage to empower new mothers with information and support to improve their mental health. A by-product of achieving maternal mental health is the promotion of secure attachment and respectively, infant mental health and healthy child and adult development (Perkel, 2007).

Summary

In this chapter the concept of motherhood has been discussed with a focus on factors impacting motherhood in the South African context. Descriptions and theories of motherhood have been presented and the link between motherhood, maternal mental health and the significance of attachment has been introduced. The chapter also contextualised the need for interventions in mediating maternal mental health and mother-infant attachment in South Africa.

Petersen, Flisher and Bhana (2010) pointed out that the implementation of programmes in scarce-resource contexts, such as those found in South Africa, must be carefully thought through. There is a moral obligation to seriously consider the implementation of health and mental health programmes in order to improve maternal mental health and mother-infant attachment in South Africa. To this end, this chapter outlined the various types of programmes that are currently on the ground in South Africa. The chapter has provided an introduction to the Babies in Mind programme and its relevance for mothers and infants. The Babies in Mind programme offers a unique emphasis on both maternal mental health and mother-infant attachment in one package. The following chapter will provide a discussion of the methodology used in the study to achieve the predetermined aim and objectives set out in chapter one.

Chapter 4

Research Methodology

"Raising kids is part joy and part guerrilla warfare."

Ed Asner

Introduction

The term 'research methodology' refers to the process in which the research question is answered (de Vos, Strydom, Fouche' & Delport, 2005). Methodology is invariably undergirded by a research paradigm. In order to explore the experiences of mothers through the Babies in Mind programme, a qualitative narrative paradigm was adopted. The narrative paradigm is underpinned by social constructionism which is rooted in postmodernism. This was unpacked in chapter two and provided a theoretical framework for this study.

In this chapter the methodology used in the study will be discussed. The chapter begins with an acknowledgement of the social nature of the research process. From that perspective, the research question, aims and objectives of the study will be reiterated. Narrative inquiry which was employed throughout the process will also be discussed. Further in the chapter, the research process will be described, including a description of the participants, their selection, the manner in which their stories were collected, recorded and analysed. The chapter will conclude with a discussion on the ethical considerations that guided the study.

Acknowledging a Social Self

Neuman (2006) asserted that a starting point in qualitative research is for the researcher to "acknowledge a social self" (p. 14 - 15). For the purpose of this study, it was required that I engage in a fair amount of self-assessment and reflection about my position in society and the communities in which the study was located. As I journeyed along with the study, I reflected a relative degree of bias on my part, as I had grown up and currently live in one of the areas where the study was conducted (Malabar). I grew up in a church community that conducted many religious and social outreaches (soup kitchens, distribution of clothing and religious services) in this area and the surrounding areas of Malabar Extension 6 and Helenvale (where this study was also conducted) in the Port Elizabeth region of the Eastern Cape.

I had always felt compassion toward the people in the communities who were struggling with poverty, unemployment and the many related social ills. Their struggles were in contrast to my own life of comfort and stability. This had often broken my heart and I longed to help in some way.

My love for people, especially those in need, is what inspired my career path in psychology. My father was a religious minister and both my parents were always deeply involved in community work. I grew up watching them help people, practically and spiritually. I endeavoured to do the same in my life. For this reason, once I had completed by studies, I spent my first three years in private practice reaching out to the community in which I lived. Later on I moved my practice into a more central business area, however, my passion for the community continued. I involved myself in community work through other projects and when I conducted this study it so happened that I had an opportunity to work in the communities again.

My reflections through the research process enhanced my awareness of my position as a ‘social self’ embedded within the communities where the study was conducted. This enhanced the trustworthiness of the data, which will be discussed later in this chapter.

The process was guided by three questions proposed by Gillham (2005, p. 9):

- What do I expect to find?
- What would I prefer to find?
- What would I hope not to find?

My personal struggles as a new mother left me wondering how other mothers (especially those without the psychological knowledge that I had) were coping with the journey of mothering an infant. My positive experience of the Babies in Mind programme and my affiliation as a therapist to the community of Babies in Mind practitioners caused me to wonder about the impact of the programme for mothers. With reference to this study, my assumption was that an understanding of mothers’ experiences of the programme would contribute to an understanding of the impact of the programme and would assist practitioners with recommendations for implementation of the programme.

In light of the above, I asked the question ’Do mothers in a South African context perceive the Babies in Mind programme to be beneficial in improving maternal mental health and mother-infant attachment?” Based on this question, I developed a workable aim for the study. The aim was to explore and describe the impact of the Babies in Mind programme on maternal mental health and mother-infant attachment through exploring the perceptions and experiences of mothers who have attended the programme. In order to design suitable methodology for the study, the research aim was broken down into specific objectives. The objectives were as follows:

1. *Explore and describe mothers' experiences of participation in the Babies in Mind programme.* This objective enabled me to arrive at constructs/conceptualisations about mothers' experiences of the Babies in Mind programme. The Babies in Mind programme was seen as a tool to externalise the journey of mothering an infant and a way to engage with mothers about their experiences through discussing the impact of the programme in their lives.
2. E*xplore and describe the perceived benefit of the Babies in Mind programme in improving maternal mental health and mother-infant attachment.* This objective allowed me to understand the impact of the Babies in Mind programme on the mothers' mental health and their attachment to their babies. This information assists to decide whether the Babies in Mind programme is a helpful intervention for mothers of infants.
3. *Explore and describe the barriers and facilitators in implementing a programme with mothers in a South African community context.* This objective assisted me to comment on the journey of facilitating the Babies in Mind programme at the community level and to discuss the factors that either facilitated or hindered successful implementation. The information obtained from this objective was used to develop guidelines for practitioners who implement mother-infant programmes at the community level.

These above-mentioned objectives and reflections facilitated the selection and implementation of suitable research methodology that made it possible for me to conduct the Babies in Mind programme with mothers of infants and to allow me to follow the relevant steps of a qualitative research process.

Significance of the Research

As mentioned above, the current study aimed to provide information on the effect of the Babies in Mind programme on maternal mental health and mother-infant attachment. Attention was given to the stories of mothers at the community level regarding their experiences of participation in the programme. It was hoped that the findings would provide practitioners with insights on how mothers perceived motherhood and also how these perceptions might be reconstructed through the implementation of a programme. It was also hoped that the study would be able to provide information on relevance of the Babies in Mind programme for mothers of infants at the community level. Furthermore, it was intended that the study would provide practitioners with guidance on how to access mothers of infants in communities and how best to conduct mother-infant programmes with this particular population.

Research Design

Research design is understood to be the plan, structure and strategy of a research study (De Vaus, 2001). Akhtar (2016) described it as the 'glue' that holds the elements of a research study together. The current study adopted the lens of a narrative paradigm which is informed by postmodernism and social constructionist assumptions. In order to answer the research question, the researcher had to employ an appropriate research approach with relevant research methods. The two main research approaches in social science research are qualitative research and quantitative research. In deciding on an appropriate research approach, the researcher had to make two major considerations before beginning the study:

1. What are the ontological issues in the study, in other words, what can be regarded as reality in the social world? Is reality something external to individuals or is it something that individuals are in the process of creating (Willig, 2013)?
2. What are the epistemological issues, that is, what can be regarded as appropriate knowledge about the social world? Positivism holds that the social world can only be known through the senses and it needs to be objectively assessed in a value free context (Bryman, 2016). Interpretivism is alternative to positivism in that it acknowledges the differences between individuals and objects, and this requires researchers to grasp the subjective meaning of social action (Bryman, 2016).

From the beginning of education in the field of human sciences there has been tension between the scholars who attested to objective results, that is, positivism (quantitative researchers) and those who felt that the 'human' sciences needed a more speculative approach because of its complexity, that is, interpretivism (qualitative researchers) (Tesch, 1990). Quantitative methods are seen as standardised, systematic and deductive (de Vos, et al., 2005). These methods reduce phenomena to numerical values to facilitate statistical analysis, while qualitative research aims to provide rich, descriptive accounts of the phenomena under investigation (Smith, 2003). The two research approaches produce significantly different outcomes. In considering this study's aim and objectives, it was evident that a qualitative research approach was most appropriate as the researcher sought to obtain data that would reveal perceptions and experiences of mothers in a particular context.

The chosen research approach informs the philosophical paradigm that orientates a study. According to Guba and Lincoln (1994) a paradigm "represents a worldview that defines for its holder the nature of the world, the individual's place in it, and the range of possible relationships to that world and its parts" (pp. 107 - 108). As previously mentioned,

the current study follows a narrative paradigm which is rooted in social constructionism, which itself is further rooted in postmodernism. The following sections provide a discussion on narrative inquiry which is the methodological approach commonly used in the narrative paradigm.

Narrative Inquiry.

Oliver (1998) aptly pointed out that since individuals give meaning to their experiences through stories, it is appropriate for researchers who study human experiences to use a research methodology that connects with storytelling. Narrative inquiry provides methodology for this purpose. It was therefore an appropriate choice for the current study as it allowed the researcher to engage in a meaning-making process around the stories that mothers' shared of their experiences of participating in the *Babies in Mind* programme.

What is narrative inquiry?

Polkinghorne (2007) stated that narrative inquiry is the study of stories. In other words, it is the study of the ways individuals experience the world (Connelly & Clandinin, 1990). Since researchers work with narratives of stories, it can be seen as a method of inquiry into the narrative. The term 'narrative' therefore names the structured quality of experience to be studied, and it names the patterns of inquiry for its study (Connelly & Clandinin, 1990). To preserve the distinction, Connelly and Clandinin (1990) use the device of calling the phenomenon, 'story', and the inquiry, 'narrative'. They stated that individuals lead storied lives and tell stories of those lives, and narrative researchers describe their lives by collecting and telling stories of them and writing narratives of those experiences (Connelly & Clandinin, 1990). Savin-Baden and van Niekerk (2007) emphasised that the focus of analysis in

narrative inquiry is always the individuals who tell the stories of their lives. To simplify the point, narrative inquiry is ultimately a means of understanding individuals better.

The process of narrative inquiry.

Connelly and Clandinin (1990) refer to a process called 'negotiation of entry' into the field. Since narrative inquiry is a collaborative process between the researcher and the participants, 'negotiation of entry' refers to the process of negotiating shared narrative unity between the two parties (Connelly & Clandinin, 1990). Hogan (1988) pointed out that "empowering relationships happen over time and it takes time for participants to recognise the value that the research relationship holds. Empowering relationships involve feelings of 'connectedness' that are developed in situations of equality, caring and mutual purpose and intention" (p. 12). Hogan (1998) believed that a sense of connectedness and a feeling of equality between participants and the researcher is important in narrative inquiry. Connelly and Clandinin (1990) suggested that in narrative inquiry, it is important that the researcher first listen to the participant's story and that it is the participant who first tells her story. It does not mean that the researcher is silenced in the process, but it means that the participant, who has long been silenced, is given the time and space to tell her story (Connelly & Clandinin, 1990). However, since narrative inquiry is a collaborative process, it involves mutual storytelling and re-storying as the research proceeds, thus the researcher must construct a relationship in which both voices are ultimately heard.

There are various ways of collecting narrative data, including field notes of shared experiences, journal records, interviews, story telling, letter writing, autobiographical and biographical writing and other sources such as newsletter clippings and documents collected along the way (Connelly & Clandinin, 1990). At the completion of a narrative study it is often

not clear when the writing would have began as material would have been collected throughout the process. Connelly and Clandinin (1990) point out that even when the writing up of the narrative is in process, at times is is necessary to engage in further discussion with participants, such that data is collected until the final document is completed.

Leggo (2004) found that narrative research is generally understood as a noun, a product or a construction, but if attention is given to the active quality of 'narrating' as a verb, then the focus shifts to the creating, the constructing and the writing, that is the heart of narrative research. Narrative inquiry thus requires the researcher to be constantly engaged in the active process of writing (Leggo, 2004).

But what then does the researcher write? According to Jardine (1992), the process involves being 'struck' by something, being 'taken' with it." Leggo (2004) wondered though about the 'somethings' that do not strike us. He aptly pointed out that we are usually only 'struck by' things that fit our preconceptions and personality (Leggo, 2004). Narrative inquiry accounts for this in that it does not wish to literally and univocally say what an instance is. It simply wishes to playfully explore what understanding and meanings an instance makes possible (Leggo, 2004). In this way it honours the mystery in meaning.

Story, narrative, scene and plot.

In employing narrative inquiry as a methodology, it is important to distinguish between the terms 'story', 'narrative', 'scene' and 'plot'.

- Story: A story is a sequence of events narrated in a linear, chronological order (Bullough & Pinnegar, 2001). In other words, it is a simple and straightforward telling of events (Leggo, 2004). Connelly and Clandinin (1990) suggested that it is the phenomenon under study, while narrative is the inquiry.

- Narrative: Individuals tell stories of their experiences, while narrative researchers describe the stories (Connelly & Clandinin, 1990). Narratives are therefore descriptions of stories. Narratives do not necessarily have a plot or a storyline but can be seen as interruptions of reflection in a storied life (Savin-Baden & van Niekerk, 2007).
- Scene: A scene is the physical place where experiences occurs. It is the place where individuals are shaped and moulded and live out their stories and where cultural and social contexts play constraining and/or enabling roles in their lives (Connelly & Clandinin, 1990).
- Plot: A plot is a sequence of events that have been arranged in order to evoke a sense of emotional engagement in a story (Bullough & Pinnegar, 2001). Plot consists of the beginning, middle and end of a story (Connelly & Clandinin, 1990). Time is therefore essential to plot. It allows for a story to be tied together into a coherent and compelling whole.

Researcher reflexivity.

Qualitative research involves the researcher as a witness to the process. Narrative inquiry in particular creates a space where the researcher and the participants are seen as co-constructing stories. Polkinghorne (1996) viewed the researcher and participants as co-authors of the participants' narratives. In this sense, narrative inquiry views the personal involvement of the researcher to be significantly more than 'bias' to be accounted for. According to O'Reilly and Kiyimba (2015) researcher reflexivity allows the researcher to make visible their impact on the research process and the impact of the research process on them. Frost (2011) stated that reflexivity can be seen as an interweaving of the participants

and researcher's voices. This multi-layered inquiry is enriching and an informative part of the research process. According to Kramp (2004), it identifies the researcher's own involvement as an essential component of coming to know and be known.

Self-reflexivity requires researchers not only to consider participants' understanding, but also to reflect upon their own experiences and perceptions of the topic under study (Jankowski, Clark & Ivey, 2000). An important aspect of reflexivity involves researchers positioning themselves in terms of their research, for example, in the current study I gave attention to describing my own experiences, values and beliefs regarding the Babies in Mind programme, maternal mental health and mother-infant attachment. My own experiences as a mother have attuned me to the need for support and guidance during the postnatal period. As a psychologist I have worked with mothers and infants, as well as children and adults who have been impacted by maternal mental health and mother-infant attachment issues. I have an interest in the lives of mothers, infants, children and adults. This research is thus a natural progression for me, flowing from personal experience, to private practice, to public research. Through this study I hope to be a voice for mothers and infants who would otherwise not be heard.

The challenges of narrative inquiry.

According to Connelly and Clandinin (1990), seeing and describing stories in the everyday actions of individuals requires a "subtle twist of mind on behalf of the enquirer" (p. 4). They point out that it is in the telling and retellings that entanglements become acute because it is here that temporal and social, cultural horizons are set and reset (Connelly & Clandinin, 1990). Questions become apparent: "how far of a probe into the participants' past and future is far enough? Which community spheres should be probed and to what social

depth should the inquiry proceed?" (Connelly & Clandinin, 1990). Connelly and Clandinin (1990) emphasise that in narrative inquiry the process becomes more complex because researchers become part of the process. The two narratives of the participant and the researcher become, in part, a shared narrative construction and reconstruction through the inquiry. This poses challenges for narrative researchers.

A common challenge that narrative researchers confront is how to compose a story that represents experiences truthfully while at the same time acknowledging that one can never tell the whole story since there are always far more experiences than what one can narrate (Leggo, 2004). Stories are complex and multi-layered, and even then, stories are only fragments of the whole lived experience. Savin-Baden and van Niekerk (2007) point out another challenge of using narrative inquiry which is how to manage a story so that participants are represented and spoken for accurately in the presentation of the data. A further challenge is the way in which the researcher chooses to represent themselves in the data, whether they are present, absent or backstage (Savin-Baden & van Niekerk, 2007).

Researchers must be aware of multiple realities and partial stories, while understanding that a narrative can never fully represent one's lived experience. Leggo (2004) refers to this as "honouring multiplicity" (p. 103) and stated that: "I seek to honour the multiplicity of differences that are manifested in lived experiences, always refusing to hide the ragged edges, the pieces that do not fit, the noise, the disjunctures that are all integral parts of the experiences" (p. 104). This is emphasised by Clandinin and Connelly (2000) who noted that the value of attending equally to stories that are told as well as to those that are untold. Stories are seen as constantly changing, as Leggo's (2004) metaphor illustrated: they will not stand still to have their portrait taken. Any attempt to make them stand still would result in a simplification of the lived experience (Leggo, 2004). Narrative research does not

aim to uncover absolute truths about stories. Rather, the aim is to gather information, and to find meaning in the experiences that are revealed. The narrative researcher engages in an ongoing process of questioning, and representing that questioning in research texts that invite productive readers to continue questioning (Leggo, 2004).

The following sections attend to the methodology that I followed in conducting this study. In contrast to quantitative research, narrative research does not endeavour to select a representative sample. Rather, it aims to select stories to study (Langdridge & Hagger-Johnson, 2009). The following section begins the discussion on how I selected participants and proceeded to implement the Babies in Mind programme and conduct the research study.

Sampling and Participants.

In keeping with the objectives of the study, I needed to select a sampling procedure that would give me access to mothers in the postnatal period, with infants between the ages of 0 and 12 months. With this in mind, non-probability purposive sampling was identified as the most suitable sampling method.

Non-probability sampling is generally used in qualitative research because this type of research does not require the sample to be representative of an entire population (Bryman, 2016; Sarantakos, 2000). The primary objective of this study was to explore and describe mothers' perceptions and experiences of participating in the Babies in Mind programme; therefore, the focus was not on generalising results, but instead on capturing personal accounts and stories.

The purposive technique was used in this study because there were specific criteria that participants needed to meet. According to Henning et al. (2004), purposive sampling allows the researcher to select the most suitable participants at the time that they are most

needed to “wander with” (p. 70) on the research journey. This is in keeping with the essence of narrative inquiry which aims to access individuals’ descriptions of particular experiences even if those descriptions are unique and not generalisable (Crossley, 2000).

Creswell (1994) stated that purposive sampling aims to select participants who would best answer the research question. That being said, the inclusion criteria for this study were: participants had to be mothers of infants between the ages of 0 to 12 months; and participants had to reside in the Nelson Mandela Municipality (NMM) area. Participants’ age, race and socio-economic status were not prescribed.

Participants were invited to attend the Babies in Mind programme and thereafter participate in a focus group. Initially I expected to conduct the programme in English, but later found that the nature of the interactions necessitated that participants be allowed to speak in their mother tongue where necessary. I therefore arranged for translators to be present for the groups speaking isiXhosa and Afrikaans.

One hundred and four participants across nine groups in different communities across Port Elizabeth (Helenvale, Kwazakele, Missionvale, Walmer Township, Malabar and Malabar Extension 6) signed up to attend the Babies in Mind programme. Along the way many participants dropped out. Two groups had to be cancelled due to poor attendance (in some instances non-attendance), and one of the groups could not complete the focus group due to unsuitable conditions at the venue. In the end, six focus groups were conducted with a total number of 28 participants.

The Research Procedure.

A research proposal was drafted and presented to the psychology department at Nelson Mandela University. The proposal was scrutinised by the research committee at the

university (FPGSC). Once ethical approval had been granted by the the university's Research Ethics Committee, I began the participant selection process. The following section describes the research procedure that was followed by. This section also includes a discussion of the barriers and facilitators experienced in conducting the Babies in Mind programme in the field.

Participant selection.

In the effort to obtain participants for the study, I partnered with an organisation in Port Elizabeth called Early Inspiration (www.earlyinspiration.co.za). Early Inspiration is a non-governmental organisation which was founded by Dr Lauren Stretch in 2010 (Nelson Mandela Bay Business Chamber, n.d.). The organisation focuses on empowering parents, care-givers and early development practitioners in the community with skills and knowledge to promote healthy development of their children. Dr Stretch and her team facilitate various training programmes with individuals from under-resourced communities in the area. I made contact with Dr Stretch, who being an avid researcher (Nelson Mandela Bay Business Chamber, n.d.), showed a keen interest in this study. The range of training programmes at Early Inspiration does not include a component that addresses maternal mental health, mother-infant attachment or infant mental health, therefore, Dr Stretch gave me permission to obtain participants from her organisation. She was particularly interested in the research outcomes and the possibility of further collaboration. An agreement document was signed between myself and Dr Stretch (Appendix A).

To facilitate the selection process, I planned to make contact with prospective participants from the Early Inspiration centre at a convenient time and have them recruited for the *Babies in Mind* programme. Unfortunately, when I was ready to begin sample

selection, the situation had changed at Early Inspiration, and there were no longer any suitable participants available for the study. Dr Stretch suggested that I obtain participants from primary health care facilities (clinics) around Port Elizabeth. Dr Stretch and her team were willing to assist me to contact gatekeepers (clinic managers) at the clinics as they had developed relationships with these individuals through their interventions in the communities over the years.

It was necessary for me to adapt the proposed sampling method in order to continue with the study. Several hurdles were experienced along the way and I had to navigate the process carefully. Some of the barriers and facilitators experienced in conducting the Babies in Mind programme will be discussed later in this section. My research supervisors were consulted before major decisions and changes were made to procedures to ensure that the sampling process did not divert from the proposed methodology.

The first unforeseen challenge discovered was that in order to access the local clinics, I needed to obtain permission from the Department of Health's Research Committee. I followed the required process to have this done, and after a few weeks I was provided with a letter of permission from the committee (Appendix B).

Thereafter, the designated assistant at Early Inspiration assisted me to contact the clinic managers at various clinics in Port Elizabeth to advertise the research study. I drafted an introductory email which was sent to as many clinic managers as possible (Appendix C). The study was pitched as a contribution to promotion and prevention of maternal mental health problems. Information about the Babies in Mind programme was provided to the clinic managers. The response from the clinic managers was disappointing as only a few indicated interest and only one committed to the programme.

I found that I had to carry out advertising initiatives to promote the programme to mothers who attended the clinics. As time passed, I discovered that it was necessary to market the programme uniquely in the different communities. It appeared that the advertising tools that worked in some communities did not work in others. For example, flyers (Appendix D) were effective at a few of the clinics, but not at others. At times I needed to personally visit the clinics and publicly address clinic users in order to promote the programme. At other times dropping off a "sign up" form worked and I was able to send text messages to prospective participants who provided mobile phone numbers. Early Inspiration assisted by bulk texting SMS advertisements about the programme to their database of clinic users at several of the clinics.

Of significance is the fact that I advertised the programme in such a way that it targeted mothers of infants. Clinic staff who assisted with advertising also stressed the inclusion criteria in this regard. However, at every clinic where the programme was run, caregivers and grandmothers who cared for infants also arrived and were eager to participate in the programme. I chose to adjust the inclusion criteria of the study to allow for these 'mothers' to participate in the programme. It soon became evident to to me that my initial idea of a 'mother' (biological) was challenged by the reality of motherhood at the community level as most 'mothers' were in fact non-biological caregivers.

The Babies in Mind programme.

The Babies in Mind programme was designed by Jenny Perkel in 2012. There are approximately 50 practitioners (counsellors and psychologists) around South Africa conducting the programme in various settings. The practitioners follow the basic structure of the programme which consists of 10 workshops covering relevant topics for mothers of

infants. The workshops are interactive, discussion-based and focused on the participants' experiences. The practitioners that run the programmes provide open-ended questions and discussion points for each topic, as well as concise and crucial pieces of information to share with the participants each week. Below is a summary of the content discussed in each workshop.

Workshop 1: Getting to know your baby.

This workshop is designed to give the participants and the facilitator an opportunity to get to know each other. Participants are encouraged to describe themselves before and after their infant was born. They are also asked to describe their infant (physical attributes and personality). The open ended questions focus on participants' experiences of parenting their unique infant. Participants are asked to reflect on their expectations before the arrival of their infant as compared to the reality of the experience after their infant's arrival.

The facilitator input for this workshop focuses on epigenetics. The facilitator provides a brief explanation of the "nature versus nurture" debate. She then explains how this concept should impact the decisions parents make around parenting. It is emphasised that if an infant has a genetic predisposition for a certain disorder; the disorder does not have to be potentiated, because the environment plays an equal role in unlocking genes. Participants are encouraged to provide healthy and stable environments for their infants in order to prevent, as much as possible, genetic predispositions for disorders from being activated. The participants learn that they have significant influence in preventing future mental disorder in their infant's life.

Workshop 2: The stressed out mother.

This workshop focuses on the participants' feelings. Participants are given an opportunity to share about the stressors in their lives and their feelings in response to this. The facilitator introduces the concept of postnatal depression and discusses the psychological causes of depression and anxiety in mothers (e.g. unresolved anger, losses, childhood trauma). The facilitator looks out for participants who appear at risk and who might need a referral to a mental health practitioner. The facilitator empathises with participants who are distressed.

The facilitator stresses that social support is one of the most important protective factors for new mothers. The group is encouraged to discuss coping skills that they can implement to manage the stresses associated with being a mother to an infant.

Workshop 3: Facilitators and regulators.

The idea of this workshop is to provide participants with a way of understanding the different types of early parenting styles and to learn which style is healthiest for their infant. The facilitator explains the concepts of facilitators and regulators; emphasising that these extremes are on opposite ends of a continuum. Generally, a "facilitator" is a mother who is guided completely by the needs and whims of her infant (in terms of feeding, sleeping, physical contact etc.), and a regulator is a mother who guides her infant into a strict routine and system based on her own needs. There are advantages and disadvantages of each style, and so participants are encouraged to take the middle ground where they should instil a flexible routine, but be mostly guided by their infant's needs.

The participants are asked to reflect on their own parenting style and that of their partners. They are also made aware that different infants have different needs and so some need more regulation, and others, less.

Workshop 4: Sleep problems.

Participants are asked to reflect on the quality and quantity of their and their infant's sleep at night and during the day. This is then compared to their expectations and hopes about sleep before their infant was born.

The facilitator teaches the participants about the psychological basis for sleep and sleeping problems in infants. When an infant sleeps, he feels separated from his mother. The separation-distress mechanism is activated in the infant's brain. The infant will protest because he experiences the separation as a stressor. It is recommended that infants not sleep alone because of this. If an infant is left to sleep on his own, and his mother does not attend to him, he will eventually stop protesting and fall into despair where he gives up. As a survival strategy, he will become very quiet, in order not to draw the attention of predators to himself. This is a survival strategy and observed in animals and humans. As a principle, when an infant experiences fear, mistrust or anxiety, it will affect an infant's sleep as much as it affects an adult's sleep.

The facilitator explains that there are many schools of thought on the issue of sleep training and that participants are encouraged to find the best method that works for them and their infants, but keeping in mind that infants need close proximity in the early months. Participants are encouraged to share sleep tips with one another, as it is very common and normal for infants to wake frequently at night.

Workshop 5: Attachment and separation.

The focus of this workshop is to emphasise the importance of attachment in the first year of an infant's life. The facilitator describes the separation process from birth to adulthood. At the beginning a mother and an infant are in a kind of cocoon, and gradually over the years, the infant grows to an adult who eventually separates completely.

Participants are asked to share their own stories of separation and how it affected them. The issue of gaining trust in the early years is briefly explored.

The facilitator explains that increasing independence is normal and important as an infant grows, but mothers should not try to foster independence before an infant is ready as this can be detrimental to the infant's sense of trust in the world. A guideline of appropriate stages of separation is discussed.

The facilitator guides the participants to discuss their experiences of attachment with their infant; what helps to foster attachment and what hinders it in their lives.

Workshop 6: High need babies.

The facilitator normalises that all infants experience times of being "high need". This means that they are distressed and require more attention than usual. The facilitator emphasises that infants who are "high need" are not naughty.

Participants are given an opportunity to describe the times that their infants have been distressed and demanding. The facilitator empathises as this is not an easy time to manage an infant. Participants are not judged for struggling during these times. The facilitator mentions that it is difficult not to get angry with a high need infant, and if the infant is distressed for long periods of time, it makes a mother vulnerable to develop postnatal depression and burnout. Support and assistance is imperative at times like these.

The facilitator describes reasons why infants become “high need”, e.g. physiological concerns (colic, allergies, and sickness, etc.); emotional and psychological stressors (conflict in the home, separation or neglect, etc.). The facilitator enquires what ways the participants have found to manage their infants during “high need” periods. Participants are also asked how they take care of themselves when their infants are “high need”. This encourages them to reflect back to workshop 2 (the stressed out mother).

The facilitator explains that stressed out mothers and high need infants feed into each other emotionally. Infants pick up, intuitively, on their mothers’ internal stress and tension. This causes the infant to become distressed and “high need”, which in turn stresses the mother out further and perpetuates the cycle. It is thus crucial for mothers to get help if they are distressed.

Workshop 7: The importance of fathers.

This workshop gives participants and opportunity to explore the role of their infant’s father in their life and the life of their infant. Participants are asked to share how the arrival of their infant has affected their relationship with the infant’s father. Issues such as expectations, disappointments, and willingness to share responsibilities are discussed. Typical parenting disputes are explored and ways to deal with them are discussed. It is emphasised that most mothers and fathers feel neglected by their partners during the infant’s first year because the attachment process is so intense. It is to be expected that this will cause some conflict.

Participants are also invited to share about their experiences with their own fathers. Where relevant, participants are invited to share how their relationship with their father has impacted their relationship with their infant’s father.

Workshop 8: When baby cries.

This workshop gives participants an opportunity to learn about the importance of soothing an infant so that the infant later learns to self-soothe. The concept of internal objects (representations of significant others in an individual's mind) is briefly described and demonstrated through examples. This is linked back to the infant's ability to soothe himself as he grows older.

Participants are asked to describe their own internal objects and reflect on the types of internal objects they are setting up for their infants. The facilitator encourages participants to share amongst each other the soothing techniques have worked for their infants.

Workshop 9: The feeding dance.

Facilitators describe feeding as a dance between a mother and infant; at times it is graceful and beautiful, at other times it is tricky with stumbling and falling. Whether a participant is breastfeeding or bottle-feeding, the psychological and emotional factors are very similar.

Participants are asked to explore what the experience of feeding their infant over the months has been like. Feeding problems and successes are discussed, as well as participant's feelings about this. The facilitator emphasises the concept of a "good enough" mother; that mistakes will happen and it is okay, as long as the mother continues to attempt to meet her infant's needs.

Workshop 10: The importance of trust.

The programme ends with a focus on trust. The facilitator asks the participants to reflect on their own feelings of trust or mistrust in the world. Safety and security in their environment is discussed.

The facilitator emphasises that in the first year of life, the most fundamental psychological task that an infant needs to accomplish is to learn to trust. Trust is the basis of mental health. Participants are asked to describe how they are helping their infants develop trust in the world. Obstacles to the development of trust are discussed and solutions are explored. Participants are affirmed and encouraged to continue building and maintaining trust in their infants.

At the end of the workshops, the participants might not be able to practically describe what they have learnt. This is normalised to the participants and it is emphasised that what is more important is that the information changes the way they think about themselves and their babies; which leads to healthier decision-making around pertinent child care issues.

Throughout the implementation of the Babies in Mind programme with the participants in the different communities, I followed the basic structure of the workshops as designed by Perkel (2012).

Conducting the Babies in Mind programme.

Originally, a pilot study was not proposed or even formally conducted as I did not anticipate the challenges that I experienced (which will be explained further in this chapter). In retrospect, however, it is plausible to consider the first two participant groups as a pilot study because I used those groups to figure out what worked and what did not work in terms of sampling and the conducting of the Babies in Mind programme. The first two groups were

conducted in 2017, and the other groups were conducted in 2018; therefore it can be said that there was a natural boundary of time between the the pilot groups and the research groups. With regard to the implementation of the programme, I conducted the first two groups myself, with the assistance of a translator, and the rest of the groups were conducted by research assistants who I trained, mentored and supported throughout the implementation process.

According to Denzin and Lincoln (1994), conducting a pilot study allows a researcher to focus on particular areas that may have been previously unclear. Looking back, it was certainly necessary for me to consider a pilot study because there were several challenges and unforeseen circumstances that arose which required adaptations to the proposed sampling procedure. Below is a description of the process that was followed in conducting the Babies in Mind programme.

The first clinic to respond to my invitation for participation in the Babies in Mind programme was Helenvale clinic, in Helenvale, Port Elizabeth. The clinic manager and staff were supportive of the intervention and assisted me in obtaining a sample from mothers living in the community who utilised the clinic services. A register of names was drawn up by the staff and they ensured that the mothers would be at the clinic on the agreed upon day to join the programme. Eighteen mothers were invited to participate, but only seven arrived on the day of the first workshop. The clinic manager allowed me to use the tea room as a venue in which to conduct the workshops. An assistant from Early Inspiration accompanied me to support and to provide translation where needed as Helenvale is predominantly a coloured, Afrikaans community.

Tea and snacks were provided which allowed the participants to relax and engage in light conversation. This helped to facilitate an informal atmosphere with the participants. I

explained the purpose of the programme and the details about the research study. The participants had an opportunity to ask questions before completing the forms. Each participant completed a consent form (Appendix E), a biographical questionnaire (Appendix F) and a non-disclosure form (Appendix G). Formal information letters about the programme were given to participants to take home for future reference (Appendix H).

After conducting the administration I moved onto facilitating the content of the first workshop in that first session. During the weeks that followed, no other administration was conducted, until the end in the final workshop (workshop 11) when the focus group was conducted.

A similar sampling process was followed with the second participant group which was also conducted at Helenvale clinic. I distributed advertising flyers to assist the clinic staff in sharing information about the programme in the effort to establish the second group. The second group was recruited in the same way as the first group, that is, by the clinic staff; however, I did notice a slight snow-ball effect from the first group. Snowball sampling occurs when sampled participants propose the research study to other prospective participants (Bryman, 2016).

After running the first two groups, I was able to make a few observations. There was a substantial drop-out rate and groups tended to be small (+/- 5 participants), which was essentially not a problem, considering the type of research study being conducted. The participants responded well to the translator and interacted naturally with her as she was seen to be part of the community.

I decided that it was necessary to employ assistance from individuals who could be trained to conduct the programme. The reason for this was to explore the effectiveness of task-sharing in the implementation of the programme and to make the best use of available

time. Dr Stretch from Early Inspiration offered to allow three of her staff members to be trained in the programme and to assist with data collection. I developed a two-day train-the-trainer workshop and trained the three ladies.

The train-the-trainer workshops included a full day workshop focused on the theory of attachment and early child development and a second full day workshop on information about the research study and step-by-step instructions and guidelines regarding each of the 10 workshops and how to run the programme. I agreed to be available throughout the replications for supervision, guidance and assistance with referrals if needed.

Unfortunately I was later told that the three trained staff members were unable to assist me with the conducting of workshops as they were no longer available for the full 11 weeks. I then had to find other assistants to train and prepare for the replications. Fortunately I was able to find three suitable candidates through referrals by Early Inspiration and my research supervisors. The three candidates were informally interviewed and deemed suitable for training. All three assistants had some experience in facilitating workshops and working with mothers and/or children. I trained the three assistants in the programme and then continued with the research process.

I found it necessary to expand my search for gatekeepers from clinic mangers to include other individuals like managers of community centres, leaders of churches and principals of crèches. I focused on obtaining participants from a similar socioeconomic group to that of the participants of the pilot groups, that is, from the lower income groups.

Along the way I experienced a number of failed attempts at establishing groups at the clinics. It seemed to me that the primary reasons for the failed attempts were due to poor interest levels and/or poor commitment levels. Participants indicated interest in the programme, but did not arrive at the workshops. Where I experienced success in completing

the programme; high drop-out levels and poor commitment was still noted, but in these groups there were a number of participants who showed commitment and attended most of the workshops.

With the following groups I found that it was necessary to start the programme with larger numbers of participants and to reduce the number of weeks that the programme ran for; from 11 weeks to 6 weeks, so as to retain as many participants as possible. I adjusted the material by grouping together topics that were closely related. The meetings were thus slightly longer than those in the pilot study. The adjustment of the material and the reduction in the length of the programme seemed to assist the retaining of participants and four more groups were completed.

In the end my research assistants and I conducted seven rounds of the Babies in Mind programme with seven different groups (including the two pilot groups). Each group of participants attended the full programme. Meetings were held once a week on an agreed upon day, usually Wednesdays. The length of time of the meetings was between an hour and 15 minutes to two hours. The initial meeting took slightly longer because of the information sharing and contracting. The primary data collection method was the focus groups that were conducted at the end of the programme with each group. In the pilot study the focus group was held in the 11th session, but with the other groups, the focus group was done in the 6th session after the last part of the content of the programme was facilitated. This made the 6th session a fairly longer session which was not ideal. One of the groups conducted in 2018 (Missionvale) could not complete the focus group due to unsuitable conditions at the venue. On the day of the focus group, another workshop was being conducted in the hall that was used for the Babies in Mind programme. This was an unforeseen challenge which made it impossible for a clear audio recording to be taken. I attempted to conduct a focus group with

the participants, but it was unpleasant for the participants and their infants and in the end the recording had to be discarded as it was completely distorted.

Through my reflexive process I acknowledged that my experiences of conducting the Babies in Mind programme with the participants has impacted my role as the researcher of this study. I spent a considerable amount of time with the participants, involved deeply in emotionally charged conversations and socially intimate moments. I heard the relaxed conversations between the participants and the stories they shared about the mundane details of their every day lives. I heard about their struggles and their breakthroughs. I laughed with them and cried with them. I got to know them on a personal level. Being present at the workshops meant I was able to see and experience the notion of community work. I was there when a shooting occurred outside one of the venues. Week after week I heard the sirens of the police vehicles, the chatter of a bustling community, the sounds of the paradox of freedom and fear as the community members lived their lives out in crime ridden areas. I saw what their homes looked like as I drove into the communities, I saw got a real feel of their communities as I visit them week after week. I saw the participants wait outside the venues, come through the door, chat and have tea and feed and talk to their babies during the sessions. I spoke to and carried and played with their babies myself. I really bonded with them in ways that most researchers do not have the opportunity to when merely conducting focus groups. It was a real privilege.

Being closely involved with the mothers, however, also posed a challenge for me as the researcher as I had to keep separate the process of implementation of the Babies in Mind programme (the intervention) and the researcher process (sampling, the focus groups and data analysis). This reflexive process is what allowed me to prevent role confusion through the process, and to present the research findings in a trustworthy manner.

Special considerations for community work.

As previously mentioned, I did not initially propose for this study to be conducted in a community setting, instead, the initial plan was to conduct the study with participants obtained from Early Inspiration (an NGO in Port Elizabeth). The participants at Early Inspiration are generally familiar with workshops and programmes and would have been able to converse in English. As mentioned, due to unexpected changes, Early Inspiration was not able to assist in providing participants for the study. Dr Stretch's (the director) advice was for me to access participants from local clinics in Port Elizabeth. I made the decision to take the advice. In retrospect, I did not realise the enormity or the consequences of that change at the time. From the outset I discovered the many challenges of doing community research in the South African context. Gasa (1998) pointed out a few considerations that need to be made when working in a community setting in South Africa.

1. *Familiarise yourself with the community: Gasa (1998) advised that researchers should 'do their homework' in familiarising themselves with the target community by noting relevant issues such as current problems, controversies and successes within the community.* I spent a great deal of time within the communities throughout the research process. I had many discussions with the gatekeepers about pertinent issues in the communities. I also gained knowledge about the areas in which the study was conducted through discussions with Dr Stretch and her staff from Early Inspiration.

2. *Make useful contacts in the community: Having contacts in the community gives the researcher a better idea on how to behave in a community, for example, the manner in which to address leaders, dress code, how to approach men and women, etc.* Through my previous involvements with community work (through church outreaches and NGO projects) I was to an extent familiar with the some of the norms in the communities,

particularly those near my residential area. Dr Stretch and her team provided helpful information about the norms within the communities.

3. *Enquire about the culture of the community: It is important for the researcher to establish if the community is rural or urban and under traditional power or governmental structures. It may be necessary to approach leadership in a community before beginning with a research study.* Invaluable information about the culture within the communities was proved by Dr Stretch and her team. The translators and workshop facilitators also shed light on cultural norms expressed during the workshops.

4. *Establish good relationships: Gasa (1998) advised that researchers should be open minded and listen to the concerns of stakeholders in the community with respects to research being conducted in the field.* Through the research process I focused on establishing trust and a collaborative relationship with the gate keepers, nursing staff at the clinics, and other relevant community members who assisted with the conducing of the study. For example, a simple gesture of purchasing a kettle for the nurses to keep in the tea room at Helenvale, went a long way in establishing rapport between myself and them.

5. *Do not get involved in power dynamics in the community: It is strongly advised that researchers not take sides with conflicting parties in the community.* I endeavoured not to get involved in any political or social issues within the communities and fortunately no issues arose in that regard.

The successful conducting of the Babies in Mind programme and the collection of data in the field was only made possible through the support and assistance of certain individuals within the communities with whom I had built a good working relationship.

Barriers and facilitators experienced in conducting the Babies in Mind programme.

Based on the above considerations, it is worthwhile to add that I observed several barriers and facilitators in the conducting of the Babies in Mind programme in the communities. I have discussed these factors below.

Attendance.

The rate of attendance of the participants was one of the biggest challenges encountered in the study. Of the nine groups that were implemented, two groups had to be cancelled due to lack of attendance. With regard to one of those groups, there were occasions where no participants attended on a day. I attempted to get the group going in the area for six weeks before cancelling the venture all together. With regard to another group only three participants signed up for the group (about ten showed interest when the workshops were advertised). Two of the participants in that group were family members (sisters-in-law). On weeks when the sisters-in-law were not able to attend, only one participant (a grandmother of an infant) attended as she was a preschool teacher at the venue where the workshops were being conducted. In this instance, because the participants indicated a desire to receive the information provided in the programme, after three weeks of the facilitator running the workshops, it was decided (together with the participants) that the rest of the programme should be offered as a half day workshop. This gave the participants an opportunity to receive the information without having to commit to attending the full programme. The researcher did not conduct a focus group with these participants.

Another challenge relating to attendance was participant drop out. There were three occasions where participants dropped out of the programme due to finding employment.

There was an occasion where a participants' partner showed resistance towards her attending the programme, so she dropped out to prevent conflict. And there was an occasion where a mother had to drop out after attending once because her new born baby had gotten very ill. Other than those occasions, it is not possible to be sure of the reasons for drop outs, but the researcher felt that it was due to poor interest and commitment by the participants.

A nurse at one of the clinics where a group had to be cancelled informed the researcher that the residents of that area did not seem to value programmes and interventions. It seemed to be a particular attitude towards intervention in that community. I investigated this by visiting a local community development centre in the area and discussing the problem with one of the auxiliary social workers. She informed me that their organisation also provided parenting workshop and programmes and that attendance was a general problem. It appeared to me that because programmes were being regularly provided in the area, the novelty and value of it had diminished in the eyes of the residents. That particular residential area in Port Elizabeth was notoriously known as a drug and gangsterism hub. I wondered how much those contextual issues impacted the attitude toward intervention and programmes in that community. I reflected that it was unlikely the only reason for the lack of interest because in Helenvale, which is also a drug and gangsterism hub, three groups successfully completed the Babies in Mind programme and participated in focus groups.

Despite the incentivising of attendance, only a few participants attended 100% of the workshops. All participants received a certificate of attendance if they completed the programme (i.e. if they attended more than 60% of the workshops (Appendix). The participants who attended 100% of the workshops received a special gift (e.g. a shopping voucher for a local grocery store). Most of the participants skipped a number of the

workshops in between and most of the time reasons were not provided. When participants did tender an apology for absenteeism, these were among the reasons provided:

- Weather: participants preferred to stay indoors on windy or cold days.
- Baby clinic: at times participants needed to attend the clinic for infant check-ups and vaccinations. Other times, infants were sick and had to receive medication.
- Grant days: participants needed to be present at the grant office to receive grants.
- Other reasons: some of the participants gave vague explanations for absenteeism. Some alluded to having family commitments and others forgot to attend. A few of the participants in the Kwazakele group were caregivers at creches and could not attend all the workshops due to work commitments.

There was an occasion when a bus and taxi strike happening in Nelson Mandela Bay prevented participants from attending a workshop. During a bus and taxi strike it is common for violence to erupt in the areas where public transport is used the most (i.e. the areas where the participants live). Participants feared their safety and the safety of their infants and communicated this to the facilitators. On that occasion it was arranged that the groups (three different groups at the time) should be postponed.

Of the participants who did commit to the programme, many of them made sacrifices to attend the workshops. Some mentioned that they had to make arrangements for child care (of older children); some had to cook and clean before attending the workshops. There was even a participant who was working as a security guard at the time and she made special arrangements to attend the workshops during her lunch breaks. It appeared to me that when a

commitment was made to participate in the programme, participants did whatever it took in order to be able to attend the workshops.

The workshop facilitators.

As previously discussed, I employed the assistance of three assistants who became the workshop facilitators who conducted the Babies in Mind workshops after the pilot study was completed. The use of facilitators gave me time to focus on other aspects of the study. It also allowed for more than one group to be running at a time, which assisted greatly as the Babies in Mind programme is lengthy. Furthermore, it gave me the opportunity to investigate task-sharing which is currently a trend in the field of mental health due to its feasibility and applicability (Alfedsson et al., 2017; Atif et al., 2016; Atif et al., 2017; Clarke et al., 2013; Cooper et al., 2009; Kathree et al., 2014; Rahman et al., 2013; Surjaningrum, et al., 2018). In a study conducted by Rahman et al. (2013), several guidelines were highlighted for the up scaling of services for maternal and child mental health. Two guidelines in particular relate to the use of facilitators in this programme: 1. develop ways for non-specialists with minimal training to facilitate programmes and interventions and 2. develop sustainable models to train and increase the number of culturally and ethnically diverse lay providers to deliver evidence-based services. I intended to be able to make a few observations about the usefulness of community health workers within the context of this study.

There were positive and negative aspects of the use of the facilitators, however, the benefits far out-weighed the negatives. I really appreciated the help from the facilitators as it allowed me to focus on other aspects of the study like dealing with logistical issues, overseeing the groups, conducting the focus groups, data analysis, and writing the writing up of the research document. The facilitators received train-the-training style training to

facilitate the Babies in Mind programme. As previously mentioned, the facilitators were specifically chosen because of their prior experience with working with mothers and/or children. The facilitators were equipped to conduct all the workshops of the programme, however, I attended and assisted with at least a few of workshops. I also supported the facilitators throughout the programme via a social media platform (a WhatsApp group) and one-to-one meetings wherever necessary.

An interesting observation was made regarding culture between the workshop facilitators and the participants. Two of the facilitators facilitated groups with participants of their own culture. It was observed that there was a special bond that developed between these participants because the workshops were conducted in their own language and cultural norms were observed for example, in the Xhosa culture: referring to older women by their titles. The quality of the feedback by the participants with regards to the facilitators was positive and they spoke highly of their level of knowledge and wisdom. Rahman et al. (2013) highlighted the importance of using facilitators who culturally and ethnically relate to participants. The impact of culture was clearly seen in this study.

One of the facilitators was a white female. She conducted two groups, one in Missionvale and one in Malabar Extension 6. The Missionvale group consisted mainly of black participants, and the Malabar Extension 6 group consisted mainly of coloured participants but both sets of participants were bilingual. At the time, the Xhosa-speaking and Afrikaans-speaking facilitators were occupied with other groups of their own culture.

It was noted that there was a difference in the quality of the relationships between the facilitators and the participants when there was a difference in culture (and language). With the white facilitator, the participants treated her as a teacher, a leader, an outsider. With the black and coloured facilitators, the participants treated them as a member of the community,

an insider and with familiarity and intimacy. One of the participants in the Malabar Extension 6 group said of the white facilitator: “what’s that lady’s name?” when she was referring to something she had taught the group. This was after spending six weeks in a workshop setting with her. The researcher wondered if there had been a distancing between the facilitator and the participants because of the difference in culture.

Studies have highlighted the importance of the quality of the relationship between the participants and facilitators in determining the improvement of mental health (Alfredsson et al., 2017; Atif et al., 2017; Atif et al., 2017; Rahman et al., 2013; Surjaningrum et al., 2018). Of particular importance is the ability of the facilitator to understand the participant’s socio-cultural circumstances (Atif et al., 2016; Rahman, et al., 2013). This has clearly been illustrated by the above-mentioned observations.

Another interesting and positive observation was that issue of ‘shared experiences’ between the workshop facilitators and the participants. One of the workshop facilitators had recently given birth and was also mothering an infant. Another facilitator had a child in preschool. I observed that the facilitators who had children, especially the facilitator who had an infant, were able to give personal examples and relate to the participants much better than the facilitator who did not have any children. The facilitator with the baby seemed to benefit personally from facilitating the programme and shared about her own successes in following the guidelines provided in the workshops, e.g. being open to soothing her infant in the ways he needed.

Gatekeepers.

Another factor that had both positive and negative elements in the study was the gatekeepers. A gatekeeper is an individual who has authority to allow a researcher into a

particular setting to conduct research (Terre Blanche, Durrheim & Painter, 2006). Gatekeepers usually have a vested interest either in the issue at stake or in the wellbeing of the potential participants (Terre Blanche, Durrheim & Painter, 2006). The gatekeepers in the current study were mostly clinic mangers, nurses and community leaders. In Missionvale, the gatekeeper was the director of the Missionvale Care Centre which is a community development centre that was used as a venue for the programme. In Walmer Township, the gatekeeper was a principal of a well-known crèche which was used as a venue.

I provided all gatekeepers with the same introductory information, made the same type of initial contact: telephonic and email (whichever was applicable). Some gatekeepers never responded at all and of course then we could not run the programme in those areas. When gatekeepers did respond and groups were set up, there was a qualitatively different experience in setting up and conducting the groups when the gatekeepers were not involved.

The element of gatekeeper involvement includes instances where gatekeepers assist with marketing and recruitment of participants, with assistance with logistical issues, and with general enthusiasm toward the programme. I found that when gatekeepers were involved, the programme ran more smoothly and better attendance rates were observed. When gatekeepers were uninvolved, I struggled with logistical issues and poor attendance.

A few of the gatekeepers were very involved in the marketing, recruitment and implementation process. They had a positive attitude toward the programme and the intervention. They marketed the programmes themselves by mobilising staff to tell community members about the programme. They personally supervised the recruitment process and they provided the researcher with lists of interested individuals. In these cases, I simply had to make contact with the individuals on the list and inform them of the date of the first workshops and send reminders.

These gatekeepers also ensured that the venues were suitably equipped. They also arranged for staff to be aware of the programme and encouraged them to accommodate the researcher and participants during the times that workshops were being conducted. Three gatekeepers (in Helenvale, in Malabar and in Malabar Extension 6) truly stood out as they ensured that the participants received a meal at the end of each workshop. I observed that with these groups, the dropout rates, although still high, were lower than in other areas.

Logistics.

Logistical issues included: finding venues that were suitable for participants and facilitators, finding avenues for marketing in the area and deciding on the best practical methods to facilitate the workshops. With regards to marketing, each area required unique marketing strategies. Funds seemed to have been wasted on flyers and text messages did not work. The method that seemed to have worked the best for marketing was word of mouth and marketing and recruitment by gatekeepers in their communities.

With regards to the practical conducting of the workshops, none of the venues were equipped with sound or computer facilities for screening video clips or slide shows. The facilitators and I conducted the workshops in an informal, conversational manner, which seemed to work well.

Much deliberation went into deciding on suitable venues. Venues varied between tea-rooms in clinics, community centres, a classroom at a crèche and a church hall. Venues had to be close enough for participants to walk to and safe enough for the facilitators to reach. All the venues needed to be equipped with at least a few chairs, a table and electricity to boil water in a kettle for tea and coffee. The rest of the required items were provided by the researcher.

Some of the venues were very noisy, such as the community centre halls. There were frequent interruptions by clinic staff, community members and older children. Some of the venues were too small and cramped and some of the venues were too big and echoed. The focus group that was recorded at Missionvale could not be used because the venue (a community hall) was so busy with another meeting that was being conducted in another part of the hall at the same time that day.

Despite all these challenges, the participants were very accommodating and most of them seemed to not mind at all. It was evident to me that most of the participants were accustomed to noise and crowding, and as disconcerting as that is, it meant that the venues were tolerable to them.

The fact that all the venues were walking distance from the participants' homes was a huge benefit. There were instances where I was able to phone a participant who had the tendency to forget about the workshops (but who was very eager to attend), and she would be able to leave whatever she was doing and simply walk to the venue within a few minutes. Many participants indicated that they would not have been able to attend the workshops if they had had to travel. In fact, there were a few participants who heard about the programme, but who lived far from the venues, and these participants were among the drop outs.

Infant attendance.

A significant facilitative factor was that mothers were able to bring their infants with to the workshops. Most mothers did bring their infants with. A few mothers who wanted to use the workshops as "me-time" arranged for child care. A few mothers brought older children a long at times and this was allowed so that they could attend the workshops. There were occasions where this became quite disruptive (e.g. Missionvale) but that had more to do

with the larger size of the groups and the set up at the hall, i.e. because the hall was so big and there was a much larger group of older children playing around in the venue, it became very noisy. The infants themselves were mostly pleasant and content to just be with their mothers, which is exactly what the *Babies in Mind* programme promotes; attachment.

Refreshments.

The provision of refreshments was essential. I provided funds for the facilitators to purchase tea, coffee, cold drinks, biscuits and sandwiches where possible for the participants. As mentioned, in some instances where the gatekeepers were more involved in the process participants also received meals after the workshops.

The chit chat during refreshment time was an essential part of the bonding process between the participants and with the facilitator. I encouraged the facilitators to eat and drink with the participants.

Gifts.

Each participant who completed the Babies in Mind programme was given a certificate of attendance (Appendix I). The participants were very proud of their certificates and seemed to enjoy the formality of being presented with one. Participants who attended 100% of the workshops received an additional gift (usually a R250 gift voucher for Shoprite/ Checkers).

With the pilot study groups, I was able to provide gifts to all the participants who completed the programme (i.e. shopping vouchers). However, this was not financially sustainable so I resorted to approaching a company for promotional items to give as gifts with

the rest of the groups. These were then provided to participants who completed the programme at Helenvale (group 3), Missionvale and Kwazakele.

As the study progressed I observed the need for weekly incentives due to high dropout rates from the *Babies in Mind* programme. I made a decision to provide participants with nappies (about 5 to 10 nappies wrapped in plastic) for their infants every time they attended a workshop. This was done with the Malabar and Malabar Extension 6 groups (the last two groups). This method of incentivising seemed to help with weekly attendance to the programme.

Interview transcriptions.

The audio recordings were transcribed by myself and a research assistant. Kramp (2004, p. 114) noted that like transcripts, interviews become "texts" that are "rich in thick description". Narrative methodologies often require the researcher to revisit data several times and perhaps even engage in further discussion with participants (Connelly & Clandinin, 1990). With this in mind I kept the research procedure open ended which allowed for flexibility and freedom in constructing the narratives as deemed necessary.

Feedback.

The participants will receive feedback in the form of follow up discussions where the main findings of the study will be shared in conversation. The feedback sessions will also serve as a 'reunion' for the mothers who attended the programme together. They will be advertised via text message (SMS) and conducted at the venues where the workshops were conducted.

Data Collection

The ability to narrate is universal and natural so even the simplest questions are likely to lead to narrative accounts, provided interviewing techniques do not create interference (Riessman, 1993). As mentioned, in the current study, I conducted focus groups to collect data. According to Bryman (2016), a focus group is essentially a group interview focusing on a defined topic. Kramp (2004) noted that an essential part of the narrative inquiry is selecting an interview top that allows the narrator the highest degree of personal freedom and choice to construct their own narrative. Bryman (2016) pointed out that the accent is on the interaction within the group and the joint construction of meaning. The interview is designed to bring to attention what individuals think, feel and do; ultimately one is interested in their subjective realities (Henning et al., 2004). Semi-structured interviews are suitable when one is interested in complexity or process, or when an issue is controversial or personal (de Vos et al., 2005). In this study, the topic was deemed personal because it taps into the experiences of mothers during the crucial time of parenting an infant. The semi-structured interview provides the interviewer with some predetermined questions or key words that can be used as a guide (Tutty, Rothery, & Grinnell, 1996). The questions that I used worked well and allowed the participants to reflect back on their experiences through the programme (Appendix J). Special care was taken to design questions that were suitable to the sample group, i.e. lower income mothers with limited education. Therefore the questions were phrased simply and were broad so as to generate discussion. Whilst I tried to restrict my influence on the participants' perspectives, I provided non-verbal feedback to encourage them to continue sharing and to indicate to them that their accounts were relevant and interesting. Some participants needed prompting and probing as they felt self-conscious and nervous. Some of the participants shared much more than the others, and while this was encouraged, I ensured that the

participants who were quiet were given ample opportunity to share. The following interview techniques were employed to encourage a rich description of the participants' experiences: establishing rapport, attending skills, using probes, reflective responding, empathic listening and summarising skills (Krefting, 1991, p. 220). The interview technique of summarising and paraphrasing enhanced collaboration during the focus groups and ensured that the intended meaning of the participants' stories were captured (Ollerenshaw & Creswell, 2002). The focus group interviews were recorded using an audio recorder. Later in the research process, the content was transcribed, printed and prepared for data analysis.

Data Analysis

According to de Vos et al. (2005), data analysis is the process of bringing order, structure and meaning to the data that has been collected. Clandinin and Connelly (2000) note that researchers cannot simply retell the stories they have collected. Narrative inquiries require researchers to use data to construct meanings. Hunter (2010) emphasised that representing and interpreting another's voice is not a simple task and needs to be done with respect and humility.

Willig (2013) pointed out that thematic analysis is a helpful method for analysing data because it is not tied to a particular theoretical approach, making it flexible and appropriate for most qualitative research studies. The current study adopted Polkinghorne's (1988) goal of narrative analysis which was to 'uncover the common themes or plots in the data'. Polkinghorne (1988) stated that "analysis is carried out using hermeneutic techniques for noting underlying patterns across examples of stories" (p. 177). In the current study this goal was achieved through the identification of themes by using thematic analysis.

Thematic analysis.

According to Braun and Clarke (2006) thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data (p. 6). It assists researchers to organise and describe data, as well as to interpret various aspects of the research topic (Braun & Clarke, 2006). The identification of themes was used to achieve the aims of the current study, particularly with regard to highlighting the voice of the mother.

An advantage of thematic analysis is that it is a flexible and an easily accessible method of analysing data, however, this flexibility often results in a lack of clarity regarding its use and that poses a challenge (Braun & Clarke, 2006). It is advised that researchers adhere to guidelines and aim for rigour in the data analysis process, as opposed adopting and 'anything goes' approach (Braun & Clarke, 2006). That being said, the researcher made concerted effort to use the guidelines for thematic analysis provided by Braun and Clarke (2006).

Braun and Clarke (2006) suggest that researchers make a few important decisions before beginning the data analysis process. One such decision is whether the analysis should aim to describe one aspect or one theme in detail, or whether it should describe the data set as a whole. The current study adopted the latter approach. Braun and Clarke (2006) caution that a description of the entire data set may limit the depth of the analysis. For this reason, I endeavoured to ensure that no aspect of the participant's voice was silenced.

Another decision is whether identified themes should be data-driven (inductive) or based on theory (theoretical) (Braun & Clarke, 2006). The inductive analysis approach attempts to draw themes directly from the data, as opposed to using the lens of theory or aspects of literature to search for themes. The researcher adopted the inductive approach in the current study as it allowed the themes that emerged to remain strongly linked to the data

itself. The use of an independent coder was helpful in the process as she assisted to keep the data coding process focused on the data and correspondingly, on the voice of the participants. The fact that the independent coder was unfamiliar with motherhood and the Babies in Mind programme proved useful.

A third decision to be made was whether themes should be identified on an explicit level or a more implicit or interpretive level (Braun & Clarke, 2006). According to Braun and Clarke (2006), the constructionist paradigm tends to work interpretively. The researcher therefore ascribed to the interpretive approach, although it meant that she needed to carefully balance interpretation with holding onto the voice of the participants. The researcher engaged in ongoing debate and discussion with her research supervisors in order to ensure that the participant's ascribed meanings did not get lost in her subjective interpretations of the data.

As previously mentioned, Braun and Clarke's (2006) six phases of thematic analysis were used to guide the data analysis process in this study. The phases are described below with reference to their applicability in the current study.

Phase 1: Familiarity with the data.

Braun and Clarke (2006) suggest that the first phase requires the researcher to immerse themselves in the data "to the extent that they are familiar with the depth and breadth of the content" (p. 16). This involves 'repeated reading' of the data (Braun & Clarke, 2006). I ensured that I was familiar with the data by reading through the data a few times before starting with coding. I also rechecked the transcripts against the audio recordings to ensure that the transcriptions were accurate before the next phase.

Phase 2: Generating initial codes.

The second phase involves the production of initial codes from the data (Braun & Clarke, 2006). Interesting aspects of the data are identified and the researcher attends to any basic elements of the data that generated some form of meaning with regard to the research question (Braun & Clarke, 2006). Codes are essentially small units of analysis that will eventually merge together to form themes. I initially identified 33 data-driven codes in this phase of the data analysis process.

Phase 3: A search for themes.

Once all the data has been coded, the search for themes begin (Braun & Clarke, 2006). Codes are grouped together to make up different themes. Codes are sorted into possible themes by considering the connections between them. Codes are separated into ones that may form overarching themes and ones that may form sub-themes and ones that may be discarded (Braun & Clarke, 2006). At the end of this phase two irrelevant codes were discarded because they did not assist in answering the research question. In addition, several similar codes were grouped together.

Phase 4: Theme review.

The next part of the process involves the refinement of the potential themes that have been identified. Braun and Clarke (2006) advise reading the data extracts that have been assigned to each theme to ensure that they form a clear pattern and are relevant to the theme. I grouped codes into potential themes. Four broad themes were identified. Braun and Clarke (2006) pointed out that themes are identified differently depending on whether the interpretive or explicit approach is taken. The interpretive approach of the current study

contributed to the nature of the themes that were identified. Narrative inquiry identifies themes by extracting the words and phrases used by the storyteller.

Phase 5: Defining and naming themes.

This phase involves more than simply rewriting the interview data. It is about uncovering the "essence" of what each theme constitutes (Braun & Clarke, p. 22). It requires the researcher to uncover what is of 'interest' or 'what story the theme tells'. At this stage of the data analysis, I gave careful consideration to each theme in order to ensure that I had a clear sense of what each theme entailed.

Phase 6: Producing the report.

Braun and Clarke (2006) advise that the report should present an argument in response to the research question. In order to achieve this, a coherent, non-repetitive write-up that provides sufficient and appropriate data extracts to illustrate each theme should be presented (Braun & Clarke, 2006). I kept the aims of the current study in mind during this phase of the data analysis process. The chapter on the findings illustrates the manner in which I maintained perspective of the purpose of the study as I conducted the analysis and write-up.

Ensuring Trustworthiness

Reliability and validity are more readily associated with quantitative research which has a stringent focus on employing representative samples, developing reliable measures to test research hypotheses and ensuring the replicability of research studies in similar contexts. Qualitative research, in contrast, employs "theoretical sampling of small numbers of people chosen for their special attributes" (Yardley, 2002, p. 218), in order to gather in-depth

understandings of the phenomena of interest. Qualitative researchers acknowledge that there are multiple versions of reality, thus acknowledging subjectivity in research (Ulin, Robinson, Trolley & McNeill, 2002). Gilbert (2002) emphasised that in narrative research, the "focus is on trustworthiness and credibility of the stories" (p. 228). In narrative research the participant tells a story which the researcher influences as she listens. Trustworthiness in a qualitative narrative research study therefore needs to account for the social construction of realities. Yardley (2002) proposed characteristics of a good research study that exhibits trustworthiness.

Sensitivity to context.

Yardley (2002) proposed that the context of a qualitative study encompasses different aspects, which may all be equally important. These include sensitivity to theory, to the data itself, and to the socio-cultural setting. In this study I illustrated sensitivity to the theoretical context by undertaking a detailed overview of the theoretical framework employed in this study. Chapter two highlighted the lenses of postmodernism, social constructionism and the narrative paradigm which was used. Sensitivity to the data was illustrated through my reflexive process throughout the research process to ensure that my own story was acknowledge and my experiences were accounted for in how they impacted the data. In chapter one I provided a narrative account of my own story of motherhood. Sensitivity to the socio-cultural context of the participants was illustrated through employing translators to assist with language barriers and conducting the workshops and the focus groups in the communities where the participants resided.

Commitment and rigour.

Commitment and rigour: My commitment and rigour in this study was demonstrated through the detailed processes followed in gaining entry to the research population and the consistent manner in which the Babies in Mind programme was conducted. Furthermore, my consistency and thoroughness in the data collection process and data analysis process enhanced the dependability of the findings. The data was subjected to thematic analysis. An independent coder was employed, and collaborative meetings with my research supervisors were held to discuss and agree upon the emergent themes. The criteria of commitment and rigour are also evident from the acknowledgement of my voice and biases throughout the research process, from the point of conceptualising the study, asserting my motivation for undertaking the study and distinguishing between my story versus the participants' stories.

Transparency and coherence.

I illustrated transparency throughout the research process as I detailed my my own assumptions and intentions in conducting this study. In regard to transparency around the data, this was demonstrated by my detailed account of the research process and the challenges I faced throughout the process. The findings from the focus groups were corroborated by an independent coder and through discussions with my research supervisors.

Validity of data collected in a narrative inquiry centres around the internal coherence of the story as told by the narrator. The questions asked about the coherence of the data were: how recognisable is the story? How consistent is it in terms of theories of motherhood? How plausible is the story? What is the kind of information the participant uses to tell her story? (Gillham, 2005, p. 7). There was coherence between the research question, the research paradigm and the methodology presented in this chapter and the preceding three chapters.

The literature review in chapter two also served as an important verification strategy of transparency and coherence of the data.

Impact and importance.

Yardley (2000) asserted that the "decisive criterion by which any piece of reproach must be judged is, arguably, its impact and utility" (p. 223). It was proposed that the findings of this study can be used to inform practice in the field of maternal mental health and mother-infant attachment. This study provides information about the usefulness of the Babies in Mind programme as an early intervention for mothers of infants. It also highlights the challenges and facilitative factors in implementing the programme. Practitioners can learn from the challenges and successes I experienced in the field. Researchers can also learn about the challenges of conducing research in the community context in South Africa. Most importantly, the impact and importance of this study is that it gave a voice to a group of individuals who would otherwise have never been heard, and from their stories we learn more about the social construction of motherhood in the community context.

Ethical Considerations

The dictates of the HPCSA guidelines on ethics in research and the Declaration of Helsinki was followed in every aspect of the research study (Health Professions Council of South Africa, 2008; World Medical Association Declaration of Helsinki, 2013). Before the study was undertaken, the proposal underwent a procedure of examination and critique so that any unforeseen problems could be addressed. The proposal was presented to the research committee of the psychology department at the Nelson Mandela University (NMU) where staff and colleagues were given the opportunity to make suggestions and comments. It

was then submitted to the FPGSC and finally, it was sent to the Nelson Mandela University Ethics Committee for approval. Only thereafter did the study commence.

I had to obtain permission to conduct the study at local clinics. The National Health Research committee was consulted in this regard and I had to submit an application. The application was approved and the researcher's study was added to the National Health Research Database. Further permission was sought at each of the PHC facilities, community centres and churches.

The nature of this study called for participants to openly express their perceptions and stories about a personal issue. Because of the relational aspects of narrative inquiry, it was essential that each participant's rights, needs and values were respected. The following issues are raised by de Vos et al. (2005) and were addressed in the study: informed consent; prevention of deception of participants; prevention of violation of privacy, anonymity and confidentiality; competence of the researcher; responsible release of the findings; and debriefing of participants.

Informed consent was required in order for individuals to participate in this study. The research objectives were clearly communicated to the participants verbally and in writing and the participants were required to give written consent to proceed with the study. Participants were required to complete a short biographical questionnaire. Deception of participants was avoided at all costs. Due to the fact that I utilised a tape recorder to record interview data, participants were informed of this from the start.

With regards to privacy and confidentiality; these principles were upheld throughout the research process. The participants were informed of the limits to confidentiality, i.e. necessary discussion between myself and the workshop facilitators, referrals for treatment of

participants identified as clinically depressed and referral for treatment and/or further intervention if mothers or infants were at risk of harm or danger.

In the dissemination of the research results, confidentiality and anonymity is maintained by ensuring that the research data cannot be linked to any particular individual (participant). I have stored all collected data in folders at my practice in a locked filing cabinet.

Competence on the part of the researcher is essential for any study to be successful. I selected a research supervisor and a co-supervisor to maintain oversight of the entire study. I also took special care in selecting competent workshop facilitators and provided constant supervision over their facilitation of the programme.

In the release of the findings, the participants' rights, interests and wishes have been taken into consideration. Narrative inquirers understand that persons lived and told stories are who they are becoming and that these stories sustain them. This understanding shapes the necessity of negotiating research texts that respectfully represent participant's lived and told stories. Also, in analysing the data, an independent coder was employed in order to eliminate researcher bias and make sure the results are accurate and representative of participants' voices. Debriefing will be provided in the form of a group followup meeting where the findings of the study will be shared with the participants.

Summary

This research study has been conducted in a rigorous manner. This chapter has highlighted the research process that was followed in conducting this study. Special consideration was given to the fact that this study was conducted in a community setting.

Barriers and facilitators in conducting the Babies in Mind programme at the community level were noted in this chapter.

The chapter outlined the research methods used to obtain and analyse data. In addition this chapter has also called attention to the ethical considerations that the researcher has been mindful of throughout the process. In the following chapter, the findings of the data will be presented.

Chapter 5

Findings and Discussion

"A baby is an inestimable blessing and bother."

Mark Twain

Introduction

Through engaging together in the Babies in Mind programme, a narrative of the experience of motherhood began to unfold between myself and the participants of the study. This chapter describes these narratives and the meanings I have attempted to make of them, in relation to the literature and theories of motherhood discussed in chapters two and three. The thematic analysis enabled me to derive layers of themes from the data that was collected in the focus groups. Four major themes emerged: "Stories about society", "Stories about the other", "Stories about the self", and "Stories about the baby". Each major theme consisted of sub themes, additional themes and at times further themes, all relating to the stories that the participants told about their experience of the Babies in Mind programme and its impact on their mental health and relationships to their babies. With the aim of the study in mind I was careful to report findings that reflected as closely as possible the words and stories that the participants used.

The Participants

For the purpose of this study a distinction between the participants of the Babies in Mind (BIM) programme and the participants of the focus group needs to be made. There were 96 mothers (including grandmothers and caregivers) who signed up for the Babies in

Mind programme. During the course of the programme many participants dropped out. Eventually, only 34 participants completed the programme and participated in the focus groups. Table 1 presents biographical information about the participants of the Babies in Mind programme. It is not possible to describe the 34 focus group participants individually, however, the table below provides a description of their demographics.

Table 1. Biographical information of the participants.

Participant Group	Total number signed up for BIM programme	Age Range	Number of Dependents	Marital Status	Race	Occupation	Total number of participants in focus group
Helenvale 1	7	16 to 24	1 to 2	7 single	7 coloured	7 unemployed	3
Helenvale 2	6	19 to 38	1 to 5	4 single 1 married 1 unknown	6 coloured	5 unemployed 1 unknown	3
Helenvale 3	3	21 to 27	1 to 2	2 single 1 married	3 coloured	3 unemployed	2
Kwazakele	21	22 to 58	1 to 4	7 single 8 married 1 divorced 5 unknown	21 black	5 unemployed 10 employed 1 student 5 unknown	5
Missionvale	28	15 to 54	1 to 4	20 single 8 married	18 black 10 coloured	28 unemployed	6
Malabar	16	17 to 43	1 to 6	7 single 6 married 1 divorced 2 unknown	16 coloured	9 unemployed 2 housewives 3 employed 2 unknown	8
Malabar Extension 6	15	19 to 32	1 to 3	14 single 1 married	14 coloured 1 black	12 unemployed 1 scholar 2 employed	6
TOTAL	**96**						**34**

As can be seen, the participants were between the ages of 15 and 54 years of age. The extensive age range is due to the fact that no age restrictions were placed on the participants. The selection criteria was that their infants had to be between 0 and 12 months of age.

The participants all resided in poor socio-economic areas in Port Elizabeth. Kwazakele is predominantly a Black township. Helenvale and Malabar Extension 6 are predominantly low-income Coloured areas. Malabar is predominantly a mixed income area, with Indian and Coloured residents. Coloured residents usually fall into the low-income bracket. Missionvale is a mixed Black and Coloured township. The participants who joined the programme were Coloured and Black. They spoke either Afrikaans or Xhosa. All of the participants could converse in basic English.

The participants experienced many social challenges, for example, high poverty rates, high unemployment rates, low education levels, low literacy levels, high crime rates, poor service delivery, a lack of resources and poor housing conditions (Stewart, 2016). Out of the population of 96 participants who signed up for the programme, 69 were unemployed. The participants had limited education and literacy levels.

Most of the participants of the programme were single and had one or two children. The youngest participants were all first time mothers. The married participants generally had more children. There were two divorced participants. A few participants did not indicate certain information on their biographical questionnaires, therefore their information could not be added. High child mortality rates have been found in the areas where the participants reside (Stewart, 2016). This is linked to HIV/AIDS and other communicable diseases, perinatal conditions and nutritional deficiencies (Stewart, 2016).

It was in this socio-economic setting that I met the participants of the study. My impression was that they saw me as an outsider. They might have perceived me as young, educated and professional. Someone from the ‘rich areas’ perhaps? They seemed to be surprised that I was coming into their world, parking my car outside their clinics and community centres, walking in with baskets of food and drinks and smiling at everyone. They

were curious about me, as I was curious about them. It was a good as any place to start a journey together.

Positioning Myself

As described in the first chapter, I have my own story of motherhood and my own experience of the Babies in Mind programme. I was, therefore, not a blank slate in the research process. The very inspiration for me starting this research study was because of my personal experience of motherhood.

Clandinin and Connelly (2000) describe that researchers are part of the landscape of the research process. As a counselling psychologist, I work with mothers and children and at times I have also worked with mother-infant dyads. As a mother, I have my own experiences of motherhood. As a daughter, I have my own experiences of being a child in relation to my own mother. As a female, I experience some bias as a result of feeling more attuned to the experiences of mothers than fathers. My own journey and my own stories are infinitely entwined with the very way I think about the research, the participants, their experience and their stories. From the beginning it was impossible for me to silence my own stories in the process of turning up the volume of the voices of the participants. I have had to be mindful of this throughout the study and I therefore positioned myself as a respectful, curious and not-knowing collaborator (Anderson, 1997). I have made every effort not to make assumptions, but rather to check myself, and critically assess myself throughout the research process. I have tried to remain as close as possible to the words of the participants in presenting the findings in this chapter while I acknowledge that the findings are co-constructions between myself and the participants.

A note to self: Throughout the research process I was aware that I was bringing a discourse about motherhood, infancy and mental health (via the Babies in Mind programme) into a community where discourses around those experiences already existed. I was careful not to assume that the discourse I was bringing was superior to the pre-existing culturally informed discourses of the participants. The Babies in Mind programme is influenced by psychological, biological, and to a degree, medical discourses. New concepts were presented to the participants and a new way of thinking was introduced, for example, “attunement" and “attachment to a baby”. That is simply the nature of implementing a programme in any context. I was acutely aware of the fact that the participants may already have had meaningful and helpful ways of understanding and relating to their babies. By taking on a curious, not-knowing attitude, I could assist the participants draw to on and master some of their own resources. I could acknowledge that the participants had ways of experiencing and expressing their lives that are different, but, just as valid as the ways of experiencing and expressing that I was bringing into their context.

I was also careful not to assume that the participants were struggling prior to my intervention. I asked myself pertinent questions such as: did the participants only realise they were burdened through the unburdening process? If the unburdening process was not encouraged, would they have even felt burdened at all? I attempted to check myself to ensure that I was not providing findings that were underpinned by assumption, but rather findings that authentically represented the views and experiences of the participants.

Findings

From the thematic analysis I arrived at four major themes in the stories that were being told by the participants about the impact of the Babies in Mind programme in their

lives. The themes were: “Stories about society”, “Stories about the other”, “Stories about the self”, and “Stories about the baby”. Each of these themes consist of sub-themes, additional themes and in some instances further themes which detail the experiences around these major themes.

An overarching theme from the study was about the participants and their relationships to their babies in the context of their community. I found that in describing their stories about the other (for example, their partners), the participants were also referring to their relationships with their babies. And in describing their relationships with themselves, they also referred to their relationships with others. The participants told stories of how society (their cultural norms etc.) impacted them as mothers and their relationships with their babies and others. This overarching dynamic necessitated a presentation of the data that would illustrate the complexity in the findings. The below model was developed in order to present the findings (see diagram 1).

The diagram represents the major themes that emerged from the thematic analysis. It depicts the connections that exist in the world of a mother and her infant. A mother cares for her baby within a context which includes “the other” (parents and partners) and “society” (culture and community). Relationships exist between the baby and the mother, the baby and the other, the baby and society. Relationships also exist between the mother and the other, the mother and society, and the other and society. Each of these relationships are mutual and the impact goes both ways. They are dynamic and inter-connected.

Diagram 1: The Relationship Model for Mothers

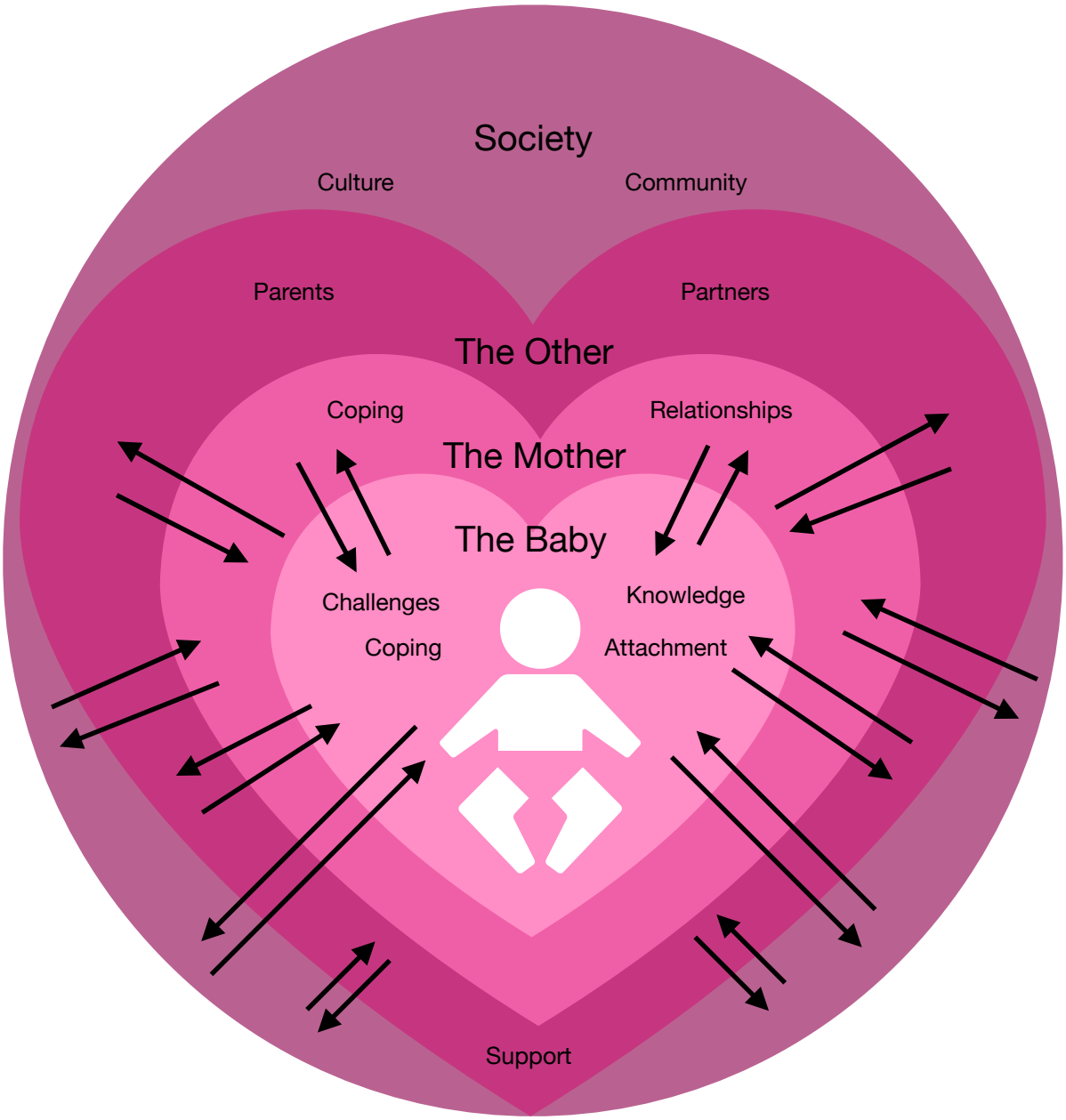

Table 2 below provides a breakdown of the themes and sub themes that will be discussed in relation to the model in diagram 1 and in relation to the aim of this study. The themes are multi-layered and take the reader on a journey from the outermost part of *The Relationship*

Model for Mothers (a mother's relationship to society and others), through to the innermost part of the model (a mother's relationship to her baby).

Table 2. Table of themes.

Major themes	**Sub-themes**	**Additional themes**	**Further themes**
Stories about Society	Culture Community		
Stories about the Other	Partners Parents Support	• Uninvolved fathers • Sharing openly	
Stories about the Self	Coping	• Improved coping with life • Improved self care • Improved mental health • Improved decision making • Improved confidence	- Reduced anxiety - Improved mood - Improved behaviour regulation - Lowered suicide risk
	Relationships	• Improved relationship with others • Improved relationship to self	- Identifying problems - Helping others - Being kinder to self
Stories about the Baby	Challenges Knowledge Coping Attachment	• Naughty baby • Lack of knowledge • Improved understanding of baby's needs • Improved coping with baby • Improved maternal sensitivity	

Stories about Society

The participants shared about the impact of culture and their community on their mothering.

As discussed in chapter three, mother's experiences of motherhood are deeply influenced by their culture. Sudarkasa (2004) explained that the biological aspect of being able to conceive and give birth derives from nature, however, in human societies the rules and expectations of mothers are culturally determined. Practices and experiences of motherhood therefore differ from culture to culture as they are socially constructed.

Table 3. Themes relating to Stories about Society.

Major themes	**Sub-themes**	**Additional themes**	**Further themes**
Stories about Society	Culture Community		

Culture.

Apart from perceiving certain topics of the Babies in Mind programme as thought provoking, some participants also perceived that at times the concepts discussed in the workshops challenged their cultural understandings of parenting. For example, a participant said:

> *"...you know mos, we are black people, ja we don't know everything about babies. When you feed the baby, and put the baby at the back and something at the, at the bed, you think you finish. But we learn more things, like the new name that you don't know; regulator and facilitator mother. What was interested to me, you know, it's a*

new thing what I hear about the regulator and something like that. It was very, I, I, I, benefit so much in this sessions."

The participant, a Xhosa speaking caregiver of an infant, shared that she realised that caring for an infant entails more than just feeding them and then putting them onto her back or onto a bed. She indicated that in her culture there is a lack of conversation and language regarding the specific nuances in the mothering experience. She benefited from obtaining knowledge about the intricacies of a baby's mind and parenting practices that are best suited to the development of a healthy psyche. The participant mentioned that "parenting styles" in particular (regulator and facilitator styles) was seen as a new concept and a beneficial way of restructuring the way she thought about caring for an infant.

Another participant said something similar:

"You know our A Africans, yeah, we are Africans, we, we , we don't know about these things… You only, you know, see your child is growing."

The narrative here indicates that the participant viewed mothering (for black mothers) as simple and task orientated, focused on doing tasks relevant to seeing a child grow.

With regards to parenting practices, one of the mothers noted that there are definite cultural differences in the way babies are raised. For example, she said:

"…you use a cot, your culture, you know you put your child in a cot and we, our culture, we sleep with our child next to us."

As mentioned, the literature indicates that the experience of motherhood is deeply influenced by an individual's culture. Researchers have found differences in parenting practices between different cultures (Barlow & Chapin, 2010; Berg et al., 2018; Graham et al., 2015; Maiello, 2003; Ntarangwi, 2012; Wardrop & Popadiuk, 2013). Parenting practices in rural African contexts have been explored. In these cultures, babies are raised in a communal setting where parenting and daily life involves extended family members and community members. Some practices in these settings are unlimited breastfeeding, back carrying and maintaining constant physical contact (Berg et al., 2018; Graham et al., 2015; Ntarangwi, 2012). According to du Toit (2017), urbanisation and acculturation has led to the diluting of traditional parenting practices in cities and informal settlements in South Africa. The result is that the experience of motherhood is changing and complex. This may be the case, however, according to the above excerpts from the participants, some key traditional practices still remain, e.g. back carrying and maintaining constant physical contact (e.g. sleeping with the baby in the same bed). It was observed during the workshops that most of the participants breastfed their babies on demand, which means that the traditional practice of unlimited breastfeeding has also still survived.

During the focus groups I noted cultural differences in the ways the Xhosa speaking black, mothers and the Afrikaans speaking coloured, mothers spoke about their experiences of motherhood. Black mothers had more of a sense of 'us and them'. They commented directly on cultural differences in mothering practices whereas the coloured participants did not comment at all on cultural differences. My perception was that the black participants seemed to see the programme as entailing new and foreign concepts and practices, whereas the coloured participants seemed to accept the information as normal and 'correct'. In other words, the coloured participants appeared to see themselves as ignorant of 'the way things

should be' and perceived their way as incorrect or lacking, as opposed to culturally different. This theme was not impacted on by the culture of the workshop facilitators as the black participants had a Xhosa speaking black facilitator and the coloured participants had an Afrikaans speaking, coloured facilitator in these instances.

Notwithstanding the different ways in which the participant's related to the new information, what was evident was that their narrative about motherhood began to change with regular exposure to the programme. This then impacted the way in which they reflected on their previously held notions of motherhood, and the way in which they mothered their infants from that point onwards. In other words, a reconstruction (of motherhood) through co-construction (via the programme) had begun.

Community.

During the focus groups the participants had an opportunity to indirectly reflect on their attitudes about their community through answering questions about their experiences of the Babies in Mind programme. The semi-structured questions created an opportunity to externalise their experiences so that I could have a window into their perceptions. For example, participants said:

> *"…for me this group and every group I had, I see it as a safe haven where people look at you, and they only see you and they don't judge you."*

> *"I had a chance to speak to friendly people around my situations that I'm not able to talk about and… somebody like hears and understands what I'm going through and all of that…and actually does care and is positive about it."*

Individuals exist in community. As Dickerson and Zimmerman (1996) stated, social constructionism locates meaning in an understanding of how ideas and attitudes are developed over time within social contexts. It is therefore meaningful to unpack this theme as it is a social construction that impacts on the way the participants view themselves in relation to their communities.

Communities develop cultural norms and attitudes through socially constructing them among themselves (Owen, 1995). This is an unconscious process over time. Norms influence the individuals within the community and impact the way they view themselves in relation to others. Through interpreting the comments that the participants indirectly made about their communities, I arrived at an understanding that some of the participants felt that their community was a critical and judgmental voice in their lives. They did not necessarily expressly indicate this, however, in describing the way they felt about the Babies in Mind programme (that is, that is was a safe and comfortable space), I perceived that their attitude toward their community was not positive. During the workshops, the participants shared many stories of conflict with neighbours and family members. Gossip and slander was a common stressor for the participants in their community. I sensed that they had a defensive attitude toward the outside world.

It is necessary for me to acknowledge that this notion (that the community is a voice of criticism and judgment) is a social-construction between myself and the participants since they shared during the workshops and in the focus groups, and I have interpreted their stories in this way. That being said, it may not be a general feeling among all the participants or even among the general population within the communities in question.

Stories about the Other

The participants shared stories about themselves in relation to those around them. They commented on their relationships with the fathers of their babies, their relationships with their parents and the general issue of social support.

Table 4. Themes relating to Stories about the Other.

Major themes	**Sub-themes**	**Additional themes**	**Further themes**
Stories about the Other	Partners Parents Support	Uninvolved fathers Sharing openly	

One of the participants shared:

"…it's the people and the stuff around me the is affecting me, that's why I did feel so stressed and depressed."

Another participant shared:

"It's a triangle, parent, father, child neh. Uhm, but, oh, I learn something, if I got my brother, I, I trust my brother and take him as the father of my child."

This participant acknowledged the complexities of her relationships with others. She was able to conceptualise the dynamics of raising her baby without her baby's father being

involved. She described a triangular model of parenting between herself, her child and a father figure for her child, whom she felt could suitably be her brother.

Participants reflected on their relationships with their partners (the fathers of their babies). They also reflected on their relationships with their own parents as they raised their babies.

Partners.

Many of the participants are single mothers who are raising their babies without the support of the fathers, practically or financially. For these mothers, discussing the problems they had with the fathers of their babies was challenging but welcome.

One of the participants shared extensively about her conflicting relationship with her partner. He was the father of her baby and she tried to make their relationship work because of that fact. Unfortunately their relationship was not healthy and she was struggling with his general apathy and, at times, his verbal abuse. She shared:

> ***"…****when we argue, I don't keep quiet, I always have my last say, but like, now, he said a lot and I don't answer him back, and he cry. Like it's for him, joh, she used to say something, she don't have the last say, but I keep quiet when he say all that bad stuff to me, I don't answer him back anymore.*

She shared that through her participation in the programme she felt calmer and better equipped to cope with the conflict:

"I have a lot of anger but every time when I go out here I forgot I have that anger…I don't evens feel stressed anymore… it really help me a lot…But I'm still working on that anger of mine…"

As can be seen, the participant was able to reflect on her relationship with her partner and her own reactions to him. She felt empowered to respond differently and to navigate a different experience for herself. Gergen (1985) emphasised that a great deal of human life exists due to social and interpersonal influences. Individuals are social actors in their worlds. They have the power to improvise and to revise their scripts. This participant's narrative illustrates this point.

Uninvolved fathers.

The participants had an opportunity to share deeply about their baby's fathers during the "role of the father" workshop (workshop seven in the programme). In the focus groups participants took the opportunity to share more about their frustration and disappointment with uninvolved fathers. They said:

"…the father isn't really there….he is only spending 15 minutes with her."

"…I want more from his father for him but I can't change it so that was a little bit…I would like something to change…be able to help with more things with him."

"I have to raise this grandchild, how and gonna raise this grandchild when my children was not raised by their father."

Ntshongwana et al. (2015) stated that single mothers experience unique difficulties and are more deprived than their counterparts who live with their spouses or partners. Of particular concern was the amount of time the father spent with their babies, the lack of practical support and the frustration of not being able to change the situation.

The following is an interaction between myself and a participant as she shared during the focus group about an experience where the father of her baby visited after a long absence. She was particularly surprised at her infants' reaction to his father during the encounter:

> Participant x: *"Out of the blue, no one phoned him, nothing, he just showed up, walked around with him and conveniently he was quiet, normally he scream at anyone who doesn't like know him. He was fine the whole time."*
>
> Samantha: *"…What, what about the father, the, the focus on the father workshop was the most helpful for you; can you think about why it was the most helpful for you?"*
>
> Participant x: *"By talking about it; and here you learn the, the, apply it, like what actually is the 'mental' and how it revolves around everything and how it comes about. But just the basic point is just to talk about it…"*

Research indicates that uninvolved fathers and inadequate partner support is directly linked to postnatal depression (Stellenberg & Abrahams, 2015; Fischer et al., 2012). Stellenberg and Abrahams (2015) pointed out that in rural South Africa; one in three women experienced a lack of partner support and/or partner abuse. Rabe and Naidoo (2015) argued

that it is a problem in South Africa on a whole. The experiences of the participants confirms this finding.

Participants who also had absent fathers of their own, for example, participant x, became quite emotional during the workshops when the topic of fathers was discussed. It appeared that they had developed constructions of what fatherhood entailed through their own experiences, and when their children experienced the same, it confirmed their ideas. There was a deep sense of sadness from those participants. On a positive note, the participants found it helpful to talk about their feelings and receive support and encouragement in the workshops.

Parents.

Participants shared about challenges they experienced with their parents. One of the participants shared about daily conflict between her parents, and how she was thrown out of the home each time. She said:

> *"My pa en my ma het elke dag gestry. My pa het my uitgevat elke keer."*
>
> *Translation: "My father and my other fought every day. My father threw me out each time."*

The participant shared often during the workshops about her family context and the strained relationships in her life. Many participants shared during the course of the programme about their family lives, most especially their relationships with their parents. Most of the participants grew up in unstable home environments. It was common for them to

move from family member to family member as their parents could not take care of them, or due to domestic violence or conflict.

One of the participants shared that she had had a close relationship with her father but he passed away recently. She shared that separating from her father was very difficult and she wondered if it would affect her parenting of her son because he was not around to guide her.

Since much of life is socially constructed (Gergen, 1985), it can be understood that the participants' home environments and relationships to their parents have played a role in the way they perceive 'the other' in life. That is, the quality of their relationships to their parents have likely led them to construct particular notions about what relationships should and will entail, be it conflict and abandonment or love and care. These constructions will either be confirmed or refuted based on other relationship that they develop later in their lives, as described in the section above on uninvolved fathers. Through social constructionism it is possible to change the patterns in their lives as they adapt the social scripts which they follow and alter the plots of their stories. Therapy provides a space for individuals to work through issues like this. In the case of this present study, the Babies in Mind programme provided a similar space for participants to reflect on their stories, make decisions and effect change in their relationships if need be.

Support.

A common theme that emerged from the thematic analysis was that of support. The participants felt they needed support and they found the Babies in Mind programme to be supportive. Participants expressed gratitude for the programme as they experienced it as a safe space. The following are examples of participants' comments that illustrate this point:

"…I'm used to every Wednesday…it's like a weight off my shoulders you see…"

"It was very comfortable to come here and to talk and to learn to trust each other because it's not like going to a friend and talking, here it's different, you feel to talk about everything that is inside you and around you."

The participants readily described their appreciation for the safe space provided for them to share their stories and receive support. Sufficient social support is crucial for mothers of infants (Krauss, 2010; McKenzie, Patel & Araya, 2004; Tomlinson, Cooper & Murray, 2005). Research indicates that inadequate support is a risk factor for maternal mental health issues (Fischer et al. 2012; Tomlinson, Cooper & Murray, 2005). One of the main objectives of the Babies in Mind programme is to be supportive and provide mothers with an informal space to connect with other mothers and have an opportunity to be understood. Participants were given sufficient time to share about their stressors, their relationship difficulties and their challenges with their babies. They also had an opportunity to hear from other participants and to relate to others' experiences. This mutual sharing seemed to create a bond between the participants and in each group the participants described feeling a sense of trust and connectedness with each other.

The participants' appreciation for the space provided in the workshops may indicate that they do not have many other spaces like that in their lives. Through the Babies in Mind programme, participants can reconstruct their ideas of support and the quality that supportive relationships may possess.

Sharing openly.

The participants felt that they could open up at the workshops and share about themselves, their infants and their experiences during this unique period of time. Participants said:

"Every week I get an hour away from home, sit with other women, can hear their experience in life and whatever we talk so I don't have to feel like I'm the only one going through stuff…all of us are having our problems at home."

"…it also taught me to open up to the, to the other ladies that's been here there because normally we only keep this things to ourselves not knowing that it's putting us into a depressive mode or making us sick in a way."

"I didn't have anyone to open up to about my problems with the, with the baby, but as I joined this, this, this, group, I've learnt to open up and talk about how I feel and how my baby makes me feel…so that has helped me a lot."

"I did feel very sad because I don't have no one to share with because of trust…you can't trust anybody…but ever since I joined this group, I feel much better."

A mother's experience of mothering an infant is intense and can be overwhelming (Wardrop & Popadiuk, 2013). Bowlby (1969) found that mothers deliberately and instinctively keep their infants close to them in the earliest months. Therefore, most of a mother's activity during the day and/or night revolves around taking care of her baby and

every little nuance in her interaction with them is experienced. Mothers may feel as though they are living in a parallel world, seeing normal life from afar, whilst having to engage in it and at the same time one hundred percent focus on their infants. Mothers are thus often exhausted, vulnerable and alone, it can make infancy an isolating and sensitive period for them (Lewis, 2002). One of the participants said that she looked forward to the workshop days because it gave her an opportunity to share and also hear from other mothers, and thus not feel alone in dealing with motherhood and normal life problems. Another mother expressed that she could talk about her experiences and feelings toward her baby which she could not do in any other space.

In the programme, the participants were deliberately given opportunities to talk and be heard. They reported that they used the space to open up and share about their lives. As mentioned above, support is an essential protective factor for mental health issues (Fischer et al., 2012). One of the mothers actually mentioned that she felt sad because she had no one to talk with, due to lack of trust, but when she shared within the group, she felt much better. Another mother said that opening up helped her realise that she had actually bottled things up and did not notice that it was making her depressed. Participants either felt they had a lot to share but no one to share it with, or that they did not realise that they needed to share in the first place. In expressing their feelings about sharing openly in the workshops, the participants started to develop the idea of the importance of having a safe space to talk. In other words, their narrative about support was being developed through their engagement in the programme.

Stories about the Self

The participants shared stories about how the programme had impacted their sense of self. Their stories gave an indication of how they viewed themselves prior to the programme and after the programme. Through engagement in the programme their narratives of "self" were revised.

Table 5. Themes relating to Stories about the Self.

Major themes	**Sub-themes**	**Additional themes**	**Further themes**
Stories about the Self	Coping	• Improved coping with life • Improved self care	
		• Improved mental health	- Reduced anxiety - Improved mood - Improved behaviour regulation - Lowered suicide risk
		• Improved decision making • Improved confidence	
	Relationships	• Improved relationship with others	- Identifying problems - Helping others
		• Improved relationship to self	- Being kinder to self

Regarding this theme, a participant shared:

"I have a peace of mind now…I was a lot disturbed in my mind, but now I have a peace of mind. Class did help me get a peace of mind for myself and sometimes I , I thought it's the children that make me so stressed, but it's not the children. I have found its things in my life, persons like, like I told you, my mother and my boyfriend and financial things. It's not my children that I have to stress, when I'm stressed then I

hit them and so it's not anymore so, it's better now. It's really a benefit for me coz I have a peace of mind , not stressed anymore. That feeling that I got when I got here the first time, to take my life and that depression, it's not anymore. The load is just a bit lighter and it help also to give advice to other women that is also going through stress in their lives. I can give them advice and… Like I have one friend…I speak to her what…like what I'm dealing with you here in the class and I can, she she's also benefitting from because now she also know how to deals with her children in the house and also how to deal with the abusive husband."

Through sharing and learning in the workshops, the participant realised that her mood and coping was significantly impacted by the stressors in her life. She had previously thought that her children were the problem, but she learnt that the real problems in her life were her relationships with her mother and her boyfriend and financial difficulties. Those stressors impacted her and her relationship with her children. Since participating in the programme, receiving support and deciding on solutions, she was able to cope better. She was empowered to the point where she felt capable of advising and supporting a friend in need.

During the course of the programme, the participants gained insight into their inner world and even seemed to gain a language by which to express their feelings and describe their experiences. For example, one of the participants shared:

"Samantha, I don't really feel depressed anymore and feel like just dying and stressed on my children because I used to stress a lot on them. It's just I'm still struggling with the sleeping part because now the few, past weekend, this week I struggled to sleep at night and when I stand up in the morning I have a headache because I didn't sleep."

As previously mentioned, throughout the programme there was deliberate focus on providing the participants with occasions to express themselves, listen to each other's stories and ask questions. Workshop two of the programme, that is, "the stressed out mother", brought attention to the feelings and experiences of motherhood. The causes of distress and depression were discussed as well as common triggers for anger and the impact of loss and trauma. With time and the space to explore, the participants gained insight into their emotions and behaviours and developed a capacity to reflect inwardly. As seen in the first quotation above, the participant was able to discover that it was not her children that distressed her, but rather other individuals in her life. The same participant shared in the focus group that she had stopped hitting her children when she was frustrated and instead showered them with extra attention when they acted out. She was so excited about her discovery that she was going around sharing about it to other mothers in the community.

The programme not only cultivated within the participants an ability to introspect; it also offered them a tool by which to express themselves, i.e. a language to name their experiences. The second quotation is by a participant who was able to reflect at the end of the programme that she had experienced "postnatal stress". The researcher understood by her use of past tense that she no longer considered herself "*postnatally stressed*". The participants discussed coping skills and the researcher and facilitators provided them with many examples of healthy coping strategies for dealing with stress as well as the every day, regular experiences in the postnatal period.

Coping.

An important theme that emerged was that the programme assisted the participants to cope better. For example, one of the participants said:

"All I can say is I, this classes has been very great to me…learnt a lot, learn me more to be, how to can cope better with my child and evens myself. I had too much on my shoulders. And really Babies in Mind is something, is something great for mummies who have babies…"

"..I can know how to deal with things. Don't bottle it up. Because I have to do it for him…"

Lewis (2002) described that mothers need to cope with various psychological conflicts about themselves and life, over and above the usual demands of caring for an infant. Mothers often deal with difficulties in accepting their role as mother, disappointments in terms of their expectation of motherhood, loss of freedom and elements of their previous life, challenges in their relationships, feelings of loneliness and a sense of loss of control (Lewis, 2002). There is a lot that a mother has to process and cope with in the first year of her baby's life, and even though Lewis (2002) described factors that depressed mothers deal with, it is plausible to argue that most mothers will contend with some of these issues, in varying degrees, at some point during their offspring's infancy and early years. Epstein (2010) pointed out that one of the most important competencies that mothers need to have is the ability to manage stress. The participants described that after attending the programme, they were better able to manage their stress and cope with challenges.

Improved coping with life.

Participants expressed that since participating in the programme, they gained strategies which assisted them in coping better. A few participants said:

"...she said if we don't want to share our feelings we can write on a piece of paper and we can tear it up, throw it away or just go for a walk and come back and I've done that and I, and it help me a lot."

"...sometimes I stress...she teach me like, uh, if I'm stressful then I have to like go, walk away from baby or take, take a break..."

"...when you stress and you feel I can do something to your baby, you must just give your baby to someone and just take a walk or go to your friends and talk about it so that you can feel better."

During workshop two about "the stressed out mother", participants were encouraged to brainstorm strategies to cope with stress. Participants shared what strategies worked for them and the workshop facilitators and I provided them with helpful strategies, such as taking breaks, relaxation techniques and reaching out for support.

Improved self care.

Another major theme that emerged was that participants improved their self care. They resumed grooming activities and were more inclined to take time out for themselves. Participants shared:

"...I've learnt also that, I need to, to, to, to pamper myself because sometimes I would just do everything, I forget to blow my hair out or make me pretty and whatsoever."

"...my highlight was, uhm, getting prepared for myself. I need to, to make time for myself."

Epstein (2010) pointed out that a key competency for good parenting is the ability to promote a balanced lifestyle and good health. Participants who previously did not consider the importance of self care made efforts to improve this area of their lives. They shared that they took better care of their appearance, for example, washing and blow drying their hair, putting on make-up and dressing up. They also more readily took time out for themselves to rest and do enjoyable activities. The importance of self care was stressed with the participants in workshop 2 on "the stressed out mother" and participants learnt the concept (metaphor) and importance of topping up their own energy tanks first so that they could have more energy available to give to their babies and families.

Improved mental health.

Maternal mental health is a major focus in this study. I was interested in establishing whether the Babies in Mind programme had any perceived effect on maternal mental health. The Babies in Mind programme intentionally intervenes at an early stage to empower mothers with information and support to improve their mental health. As already emphasised, one of the reasons for the focus on maternal mental health is because a by-product of achieving maternal mental health is the promotion of secure attachment, and consequently,

good infant mental health and healthy child and adult development. It can be argued that the mental health of society depends on the mental health of a mother during a child's infancy. It was thus of particular interest to me to establish whether the participants of the programme perceived any improvements in their mental health. As the findings indicated, the participants did perceive improvements in various aspects of their mental health. The sub-themes below describe the specific areas of improvement.

Reduced anxiety.

Participants reported experiencing reduced levels of anxiety. Participants said:

"It's really a benefit for me coz I have a peace of mind, not stressed anymore."

"...but it's better now, we are happy, I don't stress anymore on them even if they are naughty, I just tell them not to do it and just relax not get overwhelming inside coz I hit them every time."

According to Wardrop and Popadiuk (2013), postnatal anxiety constitutes the same symptoms as generalised anxiety, i.e. restlessness, racing heart, worry and rumination, a sense of dread, panic attacks, fears and phobias, irritability and sleep disturbances. Some studies showed that there is a marked increase in anxiety during the postnatal period for most mothers (Wardrop & Popadiuk, 2013). The participants of the study referred to anxiety as *stress*. They shared about the various stressors in their lives. These very often included family relationship issues. A few participants described having to endure abusive partner relationships. Kathree et al. (2014) stated that women struggle to leave abusive relationships

because they become dependent on their partners financially or emotionally. This was certainly the case in this study. One of the participants shared that she initially did not have the emotional resolve to leave her boyfriend. During the period of time that she attended the programme, she gained courage to escape the abuse and ended her relationship with him. She shared:

"…me and my partner, we broke up, but I don't feel un, unhappy, ja."

Another participant described experiencing anxiety about the conflict in her home between her parents. She said (in Afrikaans):

"My pa en ma het elke dag gestry. My pa het my uitgevat elke keer."

Translation*:"My father and mother fought every day. My father threw me out every time."*

The participant shared that the situation at home made her very anxious and the constant conflict caused her significant stress with which she did not know how to cope with. It also meant that she did not receive sufficient support from her parents and she had to go to family members in other suburbs to seek emotional support and assistance with her infant.

The participants of the study shared that having the ability to share about their stressors, understand the dynamics thereof and receive guidance on how to cope with these situations benefitted them greatly. The general consensus of the participants was that their anxiety levels had reduced by the end of the programme.

One of the participants shared that she was overwhelmed with distress and anxiety due to conflict between herself and a friend who was also a participant in the programme. The participant used the space in the focus group to approach her friend, express her remorse over their conflict and request that they talk through their issues. It seemed to everyone who witnessed the interaction that day that that was the beginning of reconciliation between the two participants. The workshops and even the focus groups seemed to have provided the participants with opportunities to express and process their worries.

Improved mood.

Participants also reported that their mood had improved by the end of the programme. For example:

> *"…before I started this uhm, this course, I was, uhm, my mood wasn't at all times at a high level, for instance, I notice I did feel very sad because I don't have no one to share with because of trust, you can't trust anybody, but ever since I join this group, I feel much better…"*

> *"I feel better, yes, I also feel light. That burden isn't there anymore and my soul, just, I don't feel stressed and depressed, don't have time for myself. I have, have more experience now, I have lus for life, to go on, smile again, and go out and so."*

Andrews-Fike (1999) described three categories of maternal mental health, apart from postnatal anxiety. The two categories that relate to mood are postnatal blues and postnatal depression. The other category is postnatal psychosis which is acute and uncommon;

affecting only 0.89 to 2.6 cases per 1000 mothers (VanderKruik et al., 2017). Manjunath, Venkatesh and Rajanna (2011) described that postnatal blues is very common; 60% - 80% of mothers experience the condition which starts within the first week postpartum and ends usually two weeks later (Manjunath, Venkatesh & Rajanna, 2011). Most of the participants who attended the programme had infants older than 6 weeks of age. It was thus more relevant for the researcher to address postnatal depression.

According to Andrews-Fike (1999), postnatal depression is more severe than postnatal blues, manifesting similar symptoms (fatigue, insomnia, low mood, anxiety, crying and poor concentration) but it manifests more severely depressed mood and irritability. Postnatal depression also leads to feelings of suicide (Almond, 2009). Brockington (2004) suggested that postnatal depression can be seen as an umbrella term that encompasses several disorders in the postnatal period. Globally up to 15% of mothers are affected by postnatal depression (Sawyer, Ayers & Smith, 2010). In South Africa, our statistics for the condition are poorer as the prevalence rate is between 34.7% and 50.3% (Copper et al., 1999; Kathree, et al., 2014; Stellenberg & Abrahams, 2015). Postnatal depression affects a mothers' sensitivity which prevents her from being able to attach to her infant (Cooper et al., 1999; Diener, Nievar & Wright, 2003). The lack of secure attachment between her mother and her infant, as emphasized in chapters 1, 2 and 3, leads to a range of long term deleterious consequences for the growing infant.

Beck's (1979) cognitive theory of depression explains that individuals develop distress and depression when they develop erroneous ideas about themselves in relation to the world. Mothers can be plagued by irrational and destructive beliefs, assumptions and thoughts about themselves and/or their role and relationship to their infants. For example: "I

must be adept at everything, or else I will be a failure". Some of the participants described having similar thoughts.

Beck (1979) stated that when irrational beliefs, assumptions and thoughts are challenged, individuals can develop healthier ways of thinking and find relief. For instance, the mother who believes she is a failure can find evidence for the contrary in the way she cares for her child. This can then assist her to develop a more accurate view of herself as a mother, and discard the notion of being a failure. The concept of being a 'good enough mother', which was coined by Donald Winnicott (1960) and discussed in the programme, assisted the participants to be more accepting and gentler with themselves and this helped them to frame situations with their infants in healthier ways. The participants' narratives about themselves were being reworked to include more rational and evidence-based thoughts about their identities.

Considering the findings of the focus group, when the participants were asked to reflect on their perception of how the programme impacted their mood and well being, the qualitative feedback provided indicated that the participants experienced an improvement in this regard. In fact, the feedback was unanimous.

Improved behaviour regulation.

Another theme that emerged was improved behaviour regulation. Participants described that by learning more about their own reactions to situation, and gaining healthier strategies to cope with difficulties, they were better able to control their behaviour and respond appropriately. For example, a participant who was struggling with anger management said:

"I have a lot of anger but every time when I go out here I forgot I have that anger and that. I don't evens feel stressed out anymore… I'm still working on that anger of mine… When we argue I don't keep quiet, I always have my last say but like now, he's said a lot and I don't answer him back and he cry. Like it's for him, joh, she used to say something, she don't have the last say…"

Beck (1979) suggested that when individuals develop healthier thinking, they are better able to make delicate adjustments to their behaviour and make split-second corrections to judge, interpret and predict, so as to handle conflicting situations better. The above participant shared that in arguments she always used to want to have the last say and would become irrational at times in order to do so. Since participating in the programme, she made efforts to control her anger during arguments. Instead, she expressed her frustrations in the workshops and with trusted friends. She described that her partner was surprised by her new-found ability to control her behaviour and it actually gave them a space to start dealing with the emotions behind the anger.

Lowered suicide risk.

Closely linked to mood, is suicidality. Two participants commented in this regard. One experienced suicidal ideation and the other both suicidal and homicidal ideation.

"Mine has improved. Better. Samantha I don't really feel depressed anymore and feel like just dying and stressed on my children because I use to stress a lot on them. It's just I'm still struggling with the sleeping part because now the few past weekend, this

week I struggled to sleep at night and when I stand up in the morning I have a headache because I didn't sleep…"

"…this programme really did help me…because I did also go through some stress and I did just wanted to kill my child, honest now, I wanted to kill him, and me after that because I did feel life is just too much for me…"

Suicidality and homicidality, is linked to severe cases of depression and psychosis (Almond, 2009; Andrews-Fike, 1999). Two participants shared that at times their depression was so bad that they felt suicidal. These participants were given opportunities to share their feelings, receive support and discuss more intensive treatment. Both shared that participating in the programme assisted them.

Improved decision making.

Participants gained confidence in making better decisions around the mothering of their infants. One of the participants said that she learnt to speak to herself and weigh up options in order to make a decision:

"…*then I can say no man not that way, do it this way, ja, I can help, I can say what I've learnt by Samantha."*

Another participant said (in Afrikaans):

"Uh, volgens my is dit lekker vir my om 'n ma te wees want nou alles gehoor het en my gedagte oopgemaake het volgens die program wat alles gehoor het en wise gemaak het…"

Translation: *"Uh, according to me, it is nice for me to be a mother because I have now heard everything and my thoughts are open after the programme and hearing everything and now I am wise…"*

Mothering in the first year of life is challenging as a baby grows and needs different things at different times. Mothers need to adapt to these changes. This requires knowledge and the ability make decisions that keep their baby and their own best interests in mind. The second quotation illustrates that the participant felt wise after participating in the programme, i.e. she felt capable of practically applying the knowledge she had gained in the programme.

Another theme, closely linked to improved decision making is, improved problem solving. Participants said:

"My children cry for everything and I just give them to be off my back but the, the class and that highlight made me realise uhm that stuff that I give them won't let them be off my case. Sometimes they just need love and attention from me and that uhm highlight made me realise if they fussy sometimes they need love and attention, maybe you just don't give them enough attention and love or play with them enough, but that really made me realise just stop giving them stuff and I'm, the bond of playing and laughing with them it's getting closer and it's getting better."

"…he was one he was just crying. I don't know for why he was crying but it feel like it's something is, something is, is getting hurt. But now I know how to cure that problem of his."

"…now I can differentiate them and tell okay, this happens, this is the thing that (name of facilitator) was talking about and I must do this to solve this problem."

Participants felt more confident in solving problems that they encountered with their babies. Crying and fussiness was often seen as a problem to the participants. At times participants even described it as naughtiness. Solantis (2004) stated that infants cry in order to communicate their needs. According to him, mothers should recognise their infants' crying and the variations in crying which indicate specific needs (Solantis, 2004). A mother's role is to soothe an infant, either practically by making them physically comfortable or emotionally by paying them positive attention. It appeared that some of the participants were not consciously aware of this and realised it for the first time in the workshops. They thus began to view 'soothing' as a solution to the problem of them crying and fussing. This contributed to their increased sense of confidence in being able to care for their babies.

Improved confidence.

A theme that seemed to thread through during the analysis was that the participants had gained confidence through participating in the programme. One of the participants said (in Afrikaans):

"…En ken net se ek het confidence gekry…"

Translation: *"…And can just say, I gained confidence."*

As previously mentioned, one of the major objectives of the programme is to build participants' confidence and self-esteem as a parent. Being a mother is anxiety provoking and feelings of failure and self-doubt loom constantly. Wardrop and Popadiuk (2013) stated that anxious mothers worry about every aspect of mothering. It is common for mothers to see themselves and incapable of handling difficult situations with their babies. Self-efficacy thus becomes affected. Baron et al. (2011) stated that self-efficacy is the speculation and judgment of whether one is capable of completing an action. It is seen as the self-belief in the competence of one's own actions and motivations (Baron et al., 2011).

Beck (1979), in his theory about cognition described specifically how individuals develop unhealthy assumptions and beliefs about themselves in the world. He described that through making negative assumptions about the world, individuals develop cognitive distortions which lead them to develop negative views about their identity and abilities. In the study, the researcher observed that with improved knowledge and the application of common-sense tools to solve situations, the participants developed healthier thinking about their ability to make decision and solve problems. This led to an increased sense of confidence and self-efficacy and a change in their narratives about self.

Relationships.

As depicted in the *Relationship Model for Mothers* (see diagram 1 on page 153), a mother cares for her baby in the context of relationships with others and within a particular society. A mother's success at maintaining good relationships impacts positively on her sense

of well being and mental health. The participants shared that through the programme they gained knowledge and grew to the point where they were equipped enough to help others.

Improved relationships with others.

The participants shared about an improvement in their relationships with those around them, especially their peers. The found that they were better able to identify concerns in their friend's behaviour and they were now equipped to support and offer guidance.

Identifying problems.

One of the participants shared how she had been able to identify problems in the way mothers around her were raising their children. She shared a story about one of her neighbours.

> "*…I can see other children's needs also now, their needs here inside because some mothers don't give their children attention and they need comfortability, playing. I sees children who doesn't get love and I give them. Like down in my street is another girl that is using drugs and she's still breastfeeding the child. Now she was in Dora once of that stuff, it did affect the child's tummy but she's still giving the child the breast, she's hurting him emotionally and outside, she's hurting him and it's hurting me too because when she brings the child to me and I can play with the child here and the child feels safe because he's getting, he feels this is the love that I must get but when she take him away then he's getting hurt again because she's making him sick with the breast. And the child must be whole day here, dirty, you never see the child*

clean and playing, or, and it's still a baby, he just make last month one. A one year old."

Helping others.

Another participant shared that in being able to identify problems in the way mothers around them were caring for their babies, they are able to advise and offer help.

"Like now maybe she got a baby, her baby is crying and she's doing that, then I can, then I can say, no man, not that way, do it this way. Ja, then I can help, I can say what I've learnt."

It appeared that the participants were proud of themselves for knowing more than their peers and for being able to identify problems and lend a helping hand. It empowered them to make a difference. Their concept of self in relation to other was being re-constructed through the information they had obtained in the programme.

Improved relationship to self.

Motherhood is a demanding time in a woman's life. Not only because her infant constantly needs her, but also because of the demands of everyday life, and societal expectations and community norms. Participants reported that the programme gave them permission to be themselves, to struggle and to find ways to feel better. Participants said:

"…there is an improvement in my motherhood because sometimes I would feel that I'm not the perfect mum and sometimes I would feel like oh, I'm not doing my best

because there's a lot of things I need to do and then I would just start to blame myself and would like feel like just leave everything and just go away or run away from everything, but I've learnt it's normal to feel like that."

"…it taught me that uh, it's normal to be angry with my children, to, to, shout them now and then and not feel guilty and also it's normal for me to feel that I can go out and I can have…eating a pie by myself, not having to think what are they having now at the moment or why am I spoiling myself and not giving them."

A few of the participants expressed a sense of inadequacy, blame and guilt about not being a perfect mother. They found it emotionally distressing and one participant even described that this issue used to make her feel so negative that she felt like running away. Another participant described feeling guilty for getting angry and for scolding her children. The same participant also felt guilty for indulging in little things that she enjoyed, for example, eating a pie. Perkel (2007) suggested that it is common for mothers to experience feelings of inadequacy and guilt. The participants who commented on this seemed to have a perception of what was normal and acceptable based on society's norms and their community's idea of an ideal mother. The notion of the ideal mother was discussed in chapter three. It is a romanticised dominant discourse of what a mother should be in terms of her values and behaviours. Skott (2016) referred to the phenomena as the motherhood mystique. It appears that the influence of the motherhood mystique has reached the far corners of the world, where even in the poverty stricken townships of South Africa, mothers are dealing with the conflicts of having to live up to certain societal ideals. In the literature, the notion of ideal mother is being challenged and mothers across the world are speaking up against the

pressure to conform to this ideal. It seems the participants of this study can be added to this group of mothers who are speaking up.

The participants responded very well to the reassurances provided by the programme, that is, that it is normal to struggle during motherhood, it is okay to seek help and indulge in self soothing activities, and it is good for them to look after themselves even if it requires them to take a break from their babies. These reassurances contributed to healthier constructions of self. Workshop two of the Babies in Mind programme focused on "The stressed out mother" and during this workshop in particular, participants had the opportunity to discuss ways that that they could look after themselves and develop healthy strategies for dealing with stress and burnout.

Being kinder to self.

Closely linked to the previous theme, the sub-theme of being kinder to oneself was highlighted by the participants. They reported:

> *"…sometimes I really stress then it makes me feel bad. So she said, no, I mustn't feel bad because it does happen…"*

> *"…she teach me something…I'm not a perfect mother and I will never be perfect. I can only be good enough."*

> *"…before this I was very stressful like I said about the breastfeeding and the stress on my baby so she told me not to do the stuff, like stress on the child, and I mustn't…it's not a big deal because I can't breastfeed…I mustn't make a big deal and stress*

because the child can also feel that stress and stuff…so I'm better now, I don't stress unnecessarily."

Wardrop and Popadiuk (2013) stated that mothers with anxiety worry about every aspect of mothering an infant. One of the participants described that she felt guilty and anxious about struggling with breastfeeding. Another participant described that she would feel guilty for experiencing stress in general. There is evidence, based on these participants' comments that they felt less anxious and guilty about these issues after participating in the programme. Participants were able to be kinder toward themselves and were less fixated on a perfect mother. These participants became more confident and embraced the concept of being a "good enough mother". The researcher sees this theme as an achievement of one of the major objectives of the Babies in Mind programme which is to build participants' confidence and self-esteem as a parent.

Stories about the Baby

Participants shared stories about their relationship to their babies and how that had changed through their participation in the Babies in Mind programme. Through discussing the impact of the programme, they disclosed culturally held norms and perceptions about parenting practices. They also shared about their personal insights and feelings towards their babies. Here again, participants reconstructed their narratives about their babies through engagement and learning in the workshops.

Table 6. Themes relating to Stories about the Baby.

Major themes	**Sub-themes**	**Additional themes**	**Further themes**
Stories about the Baby	Challenges	Naughty baby Lack of knowledge	
	Knowledge	Improved understanding of baby's needs	
	Coping	Improved coping with baby	
	Attachment	Improved maternal sensitivity	

A participant shared a story of how the Babies in Mind programme had impacted the way she related to her baby:

> *"I've learnt a lot about my baby. Like when she's crying or sleepless nights then you told us why the baby is crying…why they so restless and I learnt a lot about that because I was doing my own way. Maybe like sometimes when she's crying and I'm, sometimes I don't take notice of her. Then you said most we must take note of like in its the, when they cry we gave them something to play and stuff like that and to keep quiet. When they restless then we stress or you see something like that. But I learn a lot…"*

Another participant shared a story of how she learnt to build trust with her baby:

"The best topic for me was the…trust, because sometimes I leave my baby with other people, go away, don't say for him goodbye. And then I'll come back and then it's like uh? Sometimes I make him lay down let him play, then I go around walking without him and noticing I'm gone and when he does, he keeps on crying, crying but when I come back, he, when he sees me he always smiles and carry on like his happy. The day I learnt about it, when I go away I, I will make him visible that I am going away now and I will come back."

Challenges.

Throughout the workshop with the participants they shared stories of their challenges with their children and babies. In the focus group mothers made reference to these challenges. For example:

"I used to think, before I attend the class, it's the children that are stressing me so out and I used to stress on them and hit them, but now…I have found it's not them, it's the people around me because I'm too much worrying about everyone's needs and not my children. I didn't think about their needs and my needs, myself so we can be happy, but it's better now, we are happy, I don't stress anymore on them even if they are naughty, I just tell them no to do it and just relax. Not get overwhelming inside coz I hit them every time. I'm thinking about it.

"Sometimes I feel like I hit her…like you said, we hit her then she don't know why… she cries, she don't understand."

"…when I'm stressed then I hit them…"

Participants previously viewed their babies as naughty when they cried or made demands on them. These situations inconvenienced them and caused them a great deal of stress.

Naughty baby.

A participant shared a story of how she thought her grandchild was naughty as she was demanding a balloon in a shop.

"my grandchildren are, are growing with me, staying with me sometimes in the holiday you know…One time we going to Kenako to bought them the pizza, and we bought the pizza and she's crying about something that is not around on to the shop, and then I was so hurt, I want to beat her so much. And then came my friend, working from Dora Nginza.."What's wrong with 'Lindi'?" I say "I don't know"… then I sit down. "Lindi, what do you want?" "Ese makulu I'm looking for eballoon." You know the balloon, and then I see there's no balloon here and she, she see the balloon around the shop. I didn't see the balloon and then we go to another shop…I go to ask to all the shops…there in Debonairs they got the balloon sometimes, but there's no balloon this time and I sit down with her and I say "what do you want? because you made me a disgrace you know, you crying for nothing that is not around." …I'm a grandmother…I'm tired mos you know…"

After attending the Babies in Mind programme, she reflected over the incident and realised that her grandchild was actually behaving in a developmentally appropriate manner for her age. This helped her to reconstruct her narrative around naughtiness and change her attitude toward her grandchild's behaviour.

Another participant, a caregiver at a day-care for babies, shared about the frustrations of not understanding why a baby cried continuously. She now realised that the baby needed attention and for her to focus on its needs.

> *"…we don't know this in, in our culture, that a baby like attention, you you must focus ja, sometimes the children cry, cry when it's young, you, you can't do nothing, you put at the back, you gave them the bottle, you gave them, but didn't stop crying…"*

Another participant, also a caregiver, shared about her personal story of fostering two boys, and her realisation of the importance of understanding their demands as a need for her attention.

> *"I have some two boys I'm raising, hey, foster mum…And you know the way I'm busy, so I'm always tired, tired. And when they said "aunt we want this", "aunt at school this", and I'm like "no man, just keep quiet and sit" But now ah, as I'm here I realise that, okay I must give them their time, I must love them as my own. And now I gave them the attention so that they, they, they will be free, they must be free talking to me in anything they must be free. Aye it's a positive thing.*

Participants were able to construct healthy understandings of normal development: curiosity, exploration and learning. The previously held notion of the "naughty baby" was challenged.

Lack of knowledge.

Participants expressed that after attending the programme, they felt they had gained greater knowledge about themselves and their babies. For example, participants said:

"…before this classes I wouldn't have know all that things I've learnt here."

"I'm so worried that I've missed some sessions, but I've gained a lot…"

Many of the concepts discussed during the workshops seemed to be new information to the participants. It was apparent that the poor socioeconomic status of the participants significantly disadvantaged them in terms of their level of knowledge about simple concepts regarding parenting. It is known that socioeconomic status directly affects education (APA, 2018), and education affects quality of life. Many of the participants were never afforded the opportunity to expand their knowledge about various topics, including parenting. The participants thus found the programme informative and were eager to learn and rework their narratives around parenting and child care.

Knowledge.

The researcher and the facilitators took special care to present the concepts in the workshops in a manner that would assist with learning at the participants' level of education. Relevant examples, illustrations and personal anecdotes were provided. The literature stresses the importance of programmes being contextually appropriate (Atif et al., 2016; Atif et al., 2017; Kathree et al., 2014; Minde et al., 2006; Nakku et al., 2016; Surjaningrum et al., 2018). The participants seemed to respond well to the informal and contextually sensitive nature of the learning experience.

Participants reported that there were aspects of the programme that were particularly thought-provoking and helped them think differently about situations with their babies. A few of the participants commented in this regard and said:

"...I learnt a lot about that because I was doing my own way. Maybe like sometimes when she's crying and ...I don't take notice of her. Then you said, mos, we must take note of...gave them something to play and stuff like that..."

"There were times then I can't handle then I thought, Samantha said, mos, that's why babies..."

"My children cry for everything and I just give them to just be off my back but the, the class and that highlight made me realise uhm, that stuff that I give them won't let them be off my case. Sometimes they just need love and attention, maybe you just don't give them enough...made me realize just to stop giving them stuff and I'm, the bond of

playing and laughing with them it's getting closer and getting better. I'm giving them more attention now then first."

The participants described that there were times when they would be about to react to their babies in their usual impulsive ways, but would then stop and think about lessons they have learnt during the workshops. This would cause them to rethink their assumptions about the situation and adapt their responses in healthier ways. The researcher noticed that in the communities where the participants lived, there was little understanding of normal infant and child development and competencies required for parenting. Individuals often parented their children completely intuitively and reacted to them on impulse. Tomlinson et al. (2005) raised concerns about the type of parenting that is possible in the context of poor education, illiteracy, poverty, and hardship. Individuals in these contexts struggle to understand and regulate their own behaviour, let alone their children's behaviour. Lewis (2002) pointed out that when mothers suffer emotionally, a sense of being out of control is experienced. Instances of infant and child beatings were rife in the communities that the participants lived. Some of the mothers admitted to ignoring or hitting their children when they became frustrated. These mothers initially perceived their babies' demands as naughtiness, not realising that these were normal protests that the babies resorted to in order to have their needs met. Through the programme the participants gained a better understanding of normal infant behaviour. This assisted them to think about their feelings and behaviours and react more appropriately to their babies' needs.

Improved understanding of baby's needs.

Participants felt that some of the workshops were particularly helpful in assisting them understand their baby's needs. Participants shared:

"...the crying topic with the babies because it's not like I can't take it when they cry, for me it's like I just need to be there, even when I'm busy, I will leave that stuff just like that. Even if there's someone else in the room, you can go, I don't...I want to pick her up first and then see what is it."

"I got grandchildren there at home, but it's not my grandchild, I'm a foster mother they come from a coloured woman, and it's, this, the social workers just bring them to me. Ooh I've got lots of challenges because they, they slow at school because their mother they use to drink every weekend. They fight, now we left, are left to take them to church all those, but most of them, they slow, and, and reading at school. I've got those challenges at home, but now since I was in, in, in this inspiration, this classes you know and this class, I've learnt a little bit to understand them, ja. I'm understanding them now, I'm trying to help them."

Participants also found the "trust" topic in the final workshop to be thought-provoking. Participants said:

"I learnt a lot about trust and how to trust my baby and how my baby can trust me a lot."

"…you must make sure that you don't disappoint the child because she's trusting you; I like that."

"I like that point…if your child feel she or he is not secured I think children feel unhappy, but if your child you feel when you around them, they feel security, they feel safe, so I'm sure all the community feel okay if they have safety…"

For the participants, building 'trust' with their babies seemed to be a thought-provoking and challenging concept. Participants did not know that this was an essential building block of their babies' psyche and a protective factor for them in terms of their mental health. Bowlby (1969) proposed that infants have a repertoire of behaviours, called the attachment behavioural system which is designed to ensure the infants' close proximity to their mothers. This will protect them from physical and psychological danger, promote safe exploration of the environment and help them to regulate emotions appropriately (Bowlby, 1969). The primary goal of the attachment behavioural system within an infant is to increase his sense of security and sense of trust that the world is a safe place and that others can be relied on (Bowlby, 1969). Erikson (1959) argued that the development of a sense of trust in the world and others is the first task an individual needs to achieve for healthy psychological development. Once the participants were informed of this they were encouraged to engage in behaviours that promoted trust with their babies. The researcher found that they were more prepared to have their babies closer to them, and they became more intentional about their responses to their babies during stressful periods and in general.

Coping.

Participants shared that they also gained strategies to cope better with their babies. One of the participants shared about her struggle with her baby's sleep routine. She said:

> *"...I always had a problem with him with his sleeping so uh like we had to say, talk out strategies how we make the child, can put your child to sleep and I only had mos, now one way like when he drink...and then I make him sleep. But other techniques as well; one of them said like signing or playing with your child, or giving your child a warm bath before so I try all those stuff now and it helps."*

Workshop four on "sleep", workshop six on "high needs babies", workshop eight on "crying" and workshop nine on "feeding" provided participants with opportunities to learn strategies to deal with challenging situations with their babies. Sleep, crying and fussiness are often perceived as difficulties to mothers with babies. At times, feeding can also be seen as challenge. Thus, having strategies to cope with these situations is of utmost importance for mothers.

Improved coping with baby.

One of the participants shared:

> *"I've learnt a lot about my baby. Like in when she's crying or sleepless nights then you told us why the baby is crying, why they didn't, why they so restless. And I learnt a lot about that because I was doing my own way. Maybe like sometimes when she's crying and I'm sometimes I don't take notice of her. Then you said mos we must take*

note of like in it's the, when they cry we gave them something to play and stuff like that and to keep quiet."

Another participant said:

"…sometimes I get so stressed at, at school, to a point where I just neglect my child, but ever since I started here, I know have that knowledge that it's not good to actually neglect my child even if I have so much stress I just have to find a positive way to, to connect with him and that's how I actually go on nowadays."

As previously mentioned, the participants had little formal knowledge and experience about parenting, especially the parenting of babies. Prior to gaining knowledge about infant development and psychological health, some of the participants were often not attuned to their babies' needs, sometimes even blatantly ignoring them. It appeared that participants were not fully aware that parenting a baby did not only entail physical care but also emotional and psychological care.

A few of the topics in the programme addressed regular activities that mothers engaged in with their babies, for example, sleeping, feeding, crying and periods of crisis (fussy or ill infants). Participants were taught about the importance of healthy attachment and how to maintain attachment through the daily activities involved in raising an infant, for example, making eye contact, smiling, responding to their babies' cries for attention, etc. Bowlby (1969) emphasised that the kind of care a baby received from its mother plays a significant role in determining the way in which his attachment behaviour develops through the trajectory of development. The participants became aware of the importance of their

interaction with their babies as it will influence the way they will initiate and form attachments as they grow. Closely linked to attachment is separation. Participants were taught what age-appropriate separation is and were given opportunities to discuss dynamics around separation, e.g. return to work and the need for secondary care-givers.

Attachment.

Mother-infant attachment is a major focus of this study since it is the bedrock of infant and adult mental health and development. Bowlby (1951) claimed that mothering is useless if delayed until after two and a half years of age so early attachment is essential. It was stressed that the first twelve months are particularly critical for attachment (Bowlby, 1951). I was particularly interested to establish whether the programme had any effect on mother-infant attachment.

The findings indicated that the participants did perceive improvements in their relationships with their infants. Participants' narratives included:

"…my relationship with my child is much better because I'm feeling much better myself."

"…it's been good, but it's better now."

"I'm giving them more attention now then first… It made me realise my children needs that more attention from me not the things I give them."

"For me it's very positive, I feel very close to my baby now because at first he was very uh, close with my mother, he just wanted to be by my mother and stuff, but now he cries after me and he just wanna be with me."

A major focus of the Babies in Mind programme is to promote mother-infant attachment as well as maternal mental health. As emphasised, good maternal health promotes mother-infant attachment, and mother-infant attachment promotes healthy child and adult development. Mother-infant attachment is so crucial that it has the power to predispose an infant to a range of negative psychological, social and emotional problems. Thus, as Bowlby (1969) puts it, the first year of life is a critical period for intervention. According to Bowlby (1969), a mother needs to provide her infant with continuous care and facilitate attachment during this time and up to three years of life.

Improved maternal sensitivity.

In chapter three, concept of maternal sensitivity was discussed. The concept is linked to both maternal mental health and mother-infant attachment as it describes exactly how the two affect each other. When a mother's mental health is affected, it affects her maternal sensitivity, i.e. her ability to attune to her infant (Ainsworth et al., 1978). Thus a mother is not able to pick up on cues from her baby and so a disconnect occurs in the relationship. This then causes the baby to become distressed, which in turn causes the mother to become more distressed and worsens her mental state. And so the cycle continues. Observing the effect of the Babies in Mind programme on maternal sensitivity was thus of interest to me.

In responding to questions in the focus groups participants shared indirectly about how their sense of maternal sensitivity had improved. For example, a participants shared that she realised that her own emotions, through social interaction, affected her baby's emotions:

> *"There were times then I can't handle then I thought Samantha said mos that's why babies are so and then restless and like that… When you are stressed out then they not…they feel like you unhappy."*

The participants described that after attending the programme and understanding more about their babies, and how to deal with situations, they became better at attuning to their baby's behaviours. Part of the change could be due to the improvement in the participants' mood and confidence levels. Literature shows that mothers with low mood are less sensitive in interactions with their infants (Arteche et al., 2011; Gil, Droit-Volet, Laval & Teissedre, 2012; Hwa-Froelich, Loveland Cook & Flick, 2008; Tomlinson et al., 2004). Depressed mothers usually display flat affect, provide less stimulation and respond less to their babies than non-depressed mothers (Field, 1984). They struggle to be sensitive to their infants' emotional states and experiences because they are so preoccupied with their own experiences (Murray et al., 1993). They are thus unable to sustain social interaction which is essential to developing attachment (Cox et al., 1987b). The workshop facilitators and I used opportunities in the workshops to show participants how to be sensitive to their baby's emotional experiences. Through the duration of the programme I often observed an improvement in the participants' ability to respond to their babies, and understand and describe their behaviours. The social interactions between us enabled healthier social constructions of mothering and motherhood to form.

Discussion

This study aimed to explore and describe the effect of the Babies in Mind programme on maternal mental health and mother-infant attachment. Two objectives of the study were to explore and describe participants' experiences of participation in the programme, as well as to explore and describe their perceptions of the benefit of the programme relating specifically to maternal mental health and mother-infant attachment. The third objective of the study, which was to explore and describe the barriers and facilitators to implementing the programme in the South African context, was discussed in chapter four, and will be reiterated in the next chapter.

Regarding the first two objectives, attention was given to the stories that mothers told regarding their experiences of the programme. It was hoped that the findings would provide insights on how mothers perceived motherhood and also how those perceptions could be reconstructed through participation in the Babies in Mind programme, thereby giving and indication of whether the Babies in Mind programme is relevant and beneficial for mothers of infants at the community level.

The results in this chapter have responded to the above aim. There is significant pressure on mothers to raise their babies and children with care and wisdom, and prepare them for adulthood in our fast-paced, productivity driven world. It has been stressed that the relationship between a mother and her infant is of utmost importance in the development of a healthy psyche. A mother has to look after herself and ensure that she is able to maintain a consistent level of maternal sensitivity toward her baby. The pressure is immense. The results have shown how critically important it is for mothers to receive support from those around them as the participants themselves have indicated that that they need to navigate the relationship within (to self), the relationships around them (with others) and the relationships

beyond (to the community and society). The *Relationship Model for Mothers* presented in diagram 1 on page 153 highlights the inter-connectedness of the impact of society, the community, family members and partners on a mother's ability to care for her baby.

The Babies in Mind programme gave the participants a space where they could talk about their relationships and the support or lack thereof in their lives. Participants were concerned about uninvolved fathers and the pressure that put on them to raise their infants and children on their own. Participants also shared about unsupportive family members and social stress in their lives relating to communities issues like limited safety, conflict with others and so forth. Sufficient social support is crucial for mothers of infants (Krauss, 2010; McKenzie, Patel & Araya, 2004; Tomlinson, Cooper & Murray, 2005). Research indicates that inadequate support is a risk factor for maternal mental heath concerns (Fischer et al. 2012; Tomlinson, Cooper & Murray, 2005). To add to this it was evident that the dominant discourse of the 'ideal mother' had infiltrated to the community level and that participants were grappling with this nuance. Subscribing (albeit unconsciously) to the dominant discourse meant that the participants often felt inferior in their parenting and coping with life. Participants focused on pleasing others and neglected themselves in the effort to meet society's ideals. Consequently, it was noticed that the participants viewed society as being critical and they felt unsupported and unheard by those around them. Since this is a common experience of motherhood, particularly during infancy, one of the main aims of the Babies in Mind programme is to be supportive and provide mothers with a space to connect and be heard. The participants shared that they saw the Babies in Mind workshops as a safe space and they felt supported. For some, participation in the workshops allowed them to talk and be heard for the first time. Through mutual support and connectedness in the programme, participants were given an opportunity to re-construct their ideas of 'social support'.

Individuals create and know reality through that which is co-constructed in their social groups (Gergen, 1985). The need for each of them to reach out and create opportunities to talk was realised.

Through the adoption of new words and ideas, other co-constructions were developed. Galbin (2014) emphasised that reality is constituted through words and language and that knowledge is created and sustained through social processes like conversation. New information gained through participation and conversation in the workshops allowed the participants to think and relate differently to their babies. For example, some participants mentioned that they previously viewed their babies as ‘naughty’ as they appeared to be uncooperative and often inconvenienced them as they tried to go about their daily tasks. With new information gained about the mind of an infant, its needs and its ways of communicating, the participants adopted a new language and thus a new ‘reality’ regarding their babies. Through understanding their babies needs better, they found that they coped better with their babies’ demands and that improved their sensitivity, and consequently their attachment to them.

The acquisition of new information also resulted in improvements in the participants’ coping and mental health. Participants adopted a kinder attitude toward themselves and discarded the dominant discourse of the ‘ideal mother’ for the more accepting version of the ‘good enough mother’, coined by Donald Winnicott (1960). Participants reported improvements in their self care, their mood, their anxiety levels, their decision making and their confidence levels. A reduction in suicidal ideation was also reported. Participants shared that their relationships with others had improved as they were better able to identify problems and stressors, not only for themselves, but also for those around them. They began to offer support and be kinder to others as well. Owen (1995) stated that the content of consciousness

and the mode of relating between individuals is learned from others. The Babies in Mind programme has been a positive vehicle for change in this regard as the participants' awareness of themselves, their babies and others altered and improved.

Through story-telling and learning in the workshops the participants' social constructions of motherhood have been reconstructed. Where stories previously characterised disempowerment, after participation in the programme, the participants shared stories of empowerment and improvement. Their new-found focus on "self" encouraged them to take care of themselves, to identify problems and to apply solutions so that they could cope better with life and their babies. New concepts learned in the programme provided them with a language by which to express themselves. This contributed greatly to the social reconstruction process. Participants narratives changed as they talked about "coping", "needs", "attachment", "soothing", "trust" and so forth. Their way of talking changed their way of thinking, which in turn changed their way of experiencing. This is the essence of social constructionism and the narrative approach which holds that we are all social actors in life and that we have the power to reconstruct our scripts at any time, and in so doing, change our stories and our lives. Social constructionism has proved to be a helpful lens in this study as it has assisted me to observe, to understand and to report on the impact of the Babies in Mind programme in the lives of the participants.

Summary

This chapter focused on a discussion of the findings of the study. Literature in the field of maternal mental health and mother-infant attachment was linked to the emergent themes and where applicable, themes were linked to the theoretical model outlined in chapter two.

This chapter presented a model called *The Relationship Model for Mothers.* The model was developed in light of the findings of this study which centred around participants' stories of society, the people around them, themselves and their babies. The model emphasised the crucial role of understanding a mother and her ability to mother her baby in the context of the people around her, her community and society at large. The themes and the over-arching finding relating to the dynamic relationships in a mother's life is in alignment with the theoretical foundations of this study (social constructionism) which proposes that reality (experiences, perceptions, norms, etc.) is socially constructed.

In the following chapter, the conclusions, limitations and recommendations based on this study will be presented.

Chapter 6

Conclusions, Recommendations and Limitations

"Motherhood has a very humanising effect. Everything gets reduced to essentials."

Meryl Streep

Introduction

The present research study centred on mothers' experiences of participating in the Babies in Mind programme and its impact on their mental health and their attachment to their babies. The study was conducted in low socio-economic areas of Port Elizabeth: Helenvale, Missionvale, Kwazakele, Malabar and Malabar Extension Six. Attention was given to exploring the relevance of the Babies in Mind programme as an early intervention strategy to address maternal mental health concerns and attachment issues in the postnatal period. Literature has shown that maternal mental health concerns and attachment issues have long-term negative mental health consequences for individuals throughout the trajectory of development (Allen-Mearns, Blazevski, Bybee & Oyserman, 2010; Spence, Najman, Bor, O'Callaghan & Williams, 2002; Stein, Malmberg, Sylva & Barnes, 2008; Weissman, 1997; Weissman et al., 2006). Early intervention for mothers has been advocated for in literature (Alfredsson, Sebastian & Jeghannathan, 2017; Atif, et al., 2016; Atif et al., 2017; Baron et al., 2016; Bennett, Barlow, Huband, Smailagie, & Roloff, 2013; Denis, Michaux & Callahan, 2012; Dennis, 2005; Nakku et al., 2016; Rathod et al., 2017). This was a strong motivation for the present study.

The objectives of the study were achieved through employing a social constructionist lens, a narrative inquiry approach and qualitative research methodology that allowed me to elicit stories from the mothers who participated in the programme.

This chapter discusses the conclusions of the current study based on the findings discussed in chapter five. As part of the conclusions of the study, a discussion is provided of two unexpected outcomes that occurred through the implementation of the Babies in Mind programme. The first unexpected outcome was the establishment of a social media support group (via Whatsapp). The second unexpected outcome was the development of practitioner guidelines for implementation of the Babies in Mind programme (and other similar programmes) at the community level. The chapter concludes with a discussion of the limitations of the study and recommendations for future research.

Conclusions of the Study

From the seven focus groups that were conducted, four major themes were derived which related to the participants' experiences. The themes were: "stories about society", "stories about the other", "stories about the self", and "stories about the baby". These themes yielded eleven sub-themes, fourteen 'additional themes' and seven 'further themes'. The conclusions presented in this section are a summary of the themes that emerged from the stories that were told by the participants.

The participants experienced the programme to be supportive and they reported that it provided them with an opportunity to open up and share with other mothers. They engaged in the programme and found some topics to be thought provoking, for example the "role of the father" and the "trust" topics were frequently mentioned as challenging and/or interesting.

The participants shared stories about the way society had impacted them. They pointed out that culture and their community played a role in the way they mothered their babies. Black participants realised, through participation in the programme, that mothering entailed more than simply feeding babies and putting them to sleep. They benefited from the knowledge obtained about the mind of their babies and the importance of attachment. Black participants found that a few of the concepts discussed in the programme were foreign to them, that is, a different cultural approach. Nevertheless, they were open to learning and adopting different ways of thinking. Coloured participants seemed to relate to the new knowledge differently. They felt that the concepts were not foreign or different, rather they saw them as the 'correct ways of parenting'. They felt that they were simply not exposed to the correct ways and in that way educationally deprived.

Participants seemed to view the community around them as a critical voice. A theme that emerged from the focus groups was that the programme gave the participants permission to be kinder toward themselves. Many participants were weighed down by societal and community pressures around motherhood. The dominant discourse of the *ideal mother* seemed to infiltrate to the community level as the participants felt that they were expected to give up their lives for their children. Once the participants were given the permission to look after themselves, take a break, spoil themselves, and so forth, they reported that they felt and coped better. A change in the previously held dominant social constructions of motherhood in this case led to changed narratives about self and what being a mother entailed. This had a positive impact on coping and confidence.

The participants also told stories of significant 'others' around them, that is, their parents and their partners (in most instances the fathers of their babies). A common theme was that the fathers of the babies were often uninvolved. The participants shared stories of

their challenges in this regard. Most of the participants in the study were single mothers, struggling to raise their children on their own, practically and emotionally. Participants also shared about the challenges they had with their own fathers and mothers. Most of the participants grew up in unstable home environments and they felt that their childhood histories played a role in the way they raised their own children.

Participation in the programme allowed the participants to focus on themselves which was previously not a priority since life seemed to revolve around their babies, other people and the community at large. The participants told stories about themselves through discussing the impact of the programme in their lives. They shared that the programme facilitated improvement in their lives in several ways. A significant area of improvement was with regards to knowledge. The participants reported that they learnt about more themselves through the programme. The increase in knowledge seemed to be a catalyst for an improvement in their confidence to make better decisions around caring for their infants and solving problems that they faced. This allowed them to cope better with their babies and their lives in general. The participants began to take better care of themselves and they experienced an improvement in their mental health and sense of well-being. Specific areas that were improved were: anxiety, mood, behaviour regulation and feelings of suicide. Participants expressed that their contexts had not changed and they still faced their usual challenges, however, they coped better with life. A significant area of improvement and a major theme that surfaced was that their relationships with their infants had improved since participating in the programme. They told stories about their babies. They shared that in the past they frequently thought of their babies as naughty because they made demands and often inconvenienced them. With the new knowledge gained they were better able to understand their babies needs and cope with caring for them. Participants made allusions to maternal

sensitivity issues and it was evident that they had learnt to become more attuned toward their infants through participating in the programme. The programme was a vehicle for reconstructing thoughts, beliefs and ideas around parenting, motherhood, relationships and self-care. The programme is evidence that social constructionism is an appropriate theoretical approach to use for understanding the dynamics of motherhood.

The findings of the study allowed for *The Relationship Model for Mothers* to be developed. The model is depicted in chapter five (diagram 1). It illustrates the complexity and inter-connectedness of the relationships between a mother and her baby, those around them and society at large. It highlights that a mother's ability to care for her baby is embedded within the quality of the relationships she has with her baby, the quality of the relationships she has with those around her and the quality of her experiences within society.

Literature has emphasised the importance of social support for mothers within the postnatal period in reducing the risk for maternal mental health concerns (Krauss, 2010; McKenzie, Patel and Araya, 2004; Tomlinson, Cooper & Murray, 2005). *The Relationship Model for Mothers* illustrates the importance of this point, and emphasises the need for interventions programmes like the Babies in Mind programme which has been experienced as being effective in helping mothers.

Conclusions Relating to the Implementation of the Babies in Mind Programme

Several observations were made throughout the implementation of the programme. Barriers and facilitators in implementing the Babies in Mind programme at the community level were identified. Among the barriers were attendance issues. There were high dropout rates and poor attendance rates. It was found that the main issue that impacted attendance was attitude towards the programme. The participants who saw the value in the programme

committed and made sacrifices to attend the workshops. Other participants were less likely to make sacrifices to attend, however, in some instances there were valid barriers to their attendance, such as resistance from partners and having to travel far distances. Another barrier was cultural differences between one of the facilitators and the group of participants. The participants saw the facilitator as an outsider and this impacted their relationship to her. Finding a suitable venue was a challenge and dealing with uninvolved gatekeepers also was a barrier and a challenge to implementing the programme.

There were, however, several facilitators in implementing the programme. An important factor was having two facilitators who were cultural and ethnically suited to their groups. There was clear indication that this actually had a positive impact as compared to the facilitator who was from a different cultural group than her participants. Another factor that seemed to benefit the participants was having a facilitator who shared the experience of having a baby and/or children. The personal anecdotes and stories that were relayed allowed the facilitator to bond better with the participants, and also encouraged disclosure.

An important facilitator of the programme was having gatekeepers who remained involved. These gatekeepers assisted with marketing, recruitment of participants, retention of participants, and logistical issues. Facilitators for with regards to logistics included the venues being in the community, the fact that refreshments were provided and a safe, comfortable space to talk, and that babies were welcome to the workshops. The provision of incentive and gifts was also seen as a facilitator. It was noted that the giving of gifts was necessarily an effective tool for the retention of participants because the dropout rates were still high, however, the gifts and certificates provided for participants who remained in the programme were well received and participants seemed to have looked forward to receiving them.

The participants, all being mothers, had busy lives but those who saw the value in attending the programme made every effort to attend. Those who attended the full programme expressed their appreciation for the programme and benefitted the most from their attendance.

Unexpected Outcomes of the Study

The present study entailed the implementation of the Babies in Mind programme at the community level with groups of participants. It is easy to forget that the participants are real-life mothers with real-life babies and real-life challenges. The participants, their babies and their challenges did not disappear after the completion of this study. Their lives go on. As a researcher I was satisfied with the outcomes of the study and the knowledge gained for the field of psychology, but as a practitioner, I felt that the support offered to the participants during the implementation of the Babies in Mind programme needed to continue beyond the study. This was confirmed when the participants themselves requested further intervention and support after the programme. Their request turned into an unexpected outcome of this study which was the development of a social media support group.

Social media support group.

A Whatsapp support group was developed for participants who attended the programme and any other mothers who wanted to receive support related to mothering babies and small children. Jenny Perkel (the author of *Babies in Mind*), one of the workshop facilitators and I are the administrators of the support group. Participants are encouraged to use the platform to ask questions and make reflections about their experience of motherhood, challenges with regards to their infants and any parenting related issues. The participants

have welcomed the opportunity to interact further. Strict control is maintained regarding the content shared on the group and thus far most of the participants are using the platform for the intended purpose. The WhatsApp support group has become a beautiful way of continuing the shared narrative around motherhood between the participants and myself.

Practitioner guidelines for programme implementation.

Another unexpected outcome of this study was the development of best practice guidelines for practitioners in implementing the Babies in Mind programme at the community level. Surjaningrum et al. (2018) highlighted that guidelines are crucial for practical implementation of interventions and programmes for maternal mental health. Guidelines are specifically necessary and relevant in the landscape of mental health in South Africa as a developing country. The Department of Health needs to make the best use of the funds and resources available. Using evidence-based guidelines can assist with this as it informs stakeholders on how to operate on the ground level. This is necessary and relevant as the Department of Health has promulgated several proposals and plans to improve primary health care in South Africa (National Mental Health Policy Framework and Strategic, Operation Phakisa, National Health Insurance). Operation Phakisa in particular promoted the concept of the ideal clinic which will provide "community based health promotion and disease prevention programmes in collaboration with the community" among other provisions (Department of Health, 2015, p. 10).

Through this study twelve guidelines for the implementation of the Babies in Mind programme at the community level have been developed. These guidelines can also be used when implementing other similar programmes in South Africa as they account for contextual factors that would be applicable. The guidelines are presented in the box below.

Box 1. Guidelines for Implementation of the Babies in Mind Programme at the Community Level

1. Build relationships with gatekeepers before implementing the programme
2. Select a venue within walking distance for participants
3. Do relevant researcher before scheduling dates for the workshops: grant days, clinic days, schedule times in collaboration with staff and participant
4. Incentivise attendance and provide certificates at the end of the programme
5. Involve family members such as partners or parents in the process to mitigate a sense of threat caused by the programme as an intervention from 'the outside'.
6. Provide an informal space and refreshments and also include infants. If possible, provide childcare for older children.
7. Reduce the number of workshops in the programme, e.g. 4 – 6 sessions.
8. Keep workshops under 2 hours long and ensure that the workshops are conducted in a conversational style, but provide enough structure so that the relevant information can be relayed.
9. When teaching specific concepts, ensure that the concepts are presented according to the participant's level of understanding: use diagrams, pictures, examples and anecdotes. Do all of this in a respectful manner so as not to cause the participants to feel inferior.
10. Use facilitators that are of the same cultural background, possibly part of the same community and who are mothers themselves
11. Provide ongoing supervision and support to facilitators as they need to provide care and support to the participants
12. Facilitators should demonstrate good mental health and healthy attachment as they facilitate the groups in a manner that is nurturing, supportive and containing.

Limitations of the study

A number of limitations of the study have been identified. One of the limitations was the large sample size for a qualitative study. The fact that 34 participants participated in the focus groups probably compromised the richness of the data that was collected. This meant that the voices of the participants were likely not fully heard as they were forced to share the stage with many other participants in their groups. That being said, the voices of certain personality types and certain experiences of motherhood may have been excluded from the study because of this. A different methodology might have mitigated this.

Another limitation of this study was the lack of quantitative data to confirm the qualitative findings relating to the relevance of the Babies in Mind programme as an early intervention strategy for mothers in South Africa. In response to that, however, the participants at the community level were limited in education and literacy which made psychometric testing an unviable option with them. As it stands, South African literature on psychometric testing in our cross-cultural context highlights the problems with using psychometric measures that were originally developed for other population groups (Swanepoel & Kruger, 2011). Fortunately, there seems to be a future for psychometric testing in South Africa as researchers are making strides towards more valid, reliable and culturally applicable testing (Laher & Cockcroft, 2014). Future studies should consider the development of psychometric measures for mothers which are specifically suited for the South African community context

Another limitation of this study, due to time constraints, was that it did not consider the sustainability of the results. This is a significant concern because of the impact of non-sustainability on the effectiveness and feasibility of programmes at the community level.

Based on these limitations, recommendations can be made for future research in this area. Discussions of these recommendations are presented below.

Recommendations

It is recommended that this study be replicated, however, in future, a smaller sample group should be used so that richer data may be collected. In future studies on the Babies in Mind programme, or other similar programmes, a quantitative element can be added to provide statistical data about the impact of the programme on issues like postnatal depression, postnatal anxiety, and attachment. For this to be possible, culturally appropriate measures need to be developed to assess for postnatal depression, postnatal anxiety and attachment.

As discussed above, the findings have indicated that the Babies in Mind programme has yielded a positive impact on participants' maternal mental health and their attachments to their babies, but the study did not account for the sustainability of this impact. In order to determine sustainability of the findings future studies should aim to test longitudinal outcomes (in terms of maternal mental health and mother-infant attachment) at 6 months, 12 months and possibly even longer after the programme is completed. If programmes can be shown to be sustainable, it makes them more feasible and effective in the long term.

Reflection

The stories of motherhood shared in this research study, those of my own and those of the participants, have lent perspective about the experience of motherhood and the importance of social support, information sharing and empowerment for mothers. At the beginning of chapter one I quoted Frederick Douglas (1855) who stated that it is easier to build strong children than repair broken men. Early intervention in the lives of children is

crucial in preventing a generation of broken people in the future. What better place to start than in infancy. Bowlby (1988) held that infancy is the most important time to lay down a solid foundation for secure mental health. This is ultimately the cornerstone of the Babies in Mind programme. The future health of our society depends on what we do with this critical window of opportunity.

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Appendix A: Agreement with Early Inspiration

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for tomorrow

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Agreement of Partnership in Doctoral Research

I, Dr Lauren Stretch (managing director of Early Inspiration), agree that Samantha Naicker may conduct research with selective participants who access services at our organization.

Ms Naicker may use screening measures and conduct the Babies in Mind programme with our participants. She may also disseminate of the results of her findings, as outlined in her research proposal.

I understand that all information gathered will remain confidential and may only be used for research purposes.

Signed at PORT ELIZABETH on 08 SEPTEMBER 2016

Name DR LAUREN STRETCH Signature

Appendix B: Permission letter from the Department of Health Research Committee

Province of the
EASTERN CAPE
HEALTH

Office of the Clinical Governance Manager
Nelson Mandela Bay Health District
Private Bag X 28000,
Greenacres,
Port Elizabeth.
6057.
REPUBLIC OF SOUTH AFRICA

Enquiries : Dr L P MAYEKISO
Telephone : 041-391-8173
Facsimile : 041-391-8133
E-mail : mbasa.mayekiso@gmail.com

Our Reference: NAICKER/2017
Your Reference:
Date: 25 APRIL 2017

MS S NAICKER
FACULTY OF HEALTH SCIENCES
DEPARTMENT OF PSYCHOLOGY
NMMU

REQUEST FOR PERMISSION CONDUCT RESEARCH ON THE MITIGATING EFFECTS OF THE BABIES IN MIND PROGRAMME ON MATERNAL MENTAL HEALTH AND MOTHER-INFANT ATTACHMENT."

In response to your application for permission to conduct the above research, permission is hereby granted with the following proviso:

- Health service delivery should not be disrupted under any circumstances.
- Timeous appointments must be made with the relevant persons prior to commencement of interviews/visits.
- All required data should be collected by the Researcher or a designated fieldworker (whose name should be forwarded to the relevant Sub District Coordinators prior to data collection). The Sub District Coordinators Messrs. Msutu – 083 378 1942, Koll – 060 563 1225 and Reuters – 060 557 9732 should be contacted **before** your visit and this letter is to be presented when visiting the facilities

The Nelson Mandela Bay Health District, as the research site, will expect a copy of the final research report when the study is completed. If the duration of the research period is required to be extended, the District Office (District Manager) should be informed accordingly.

This Office would like to wish you well in your research study.

Yours faithfully

DR L P MAYEKISO
CLINICAL GOVERNANCE MANAGER – NMBHD

Appendix C: Introductory Email to Clinic Managers

SOUTH CAMPUS
FACULTY OF HEALTH SCIENCES / DEPARTMENT OF PSYCHOLOGY
Tel . +27 (0)41 504-2354 Fax. +27 (0)41 504-2101

2018

To whom it may concern

RE: Partnership in a Doctoral Study

I would like to take this opportunity to introduce myself to you and to thank you for your interest in partnering with me in my research study.

I am a practicing psychologist in Port Elizabeth, doing my doctoral studies through the psychology department at NMMU. In order to complete a doctorate, I am required to conduct a research study which will eventually contribute to the scientific body of knowledge in the field of psychology.

I am currently conducting a study on the mitigating effects of the Babies in Mind programme on maternal mental health and mother-infant attachment. The Babies in Mind programme was developed in 2012 by a clinical psychologist, Jenny Perkel, in Cape Town. The programme consists of a 10 week course which covers various topics relating to the experience of parenting an infant in the first 12 months of its life, e.g. feeding, sleeping, crying, attachment,

the role of the father etc. The programme is group based and designed to be informal, interactive, and informative to cater for mothers with infants. **The ultimate aim of the programme is to enhance maternal mental health, prevent maternal ill-health (most especially postnatal depression) and foster mother-infant attachment.**

My data collection process will involve conducting the Babies in Mind programme (full 10 weeks) with groups of mothers with infants (0 – 12 months old). Each group meeting will be approximately an hour to two hours long. A translator will be present to assist with any language barriers. It would be ideal if we could use a venue at the clinic to conduct these sessions since the mothers are familiar with this environment and it is easily accessible. My request to you is to allow me to establish a group of mothers (with infants) from the ladies who attend the clinic to participate in the programme. As mentioned, it would be ideal if I could use a venue at the clinic in which to conduct the sessions.

A focus group session will be conducted with the participants at the end of the 10 week programme to establish the effectiveness of the programme. This means that the entire process should take 11 weeks if all goes according to plan. The last session will be voice recorded; however, confidentiality will be maintained throughout the session and the entire research process. Participation will be completely voluntary. I will be providing refreshments for the mothers who attend the meetings.

If there are any questions or concerns regarding the research study, please feel free to email me at any time: naicker.psychologist@gmail.com.

I do hope that you will be interested in partnering with me. If so, you are welcome to email me at the above address or contact me on: 0736963505.

Kind regards

Samantha Naicker

Appendix D: Example of Flyers

Babies in mind

FREE WORKSHOPS

- 6 week programme
- Designed for mothers of babies between **0 and 12 months**.
- All about understanding baby's emotional and psychological needs. Topics include: sleeping, crying, feeding, attachment, separation, stress.
- Supportive and empowering.
- You are welcome to bring your baby with to the meetings.
- Refreshments will be provided.
- If you are interested, please sign up with Samantha Naicker: 073 696 3505.
- Dates, times and venue to be announced.

Appendix E: Consent form

Nelson Mandela Metropolitan University
for tomorrow

NELSON MANDELA METROPOLITAN UNIVERSITY

INFORMATION AND INFORMED CONSENT FORM

Title of the research project	***Mitigating effects of the Babies in Mind programme on maternal mental health and mother-infant attachment in a South African community.***
Reference number	207061582 (Student number)
Principal investigator	Samantha Naicker
Contact telephone number (private numbers not advisable)	073 696 3505

	Initial
A.1 I HEREBY CONFIRM AS FOLLOWS:	
Samantha Naicker 1. I, the participant, was invited to participate in the above-mentioned research project study that is being undertaken by Psychology of the Department of Health Sciences in the Faculty of of the Nelson Mandela Metropolitan University	

2.1 The following aspects have been explained to me, the participant: 1. **Aim:** The researcher is studying effects of the Babies in Mind programme on maternal mental health and mother-infant attachment. The information will be used to compile a thesis, publish an article and if the opportunity arises, it will be presented at international conferences.	
2.2 Procedures: I understand that I will be participating in a group intervention. I understand that these group sessions will be voice recorded.	
2.3 Possible benefits: As a result of my participation in this study the knowledge in the field of intervention for maternal mental health and mother-infant attachment will be expanded.	
2.4 Confidentiality: My identity will not be revealed in any discussion, description or scientific publications by the researcher. **Limits to confidentiality**: I understand that the researcher will refer me for further treatment should I need it, for my best interest.	
2.5 Access to findings: Any new information/or benefit that develops during the course of the study will be shared with me by means of a report of the findings.	
2.6 Voluntary participation/refusal/discontinuation: My participation is voluntary. My decision whether or not to participate will in no way affect my present or future lifestyle.	
3. I was given the opportunity to ask questions and all these questions were answered satisfactorily.	
4. No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalisation.	
5. Participation in this study will not result in any additional cost to me.	

A.2 I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE-MENTIONED PROJECT.

Signed/confirmed at
on 20

Signature of participant

Signature of witness

Full name of witness

B. STATEMENT BY RESEARCHER

I, Samantha Naicker declare that

- I have explained the information given in this document to the participant
- she was encouraged and given ample time to ask me any questions;
- this conversation was conducted in English

- **Signed/confirmed at**
on 20

Signature of interviewer

Signature of witness

Full name of witness

D. IMPORTANT MESSAGE TO PARTICIPANT

Dear participant

Thank you for your participation in this study. Should, at any time during the study:

- an emergency arise as a result of the research, or
- you require any further information with regards to the study

Kindly contact
at telephone number 073 696 3505

Samantha Naicker
Researcher

Appendix F: Biographical Questionnaire

Name:	
Surname:	
Age:	
Age of infant:	
Number of dependents:	
Marital Status:	
Race:	
Occupation:	

Appendix G: Non-disclosure form

Nelson Mandela Metropolitan University
for tomorrow

NELSON MANDELA METROPOLITAN UNIVERSITY

INFORMATION AND INFORMED CONSENT FORM

Title of the research project	***Mitigating effects of the Babies in Mind programme on maternal mental health and mother-infant attachment in a South African community.***
Reference number	207061582 (Student number)
Principal investigator	Samantha Naicker
Contact telephone number (private numbers not advisable)	073 696 3505

	Initial
1. AGREEMENT TO NON-DISCLOSURE	
I understand that the content being discussed during group sessions are confidential and I will not disclose any information outside the group setting.	
Signed/confirmed at on 20 Signature of participant Signature of witness Full name of witness	

Appendix H: Information letter to participants

SOUTH CAMPUS
FACULTY OF HEALTH SCIENCES / DEPARTMENT OF PSYCHOLOGY
Tel . +27 (0)41 504-2354 Fax. +27 (0)41 504-2101

2017

To whom it may concern

RE: Participation in a Doctoral Study

I would like to take this opportunity to introduce myself to you and to thank you for your interest in participating in my research study.

I'm currently a practicing psychologist in Port Elizabeth, doing my doctoral studies through the psychology department at NMMU. In order to complete a doctorate, I am required to conduct a research study which will eventually contribute to the scientific body of knowledge in the field of psychology.

I am currently conducting a study on the mitigating effects of the Babies in Mind programme on maternal mental health and mother-infant attachment. The Babies in Mind programme was developed in 2012 by a clinical psychologist, Jenny Perkel, in Cape Town. The programme consists of a 10 week course which covers various topics relating to the experience of

parenting an infant in the first 12 months of its life, e.g. feeding, sleeping, crying, attachment, the role of the father etc. The programme is group based and designed to be informal, interactive, and informative to cater for mothers with infants. **The ultimate aim of the programme is to enhance maternal mental health, prevent maternal ill-health (most especially postnatal depression) and foster mother-infant attachment.**

My data collection process will involve conducting the Babies in Mind programme with groups of mothers with infants. Each group meeting will be approximately an hour to two hours long. The meetings will be conducted at a clinic in your area.

I would like to inform you that the focus group session at the end will be voice recorded, however, confidentiality will be maintained throughout the session and the entire research process. Please note that participation is completely voluntary therefore, if you prefer not to participate, that is absolutely fine.

If there are any questions or concerns regarding the research study, please feel free to email me at any time: naicker.psychologist@gmail.com.

I do hope that you will be interested in participating in my study. If so, you are welcome to email me at the above address or contact me on: 0736963505. A register will also be available at the Early Inspiration reception area, should you like to sign up for participation.

Kind regards

Samantha Naicker

Appendix I: Attendance certificate for participants

CERTIFICATE OF ATTENDANCE

This certificate is awarded to:

Name of Participant

For attending the Babies in Mind programme

Facilitator: Samantha Naicker

Date

Appendix J: Focus group semi-structure questionnaire

Question 1: In what ways have the Babies in Mind programme been beneficial to you?

Question 2: (a) What was the highlight of participating in the programme?

(b) What topic was most helpful?

Question 3: (a) What was the lowlight of the programme?

(b) What topic was the least helpful?

Question 4: What aspect of the programme was challenging or thought-provoking?

Question 5: How has your mood and well-being been impacted (positively or negatively) since you have been through the programme?

Question 6: How has the programme impacted (positively or negatively) your relationship with your baby?