The experience of postpartum distress in the transition to motherhood: A study of one group of low-income mothers in South Africa

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Abstract

The aim of this study was to explore a group of low-income South African mothers' experience of maternal distress during the transition to motherhood. Research on mental illness in motherhood has largely focused on investigating the aetiology, prevalence rates and implications of thereof within a positivist framework. There is a dearth of studies in South Africa that has examined the lived experiences of maternal distress despite the need for a thorough and rigorous investigation of these issues from the perspective of the individual. This is especially important in South Africa, where understanding of the lived experiences of maternal distress is the first step in conceptualizing a more efficient approach to identifying and addressing postpartum distress in the resource-restricted, overburdened South African healthcare system.

The present study used data from a larger research project entitled the Women's Mental Health Research Project (WMHRP). The sample comprised of 11 low-income mothers who can be characterized as suffering from postpartum depression (given their scores on self-report measures). The longitudinal dimensions of the study enabled narrative trajectories to be collected and strategic construction and presentation of narratives to be explored. A grounded theory approach guided this study in which data was collected from interview transcriptions that were collected during the parent study. Data analysis followed the principles outlined by the social constructionist grounded theory methodology including the constant comparative method and a sequential process of open, axial, and selective coding of the data. Throughout the duration of the study, specific processes were carried out to ensure trustworthiness of the research findings.

A social constructionist epistemological analytic approach, aligned with a feminist theoretical lens was used to analyse the findings. Seven superordinate categories emerged from the interviews: the mothers, the expectations and reality of motherhood, caregiving overload, dysfunctional interpersonal relationships, mothering in poverty, the physical body and motherhood and silencing of the self. These categories demonstrate how unprepared for motherhood the women were and how their expectations were based on the dominant ideology of motherhood. Overwhelmed, fatigued, ambivalent and unable to make sense of their experiences, the women continued to suffer in silence in a context of depleting resources and the loss of their former life, wellbeing and sense of self.

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This study has demonstrated that the experience of maternal distress is deeply embedded in the cultural context within which it occurs. The ways in which women make sense of their experience has been created and sustained through powerful institutions that serve to pathologize women who do not adhere to the dominant ideology of motherhood. These findings are supported by the broader literature on maternal distress. However, this study adds to the literature by identifying motherhood as a gendered practice situated within a powerful and normative ideology of gender inequality and poverty within a particular context. As such poverty, gender inequality and the ideology of motherhood are interrelated, mutually supporting systems of domination and their relationship is essential to understanding the distress experienced during the transition to motherhood.

The theoretical and practical implications of the results are discussed with consideration of the study's limitations. Recommendations for future research are also indicated.

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Opsomming

Die doel van hierdie studie was om 'n groep lae-inkomste Suid-Afrikaanse ma's se emosionele ervaring van nageboortelike nood te verken. Navorsing oor nageboortelike depressie het tot dusver meestal gefokus op die ondersoek na die etiologie, omskakelingskoers en implikasies van nageboortelike nood binne 'n positivistiese raamwerk. Daar is 'n gebrek aan studies wat die ondervindinge van nageboortelike nood ondersoek het ten spyte van die behoefte aan 'n deeglike en nougesette ondersoek van hierdie kwessies vanuit die perspektief van die individu. Dit is veral belangrik in Suid-Afrika, waar begrip van die gelewe ervarings van nageboortelike nood die eerste stap is in die konseptualisering van 'n meer doeltreffende benadering tot die identifisering en bekamping van nageboortelike nood in die hulpbron-beperkte, oorbelaste Suid-Afrikaanse gesondheidsorgstelsel.

Die huidige studie maak gebruik van data uit 'n groter navorsingsprojek getiteld die *Women's Mental Health Research Project* (WMHRP). Die steekproef het uit 11 lae-inkomste moeders bestaan wat kan gekenmerk word as lyers aan nageboortelike depressie (gegewe hul tellings op self-verslag maatreëls). 'n Gegronde teorie benadering lei hierdie studie. Data is ingesamel en transkripsies van die onderhoude wat vir die groter studie gemaak is, is saamgestel. Data-analise het gebruik gemaak van die beginsels soos uiteengesit deur die sosiale konstruksionistiese gegronde teorie, insluitend die konstante vergelykende metode en 'n opeenvolgende proses van oop, aksiale en selektiewe data-kodering. Gedurende die verloop van die studie is spesifieke prosesse uitgevoer ten einde die betroubaarheid van die navorsingsresultate te verseker.

'n Sosiale konstruksionistiese epistemologiese analitiese benadering, in ooreenstemming met feministiese teorie is gebruik om die bevindings te analiseer. Sewe oorkoepelende kategorieë het na vore gekom uit die onderhoude: die moeders, die verwagtinge en realiteit van moederskap, versorging oorlaai, disfunksionele interpersoonlike verhoudings, moederskap in armoede, die fisiese liggaam en moederskapen en die swye van die self. Hierdie kategorieë demonstreer hoe onvoorbereid die vroue vir moederskap was en hoe hulle verwagtinge gebaseer is op die dominante ideologieë van moederskap. Die vroue gaan voort om te ly in stilte terwyl hulle oorweldig, moeg, ambivalent en nie in staat om sin

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te maak van hul ervarings nie in 'n konteks waar daar ’n tekort aan hulpbronne is en hulle nog die verlies van hul vorige lewe, welsyn en sin van die self ervaar.

Hierdie studie het getoon dat die ervaring van nageboortelike nood gesetel is in die kulturele konteks waarbinne dit plaasvind. Die maniere waarop vroue sin maak van hul ervaring is geskep en in stand gehou deur kragtige instellings wat dien om vroue wat nie voldoen aan die dominante ideologie van moederskap nie te patologiseer. Hierdie bevindinge word ondersteun deur die breër literatuur oor moederlike nood. Hierdie studie voeg egter by die literatuur aan deur moederskap te identifiseer as 'n gendered-praktyk wat binne 'n bepaalde konteks van kragtige normatiewe ideologie van ongelykheid en armoede geleë is. As sulks, is armoede, gender en die ideologie van moederskap interafhanklik van mekaar. Wedersydse ondersteunende stelsels van oorheersing en hul verhouding is noodsaaklik om ’m begrip van die nood wat ervaar word gedurende die oorgang na moederskap tot stand te bring.

Die teoretiese en praktiese implikasies van die resultate word met inagneming van die studie se tekortkominge bespreek. Aanbevelings vir toekomstige navorsing word ook gemaak.

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Dedication

In loving memory of Suné McCallaghan. You believed in me when I did not believe in myself and saw all the good in me when I could not. Thank you.

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Table of contents

Plagiarism declaration....i
Abstract....ii
Opsomming....iv
Acknowledgements....vi
Dedication....vii
Table of contents.... viii
List of Tables xii
Chapter one: Introduction 1
1.1 Significance of research topic as an area of study 3
1.2 Purpose and rationale....4
1.3 Research questions, aims, and goals 5
1.4 Outline of thesis 6
Chapter two: Theoretical framework....7
2.1 Social constructionism....7
2.2 Feminist theory 8
2.3 Feminist social constructionism....10
2.3.2 Feminist social constructionism and the good mother ideology....11
2.3.3. The good mother ideology and maternal distress. 12
2.3.4. Feminist social constructionism and the good mother ideology in South Africa..12
2.4. Conclusion 13
Chapter three: Literature review 14
3.1 Delineation of the psychiatry of maternal distress....14
3.1.1 Diagnostic categories of maternal distress....14
3.1.1.1 Postpartum blues....15
3.1.1.2 Puerperal psychosis....15
3.1.1.3 Postpartum depression 16
3.1.1.3.1 Onset....16
3.1.1.3.2 Prevalence. 17
3.1.1.3.3 Presentation. 17
3.1.1.3.4 Impact....17
3.1.1.3.5 Aetiology....19

Stellenbosch University https://scholar.sun.ac.za

3.1.2 Towards a broader understanding of maternal distress..20
3.1.3 Summary. 21
3.2 The lived experience of maternal distress 21
3.2.1 The transition to motherhood. 22
3.2.2 The experience of loss in the transition to motherhood. 24
3.2.3 The discrepancy between expectations and reality. 27
3.2.4 Social support...29
3.2.5 The experience of maternal distress in low-income women.................................31
3.2.6 The experience of maternal distress in South Africa 32
3.2.7 Ideology and maternal distress..36
3.2.8 Summary. 38
3.3 Conclusion 39
Chapter four: Methodology...40
4.1 Parent study..40
4.2 Current study...40
4.3 Research design 41
4.4 Research context 43
4.5 Procedure 44
4.6 Recruitment...44
4.6.1 Measures. 45
4.6.1.1 Edinburg Postnatal Depression Scale. 45
4.6.1.2 Beck's Depression Inventory. 46
4.7 Participants..47
4.8 Data collection 48
4.9 Data management...48
4.10 Data analysis 49
4.11 Reliability and validity...50
4.11.1 Sensitivity to context...50
4.11.2 Commitment and rigor 51
4.11.3 Coherence and transparency. 51
4.11.4 Impact and importance...51
4.12 Research and reflexivity 51
4.13 Ethical Considerations 53

Stellenbosch University https://scholar.sun.ac.za

4.13 Conclusion ...54
Chapter five: Results and discussion ...55
5.1 The mothers ...57
5.1.1 Alice. ...57
5.1.2 Elize. ...58
5.1.3 Bernadette. ...58
5.1.4 Suzanne. ...59
5.1.5 Wilmien. ...59
5.1.6 Nina. ...60
5.1.7 Sam. ...60
5.1.8 Millicent. ...61
5.1.9 Pienkie. ...61
5.1.10 Blondie. ...62
5.1.11 Robena. ...62
5.1.12 Summary. ...63
5.2 The expectations and the reality of motherhood ...63
5.2.1 Infant care. ...64
5.2.2 Adjusting to the realities of motherhood ...66
5.2.3 Overwhelming responsibility. ...67
5.2.4 Summary. ...69
5.3 Caregiving overload ...70
5.3.1 Role strain. ...71
5.3.2 The loneliness of motherhood. ...75
5.3.3 Summary. ...77
5.4 Dysfunctional interpersonal relationships ...77
5.4.1 Betrayal and infidelity ...77
5.4.2 Intimate partner violence. ...80
5.4.3 Summary. ...81
5.5 Mothering in poverty ...82
5.5.1 Summary. ...83
5.6 The physical body and motherhood ...84
5.6.1 Birth-related distress. ...84
5.6.2 Breastfeeding. ...87

Stellenbosch University https://scholar.sun.ac.za

5.6.3 The postpartum body. 89
5.6.4 Summary. 91
5.7 The silencing of the self 91
5.7.1. Summary. 94
5.8 Conclusion 94
Chapter six: Conclusion 96
6.1 Aim and Objectives of the Study 96
6.2 Summary of findings 97
6.2.1 The participant's stories. 97
6.2.2 The expectations and reality of motherhood. 97
6.2.3 Caregiving overload. 98
6.2.4 Dysfunctional interpersonal relationships 99
6.2.5 Mothering in poverty. 100
6.2.6 The physical body and motherhood. 100
6.2.7 The silencing of the self. 102
6.2.8 Conclusion. 102
6.3 Limitations 103
6.3.1 Implications for future research in recognition of limitations. 104
6.3.2 Implications for future research in recognition of the findings of this study. 104
6.4 Implications for practice and policy 105
6.5 Concluding thoughts 106
References 108
Appendix A 149
Appendix B 152
Appendix C 156
Appendix D 158
Appendix E 167

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List of Tables

Table 1: Demographic Information of Participants……………………………………………49

Table 2: Outline of Categories and Subcategories……………………………………………56

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Chapter one: Introduction

"The mask of motherhood is what mutes our rage into murmurs, and softens our sorrow into resignation." (Maushart, 1999, p3)

Maternal mental health disorders are internationally recognized as an important public health concern (Sawyer, Ayers, & Smith, 2010; Ramchandani, Richter, Stein, & Norris, 2009). The high burden of disease associated with maternal mental health disorders is well documented throughout the world (Wachs, Black, & Engle, 2009). Current data suggest that the prevalence rate of postpartum distress in South Africa is higher than other global estimates, with isolated studies on postpartum depression providing an estimated rate between 16.4% and 39% (Cooper et al., 1999; Hartley et al., 2010, 2011; Honikman, van Heyningen, Baron, & Tomlinson, 2012).

Untreated maternal distress is associated with a range of adverse developmental, emotional and cognitive consequences. In low and middle-income countries the impact of maternal distress extends beyond developmental delays to adversarial health outcomes in young children (World Health Organisation, 2007). While child and maternal health are a top public health priority of the South African Department of Health and despite mounting evidence of the impact of maternal mental health on children and women, the focus remains on the prevention of infant mortality (Kathree, Selohilwe, Banda, & Petersen, 2014). As a result, maternal health care emphasizes physical health rather than psychological health. Consequently, maternal distress is frequently overlooked and underdiagnosed in the South African context (Manikkam & Burns, 2012).

This may be because the conceptualization of maternal distress focuses on a biomedical model, relying heavily on a medicalized understanding of distress resulting from a chemical imbalance and predetermined risk factors. In the context of motherhood, this view denies the significant impact of the psychological and social determinants embedded in the cultural, economic and political context within which motherhood is inevitably situated. Furthermore, it has been argued that the labels used in the psychiatric nomenclature oppose the constructions informed by women's lived experience of distress (Johnstone & Dallos, 2013). This is especially important as women's lived experiences of distress have been demonstrated as useful in the understanding of experiences of distress, and in informing

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assessment as well as successful treatment. Consequently, the term 'maternal distress' will be used throughout this thesis. This term refers to anxiety, depressed mood, and perceived distress during the postpartum through both diagnostic criteria of maternal mental health disorders and through self-reported accounts of women.

A growing body of research conducted within a feminist framework suggests that maternal distress is of socially constructed cultural variations, related to the ideological mainstream and unquestioned assumptions about motherhood and womanhood (Ambrosini & Stanghellini, 2012). Based on indications in the literature that suggest that these factors may be obscured under the objective value-free positivist medicalized approach to women's reproductive health (Kruger, Van der Straaten, Taylor, Dukas, & Lourens, 2014), it is likely that a similar set of macro structural factors could be operating under the experiences of maternal distress for low-income women in South Africa (Kathree et al., 2014).

There is a concern that despite feminist research making ground in the researching of the experiences of women, Western researchers are still unclear on the experiences of women in other contexts (Lafrance & McKenzie-Mohr, 2013; Ussher, 2010). Some research in South Africa has attempted to explore South African mothers'experience from their perspectives (e.g. Dale, 2012; Frizelle & Kell, 2010; Mamabolo, 2009; Mjwara & Maharaj, 2017; Ngabaza, 2010; van Doorene, 2009), however, research on the experiences of distress in motherhood in the South African context is still limited (Kruger, 2006), particularly in the context of low-income South African women (Macleod, 2006; Pillay & Kriel, 2006). Furthermore, motherhood in South Africa is located within a unique socio-political history, which is characterised by race, culture, class and socio-economic status which has a marked impact on the experience of mothering (Kruger, 2006; Mamabolo, 2009; Ngabaza, 2010). As such, one cannot homogenise the experience of motherhood or maternal distress as different factors will play different roles in shaping discourses, understandings, and experiences of motherhood and maternal distress in different contexts within South Africa. In light of this, this study aims to explore how one group of Coloured[1] women, subjectively understand and experience their emotional distress in their transition to motherhood.

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[1] I am mindful of the fact that the use of racial categories in South African scholarship is controversial (Swartz et al., 2002). However, these categories are socially constructed and carry important social meanings. As such, I believe that it is impossible to conduct a meaningful analysis of this study's findings within the context of post-apartheid South Africa without making reference to previous racial classifications, since these still inform

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1.1 Significance of research topic as an area of study

A number of key issues pertaining to distress during the postpartum period require delineation to ensure efficacious preventive and treatment interventions. These issues are outlined below. This is done with the intention of situating the current study in the context of previous research studies.

Firstly, epidemiological research highlights the exceedingly high prevalence rates of postpartum depression in South Africa (Cooper et al., 2009; Madu & Roos, 2006). Low-income Coloured and African South African women have been identified as more likely to develop mental illnesses (Pillay & Kriel, 2006; Stein et al., 2008). In conjunction with high rates of poverty, insufficient access to health care and a low quality of care (Jewkes, Dunkle, Nduna, & Shai, 2010; Brandt, 2009; Van Zyl, 2014), the outcomes associated with maternal distress are increasing substantially for these population groups.

Secondly, numerous scholars have been critical of the existing classification of maternal distress, questioning the significance of diagnostic categories such as postpartum depression. Thus, the complexity of maternal distress is veiled by the bio-medically centered conceptualization of distress in the puerperium (Emmanuel & St John, 2010). In other words, existing psychiatric classifications yield an incomplete picture of psychiatric distress in the transition to motherhood (Csatordai et al., 2009; Matthey, 2010; Matthey & Ross-Hamid, 2011), thus hindering further inquiry into the diversified and multidimensional nature of this experience.

Thirdly, research on maternal distress focuses predominantly on clinically significant postnatal depression. Several studies have indicated that the focus on postpartum depression within the psychiatric nomenclature and research literature may be overly narrow (see for instance Sharma & Sharma, 2012; Matthey, Fisher, & Rowe, 2013). Based on this assumption, current assessment practices and research literature may minimise the experiences of mothers who do not meet the diagnostic criteria for postnatal depression but consider themselves distressed. Accordingly, it has been recognized that a large percentage of women experience milder symptoms of depression, anxiety and/or distress during the

existing power relations. In this paper the category of ‘‘Coloured’’ will be used to refer to South Africans said to be of diverse and mixed racial origins; designated under apartheid racial classification as ‘‘Coloured’

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postnatal period (Miller, Pallant, & Negri, 2006; Brockington, Macdonald, & Wainscott, 2006; Kohlhoff, Sharpe, Matthey, & Charles, 2009). In order to encapsulate a broader experience of distress in the transition to motherhood, it has been suggested that the term maternal distress is used (Rowe, Fisher, & Loh, 2008).

Lastly, as far as the researcher can ascertain, studies exploring the emotional experience of postpartum distress in the South African context are limited. The research literature suggests that the experience of motherhood is impacted upon by race, class, and culture (Duong, Lee, & Binns, 2005; Kruger, 2006). However, the literature focuses primarily on middle class, (mostly) white South African women, with very little attention being given to cultural and structural diversity (Van Doorene, 2009). Thus there is a need to understand how maternal distress is experienced or understood within low income, working class contexts (Dukas & Kruger, 2016).

1.2 Purpose and rationale

On the basis of the previous discussion, this study sets out to broaden the understanding of low-income women's experiences of maternal distress within a specific context in South Africa. It is built on the assumption that the current conceptualisation of distress does not fully capture low-income South African women's experiences of maternal distress. Furthermore, it takes into consideration the moderating role of the cultural context on women's mental health. Such research is sorely needed in order to establish a relevant conceptualization of maternal distress that will provide a foundation for the identification, management, and treatment of distress in the transition to motherhood.

Delineation of women's experiences of maternal distress in the South African context is therefore warranted for the following reasons: (1) existing research suggests that the complexity and multidimensionality of psychological distress during the transition to motherhood is not yet understood; (2) studies exploring the emotional experience of postpartum distress in the South African context are limited; and (3) it will be beneficial for the early identification, more efficacious management and treatment of maternal distress in South Africa, especially in light of the high prevalence rates of postpartum depression in this context.

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1.3 Research questions, aims, and goals

In an effort to capture the broader experience of maternal distress, this study focuses on the experiences of women who can be characterized as suffering from postpartum depression (given their scores on self-report measures). Based on the prevalence rates it seems that suitable provision for prevention has been made, yet under-recognition in the healthcare setting indicates ideological barriers to the recognition of maternal distress in this context.

I chose feminist social constructionism as an analytical lens, whereby the experiences that participants reported can be analysed not only as individual experiences but also in relation to the social and political contexts in which they occur (Stoppard, 2000). This research, therefore, seeks to identify and explore the experiences of one group of low-income Coloured women in order to identify the cultural milieu and ideologies that may shape their experience of maternal distress.

In more concrete terms, this study's first aim is to describe the experience of maternal distress from the perspective of one group of low-income women in South Africa. The second aim of this study is to locate the women's experience within the social context it is told. The goal is to give a voice to women who may not have had the opportunity to share their stories and, in doing so, construct additional perspectives of motherhood in the South African context. It is hoped that this study will contribute to the body of literature on this topic in South Africa and to stimulate further research in this particular area.

The research questions that guide this study are outlined below:

- How does one group of low-income South African women who can be characterized as suffering from postpartum depression (given their scores on self-report measures) subjectively experience and describe their distress?
- What contextual factors are identified by the women as pertinent in shaping their experiences of motherhood and maternal distress?

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1.4 Outline of thesis

Chapter 1 introduces the current study. Specifically, the aim of Chapter 1 was to introduce the main topic of this thesis and situate it within the existing scientific literature. This is followed by the problem statement, rationale, research goals, and questions.

Following on Chapter 1, Chapter 2 provides the theoretical framework of the study. This entails a discussion on social constructionism as it is situated in a postmodern ontological orientation, followed by a discussion of feminism. After this, the feminist social constructionism paradigm is described and aligned with the study's overall goals.

Chapter 3 presents a systematic review of the literature. This review serves to outline a concise summation of the existing quantitative and qualitative research on maternal distress. Findings from this review highlighted the main gaps in the literature structured around methodological, theoretical and conceptual issues in the exploration of maternal distress in the South Africa context.

In Chapter 4, I describe the methodological process that guided this study. Information on the study's methodological positioning, design, participants, data collection, and analysis are discussed. Finally, ethical issues are being considered.

After a brief introduction to the study participants, a presentation and discussion of the data are given in Chapter 5. Specifically, the major themes that emerged from the raw data are described and then discussed in relation to the extant literature in the field. This work highlights the importance of recognizing social, cultural and personal factors in the understanding of psychological distress during the transition to motherhood.

In closing, Chapter 6 brings together the overall theoretical, methodological and practical contributions of this research. In doing so, it provides a brief summation of the study's findings. The limitations of the study are used as a basis for the recommendation of future research and interventions. Finally, I include my concluding thoughts regarding the findings of the study.

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Chapter two: Theoretical framework

This chapter provides an overview of the theoretical frameworks guiding this study. A social constructionist approach is utilized to describe the lived experience of maternal distress, whereas the feminist theoretical approach allows for a context of analysis in which we can understand this distress. This theoretical combination allows for the uncovering of the complexities involved in the experience of distress in the transition to motherhood.

2.1 Social constructionism

Social constructionism refers to the social construction of reality and is a conceptual framework that assesses the mutually constructed conceptualizations about the world. The basis for shared assumptions about reality arises from these conceptualizations. The theory centers around the notion that meanings of phenomena are not inherent in the phenomena themselves but develop in a social context through language and communication (Robles, 2012). There are three fundamental principles emphasized in social constructionism. Firstly, social constructionists reject the traditional positivistic approaches to knowledge and emphasize a relativistic approach to reality. Secondly, reality is largely constituted through linguistic conventions and cultural/historical contexts. Thirdly, categorizing social phenomena in this way restrains certain patterns while reinforcing others. A brief discussion of each tenant is provided below.

Rooted in a postmodernist epistemology, social constructionism adopts an anti-realist, relativist stance towards epistemology. Postmodernism arose out of the rejection of the homogenous and objectivist principles of modernism. Postmodernists, therefore, maintain that reality is socially constructed (Andrews, 2012). Knowledge is an expression of the values and beliefs of the context in which it was created. In a similar vein, social constructionists assert a relativistic view of reality (Van Kham, 2013). The emphasis is on how realities are constructed over time through social interaction (Andrews, 2012; Van Kham, 2013). Additionally, social constructionism focuses on how human interaction serves to construct, modify, and maintain the status quo set out by the context they live in. In other words, in challenging the scientific notion of positivism, social constructionism is an active and subjective approach of becoming involved in and trying to understand the ways in which different people make meaning of their lives in different contexts (Andrews, 2012).

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Social constructionist scholars maintain that the meaning ascribed to phenomena is constructed through language and communication (Galbin, 2014) within a cultural/historical milieu. Thus social constructionists also argue that our understanding of the world is historically and culturally specific. This is because of the means that we use to understand the world, through categories, are relative to a cultural or historical epoch. Furthermore, language provides a means for constructing these categories which enable ordering of the world. These categories' meanings are patterned according to cultural preferences and traditions. Social modification and negotiation can allow these categories to develop into dominant ways of understanding and being in the world, known as institutions or discourse (Willig, 2013). Hence, language acts as a vector in the construction of realities. From a social constructionist point of view, when people talk about their experiences, they are thought to present the various ways in which lived experiences are impacted upon by societal discourses, as well as the consequences for those who are affected by these discursive constructions (Willig, 2013).

Social constructionists are interested in discourses which are firmly entrenched in power structures and in turn influence identity. Members of a society are gradually indoctrinated into these dominant ways of being via social interactions. These dominant discourses pathologize those who fail to fit into the dominant belief system. For this reason, social constructionists focus on the lived experiences of individuals in their social contexts rather than on 'expert' knowledge.

As power differentials, culture, context, and language are acknowledged and highlighted in this perspective, it makes it very suitable for research in the diverse and complex South African context (Dukas, 2013; Kruger & Lourens, 2016; Kruger et al., 2014).

2.2 Feminist theory

A feminist lens was utilized to understand the theoretical field of motherhood and was furthermore applied in the methodology of this research project. Feminist theory is, therefore, an extension of feminism into a theoretical discourse. In essence, feminist researchers seek to challenge patriarchal systems, gender inequalities and the oppression of women (Shefer, 2008). Feminism explores how the cultural construction of gender can be utilized as a tool of oppression whereby patriarchal arrangements allow men personal, physical and institutional

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power (Mollard, 2015). Feminism extends further than a theoretical study and endeavors to challenge and change women's subordination to men in all domains.

Feminist researchers argue that while patriarchy is universal it may take on many different forms and be experienced differently by women in diverse social, cultural and political contexts (Tichenor et al., 2016). Feminism has sought to contextualize gender research by locating it within the political, socioeconomic and ideological context of women's lives. In doing so, feminist researchers decry the objective, value-free positivist approach to gender studies (Mollard, 2015).

A common emphasis in feminist research is to give voice to women who in the past have been silenced and to address women's lives and experiences in their own words, in order to create an understanding that's grounded in the actual lives and experiences the women use (DuBois, cited in Kitzinger, 2004). Feminist research has not only created a platform for women's voices to be heard but has also altered the ontology and epistemology of social research by problematizing taken-for-granted aspects of women's lives. Some feminist researchers embrace a more critical approach and advocate for social change, while others adopt an interpretive approach (Mollard, 2015).

Furthermore, the feminist theory postulates the importance of gender in societal processes (Walby, 2005). Gender asymmetry is the central issue in maintaining inequality according to feminist theorists (Hartsock, 2004; Hooks, 2004; Lorber, 2005). Gender asymmetry explains that women and matters associated with women are not only different from, but are also inferior to and of lesser value than men and matters associated with men. In psychiatry and medicine and in various psychological and social theories of family, work, sexuality, and deviance that draw upon those disciplines, women are seen as the 'other' and often inferior to the male ideal (Hearn, 2004).

Many theorists, whilst agreeing with gender asymmetry as one explanation of inequality, have also suggested that this intersects with race, class, age, sexuality, culture, able-bodiedness, able-mindedness and other. At the methodological level, feminism implies a commitment to gender as a focus of concern and to analytic approaches that reflect the concrete experiences of women. As such, feminist ideology is context-based, emphasizing the

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subjective and the lived experience of women as they appear in context (Van Loon & Kralik, 2005).

Underlying these commitments are certain core values of a broader scope; that the personal is political (Schuster, 2014); and that psychological suffering is linked to social, economic and political contexts (Evans, Kincade, Marbley, & Seem, 2005; Marecek & Gavey, 2013). Not only is the voice of the woman emphasized in feminist-based research, it is also put into the context of those who may continue to be unheard (Kralik, van Loon, & Watson, 2008).

Feminist researchers argue that mothering occurs in contexts where power disparities exist between men and women, between economic classes and racial groups. Hence motherhood cannot escape being an arena of political contest and feminist study (Tichenor et al., 2016). There has been a shift from research with a critical focus on theories and ideologies of motherhood to more recent research which has seen an emergence of more empirical data based on the experiences of mothers (Terry, 2014). Maternal understandings, experiences, and practices have been investigated, thereby expanding the focus of earlier literature on motherhood which emphasized mothering in relation to child outcomes (Terry, 2014).

A further divergence noted by Arendell (1999, 2000) is between research which aims to describe the breadth of motherhood and capture the universality of motherhood. Whereas other more particularistic approaches seek to account for diversity and variation, in particular, maternal practices and ideas, both models converge at a point of recognizing that motherhood is ideologically laden in a way that is “powerful, pervasive and persistent” (Arendell, 1999, p.2). In this context, motherhood is seen to be variable and dynamic rather than universal, static and reduced to biological determinants.

2.3 Feminist social constructionism

With regards to distress in the transition to motherhood, Ussher (2010, 2011) has noted that there are limitations to adopting either a feminist or social constructionist analysis. Social constructionists who position women’s distress as a discursive construct could overlook the material features of these experiences. In a similar vein, feminist theorists who

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completely dismiss medicalization may negate the fact that diagnoses can serve to validate to women distress, isolating desolation from 'the character of the sufferer' (Lafrance, 2007, p. 130). As such, adopting a feminist social constructionist standpoint, that acknowledges the interaction of discourse and the sociocultural context can be utilized to address this shortcoming (Ussher, 2010). A feminist social constructionist standpoint acknowledges the distress of women, yet conceptualizes it as a discursively constructed phenomenon within a specific cultural context.

Within the field of maternal distress, the emotional experience of mothering is context-specific and shaped by particular local discourses and ideologies (Kruger, 2003). Therefore social constructionist feminists argue that dominant discourses and ideologies in which motherhood are idealized, underlie the emotional distress of mothers and the diagnosis of mental illness in the transition to motherhood (Choi, Henshaw, Baker, & Tree, 2005).

2.3.2 Feminist social constructionism and the good mother ideology. Ideologies are recursive patterns, ideas, opinions and values that create meaning. As such, ideologies form the common sense or the taken-for-granted set of assumptions that people use to make sense of their reality (Althusser, 1976). Thus, ideologies define what exists, what is good, and what is possible. However, ideology also acts at the level of the individual where it influences choices, behaviour, attitudes, and emotions (Homer-Dixon et al., 2013).

Applied to motherhood, ideology describes the norms, beliefs, and values that determine the dominant societal understanding of what constitutes good mothering (Kruger, 2006). Furthermore, ideologies and practices of motherhood are inextricably intertwined in the lived experience of motherhood and are furthermore shaped by the context in which women mother. As such, the influence of these contexts can have a positive or negative effect on how the transition process occurs and is experienced (Choi et al., 2005).

The "good" woman and the "good" mother have been conceptualized within a cultural message whereby women are expected to prioritize relationships, relinquishing their own needs for the sake of others in a selfless and self-sacrificing way (Lafrance & Stoppard, 2006; Mauthner, 2010). The good mother is expected to have a quick, planned and timely conception (Benzies et al., 2006), to have a positive, healthy and glowing pregnancy (Staneva & Wittkowski, 2012), unproblematic birth (Chadwick & Foster, 2014), and a very easy

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adjustment to the maternal role and life with a new born baby (Staneva & Wittkowski, 2012). The good mother myth consists of an all giving and nurturing mother, who is by nature capable of knowing everything necessary to raise happy and well-adjusted children (Caplan, 2013).

2.3.3. The good mother ideology and maternal distress. The good mothering ideology involves a process that requires mothers to negotiate an identity within two opposing discourses (Goodwin & Huppatz, 2010). On the one side, mothers are expected to mother in an entirely and selflessly devoted manner. On the other hand, mothers are living within social structures that operate and benefit a highly individualistic approach. Such normative discourse has been argued to be unattainable to women (O'Reilly, 2004). Setting up unrealistic standards and imposing expectations on modern mothers ultimately result in distress (Badinter, 2012).

Duncan (2005) maintains that cultural ideologies of motherhood, including historical and social contexts, intersect with more material factors, such as relationship statuses. For instance, Byrne (2006) claims that the intersection of race, class, and gender lies at the core of motherhood, with white middle-class, married, women often functioning as a norm of motherhood. Consequently, working class single mothers are typically marginalised. Thus the intersection between ideology and historical or social contexts influences the mother's experience of the transition to motherhood and ultimately her maternal mental health.

Given the pervasiveness of such cultural messages, any experience differing from the good mother descriptions would result in difficulties. The essential femininity, where motherhood exemplifies womanhood, makes articulating the negative thoughts and feeling which is frequently experienced by mothers, difficult (Thurton, 2008). A woman may silence her feelings, in order to conform to the idealized notions of motherhood, and in doing so, forego being perceived as a failure. Rather than asking for support or help, women put on a mask of competence and fulfillment (Ussher, 2006). By remaining silent about unexpected feelings and difficulties of motherhood which do not match expectations of idealized motherhood, mothers perpetuate the ideology of motherhood (Miller, 2005)

2.3.4. Feminist social constructionism and the good mother ideology in South Africa. Although feminist social constructionism offers an alternative to the instrumental

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view of mothers, feminist social constructionist ideologies may "remove women from individual experiences instead of illuminating them" (Kruger, 2006, p.193). Mothering in South Africa is positioned within a unique socio-political history. As such, the constructions of South African mothers differ along the socioeconomic, racial and cultural conditions in which women live (Arnfred, 2003). Access to material resources, adequate child care, and health care is racially stratified and inequality is evident (Shefer & Ratele, 2006). Kruger (2006) suggested that how women experience motherhood and what mediates this experience should constantly be explored, rather than attempting to generate a monolithic ideology that reduces the diverse and unique experiences of mothers. Accordingly, not all mothers' experiences are the same. Women all have unique narratives and the stories of mothers differ: motherhood is a heterogeneous experience rather than a universal, homogeneous one. As such, it is important to look at how the good mothering ideology manifests itself within the South African context for different groups specifically.

As this study aims to explore women's emotional experiences of maternal distress as they are embedded within their sociocultural, political and economic contexts, the social constructionist feminist orientation is deemed suitable for the purposes of this research.

2.4. Conclusion

The aim of this chapter was to highlight the central theoretical tenets that informed the current study's design, execution, and presentation of results. As such, the theoretical principles of social constructionism were presented first, which was followed by feminist theory. Thereafter the merit of using the combined approach of social constructionist feminism was discussed. Based on the argument presented by Ussher (2010), it was maintained that that feminist social constructionism is especially useful when investigating the experience of maternal distress. More, specifically, feminist social constructionism is employed, as these perspectives give credence to women's experiences of maternal distress within their specific cultural and political contexts, which is important in the South African context. Before investigating the experiences of maternal distress it is helpful to outline the relevant research on maternal distress. As such, the following chapter will provide an overview of two bodies of literature concerned with maternal distress.

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Chapter three: Literature review

This thesis, in essence, aims to explore the experience of maternal distress in the transition to motherhood in one group of low-income women. This is with the intention of identifying the socio-cultural milieu in which this distress is situated. As such, the institutional practices that have a hand in shaping this distress will be considered in the context of the experiences of maternal distress (McNay, 2009).

Firstly, the bio-medicalization of maternal mental illnesses, with a bigger focus on the medical understanding of postpartum depression will be discussed. The following section begins by depicting the theoretical considerations of childbirth and adaptation to motherhood. This is followed by an overview of the political, social and cultural discourses in which women's maternity experiences occur. An overview of such literature provides a contextual background with regard to the experience of distress in motherhood, which underpins the study as a whole. Although there is a dearth of research on maternal distress in the South African context, a discussion on the theoretical and empirical research on maternal distress in the South African context is provided.

3.1 Delineation of the psychiatry of maternal distress

A vast amount of research within the biomedical approach has sought to ascertain the biological significance of maternal distress in seeking to delineate the etiology, incidence, and prevalence of this phenomenon. The following sections outline the characteristics, implications, and explanations of reproductive mental illnesses as identified by the biomedical research literature. It is necessary to first analyze the dominant literature on maternal distress before attempting to bring alternative understandings into focus. As such, it is hoped that by elucidating how distress is constructed within the dominant biomedical paradigm, the implications for how academics, researchers, health professionals, gatekeepers, and women conceptualize this phenomenon, can be brought to the fore.

3.1.1 Diagnostic categories of maternal distress. There has been increased awareness that women may experience emotional distress in the transition to motherhood, which may be manifested in different ways. Three types of maternal mood disturbances are recognized in the psychiatric nomenclature: postpartum blues or "baby blues", postpartum

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depression and postpartum psychosis. Generally, these disorders are bifurcated into conceptually distinct conditions according to the onset timeframe, severity of symptoms, prevalence, clinical presentation, and clinical course (Robertson, Grace, Wallington, & Stewart, 2004). In this section, I provide an overview of postpartum psychiatric illness as it is classified in the psychiatric taxonomy. Due to the limited scope of this thesis and the high prevalence rates of depression in the transition to motherhood, I will focus specifically on postpartum depression. In addition, I discuss arguments in favour of a broader conceptualization of postpartum distress.

3.1.1.1 Postpartum blues. Postpartum blues (baby blues or maternity blues) is a mild condition characterized by a transient state of affective instability. Symptoms include emotional reactivity, tearfulness, irritability, anxiety, forgetfulness, and confusion. Postpartum blues are characterized by an acute onset and short duration of symptoms, that occur within the first 2 weeks following childbirth, often corresponding with the onset of lactation (American Psychiatric Association, 2013). The majority of women recover within 10 to 14 days without professional intervention.

Puerperal blues are considered to be fairly common, with an estimated prevalence rate of 50%-85% (O'Hara & Segre, 2008). These symptoms do not result in severe distress or an impairment of functioning and are attributed to hormonal changes following childbirth (Groer & Morgan, 2007). The inclination to develop postpartum blues is not related to the psychiatric history, the cultural context, environmental stressors, or parity of the mother (Rai, Pathak, & Sharma, 2015). However, these factors may influence whether postpartum blues develop into major depression (Henshaw, Foreman, & Cox, 2009). Research shows that up to 20% of women with puerperal blues develop postpartum depression (Muzik & Borovska, 2010).

3.1.1.2 Puerperal psychosis. In contrast to "baby blues", puerperal psychosis is the most severe form of maternal mental illnesses. It is comparatively rare with an estimated prevalence rate of 1/2 in every 1000 deliveries (0.1% – 0.2%) (Munk-Olsen, Laursen, Pederson, Mors, & Mortensen, 2006; Spinelli, 2009). It is characterized by an abrupt onset of manic or psychotic symptoms presenting within the first 3 weeks following childbirth (Blackmore et al., 2006; Heron, Robertson Blackmore, McGuinness, Craddock, & Jones, 2007; Munk-Olsen et al., 2006). Symptoms include insomnia, restlessness, mania, and

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affective instability. This is followed by acute delusions, mood swings, obsessive thoughts, and disorganized thinking and behavior (American Psychiatric Association, 2013). In addition, puerperal psychosis is associated with an increased risk of suicide and infanticide (Clay & Seeshusen, 2004; Spinelli, 2009).

3.1.1.3 Postpartum depression. Postpartum depression is considered to be an affective disorder similar to Major Depressive Disorder (MDD). Postnatal depression is not classified as a discrete entity in the psychiatric nomenclature; instead, it is classified as a subset of major depressive disorder. Postpartum depression is thus differentiated from major depression primarily by the timing of the onset of symptoms. The DSM-5 includes an onset specifier which classifies major depression within four weeks following delivery as postpartum depression (American Psychiatric Association, 2013). The ICD-10 (International classification of diseases and related health problems) extends this window to six weeks following childbirth (World Health Organization, 2007).

3.1.1.3.1 Onset. A discrepancy exists in the onset timeframe put forward by the psychiatric taxonomy and the onset time frame described in the literature. The current diagnostic criterion for postpartum depression excludes women who become depressed after the 4 week timeframe (Halbreich, 2005; Hanley, 2009; American Psychiatric Association, 2013). Current research in this area, however, suggest that depressive symptoms may occur up to 6 months postpartum (Austin et al., 2010; Kornstein, 2010) with the highest prevalence of new cases arising around 9 months postpartum (Gjerdingen, Crow, McGovern, Milner, & Center, 2011; Lobato, Moraes, Dias, & Reichenheim, 2011). Other studies have indicated that depressive symptoms may remain up to 6 years following delivery (Chaudron et al., 2010; Hewitt & Gilbody, 2009; Muñoz et al., 2006,).

For this reason, many researchers and clinicians argue for a wider scope of postpartum depression symptoms and onset specifier to be adopted (Godderis, 2013). The argument states that the intricate social, psychological and physiological changes occurring in the postpartum period should be acknowledged (Boland-Prom & MacMullen, 2012). Furthermore, others purvey that widening the scope of the postpartum depression diagnosis should include an expansion of the onset period to somewhere between 6 months to one year postpartum; a working definition already in use in postpartum distress research (Trillingsgaard, Elklit, Shevlin, & Maimburg, 2011).

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3.1.1.3.2 Prevalence. The combined prevalence of postpartum depression is estimated to be between 5% and 25% (Gavin et al., 2005; Lanes, Kuk, & Tamim, 2011; Leung, Martinson, & Arthur, 2005). However, prevalence estimates for postpartum depression vary substantially due to the lack of clearly demarcated diagnostic criteria, including different definitions and onset time frames, as well as the use of diverse measurement instruments and sampling procedures (Halbreich, 2005), although some commonalities are evident.

No current prevalence rates of maternal depression exist in South Africa. This is because research is predisposed towards white middle-class women. However, isolated studies have provided estimated prevalence rates of postpartum depression ranging from 16.4% to 39% (Cooper et al., 1999).

3.1.1.3.3 Presentation. Like major depressive disorder, the diagnostic criteria for postpartum depression include anhedonia or a depressed mood occurring for at least two weeks. It is also characterized by symptoms of sleep disturbances; psychomotor and appetite disturbances; fatigue; excessive guilt; diminished concentration and suicidal thoughts occurring for at least 1 week, resulting in an impairment of functioning (American Psychiatric Association, 2013). Evidence from clinical and epidemiological studies suggests that affective illnesses during the reproductive period are not significantly different from mood disturbances that occur in other stages of women's lives (Bernstein et al., 2008).

Symptoms associated with depression are however not necessarily the most prominent indicator of postpartum depression (Lewis, Merry, Stewart, & Gagnon, 2016). Burgeoning literature illustrates the diversity of symptoms associated with maternal distress (Venis & McClosky, 2007). These symptoms may include feelings of inadequacy; severe anxiety; thoughts of harming their infants; tearfulness; obsessive symptoms; feelings of abandonment; and unexplained mood swings (Bennett & Indman, 2005; Røseth, Binder, & Malt, 2011). Symptoms such as these are often disregarded or ignored (Chaudron et al., 2005).

3.1.1.3.4 Impact. The impact of antenatal and postnatal depression is a significant public health concern. If not treated, this disorder can have adverse long-term effects for both the mother and the child. Evidence has shown that depression related to childbearing not only has a negative impact on maternal–infant interaction during the first year of the child's life

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but also may have long-term effects on children, as well as on the mothers themselves (Field, 2010; Parsons, Young, Rochat, Kringelbach, & Stein, 2012).

Postpartum depression may comprise the mother's capacity to provide secure infant attachment which may compromise the psychological development of the infant (Milgrom & Holt, 2014). This may be especially true in adverse conditions and is a pressing concern for low- and middle-income countries. Nevertheless, some studies did look into the emotional and behavioral development of children in the context of postpartum depression in low- and middle-income countries. A study in South Africa found discernible impairments in the interactions between mothers with depression and their infants in comparison with mothers without depression (Cooper et al., 1999).

It has also been found that infants of mothers with postnatal depression may experience greater delays in cognitive and motor development, and affect regulation (Gausia, Fisher, Algin, & Oosthuizen, 2007; Perfetti, Clark, & Fillmore, 2004). Longitudinal studies have shown that language development and intelligence are more adversely affected. The gender of the baby, as well as the timing and course of the mother's depression, has been shown to affect the severity of the delay in cognitive development (Parsons et al., 2012). Poverty and low socioeconomic status appear to play a moderating role in the impact of maternal mental illness on an infant's cognitive development (Hadley, Tegegn, Tessesma, Asefa, & Galea, 2009). Only a few studies located in low- and middle-income contexts have looked at maternal mental health status and infant cognitive development. Therefore more studies in these contexts are warranted.

Postpartum depression also poses long-term risks for the mother's mental health, especially if she does not receive sufficient treatment. For the mother, untreated postpartum depression can lead to chronic or recurrent depression (Marcus & Heringhausen, 2009). Leahy-Warren and McCarthy (2007) found that without treatment 30% of women suffering from severe postpartum depression continues to suffer from the symptoms of postpartum depression after a year. It has been reported that up to 50% of women with postnatal depression continue to experience symptoms up to 2 years after initial diagnoses. Moreover, women who have experienced postpartum depression before are twice as likely to experience recurrent episodes of depression over a 5-year period, compared to women who have experienced depression not unrelated to the reproductive period (Parsons et al., 2012).

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3.1.1.3.5 Aetiology. The aetiology of postpartum depression is vast. It has been noted that maternal depression is not attributable to a single cause. Mood disorders are complex illnesses, and even if there is a genetic predisposition or vulnerability to developing postpartum depression, interaction with experiential and environmental factors need to occur in order for the illness to develop (Fiske, Loebach Wetherell, & Gatz, 2010; Lohoff, 2011). Hence, a number of risk factors may play a role in the onset of depression.

Generally, risk factors for postpartum depression are divided into confirmed, probable, and possible risk factors (Clout & Brown, 2015). A previous history of mental illness, in particular a history of anxiety and depression, is possibly the best recognized risk factor for the development of postnatal depression (Balestrieri et al., 2012; Bayrampour, McDonald, & Tough, 2015; Bunevicius et al., 2009; Edwards, Galletly, Semmler-Booth, & Dekker, 2008; Jeong et al., 2013; Robertson et al., 2004).

Social factors have been acknowledged as an important component when looking at the aetiology of postpartum depression (NICE, 2007). The absence of social support from a partner, family members or friends during the postpartum is also of particular importance (Bayrampour et al., 2015; Faisal-Cury, Menezes, Araya, & Zugaib, 2009; Golbasi, Kelleci, Kisacik, & Cetin, 2010; Hartley et al., 2011; Jesse, Walcott-McQuigg, Mariella, & Swanson, 2005; Leigh & Milgrom, 2008). Marital status or the duration of relationship has been shown to indirectly affect the development of depression. This is because relationship status may influence the amount and/or quality of support the new mother receives. Consequently, women with depressive symptoms in the antenatal or postnatal period are more likely to be unmarried, single or to have a partner living in a different household (Adewuya, Ola, Dada, & Fasoto, 2006; Faisal-Cury & Rossi Menezes, 2007; Figueiredo, Pacheco, & Costa, 2007).

Moreover, low socioeconomic status has a probable impact on the development of postnatal depression. Research on traditional indicators of socioeconomic status (such as education, income, and occupational status) indicates that these interlinking factors can influence the development of postpartum depression (Mayberry, Horowitz, & Declerq, 2007). For example, women with lower educational attainment and lower employment status are more prone to developing maternal depression. This may be because they are younger, have less social support, and are more likely to be single parents (Abrams & Curran, 2009). More

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recently, relative poverty has been identified as a stronger predictor of a variety of mental health outcomes than poverty as a whole (Wilkinson & Pickett, 2009).

Obstetric factors and complications have also been found to be a probable risk factor for developing postpartum depression. Obstetric factors can include complications associated with pregnancy such as hyperemesis; pre-eclampsia; premature contractions as well as birth-related complications such as an emergency and/or elective caesarean; premature delivery; instrumental delivery and excessive intrapartum bleeding (Adewuya et al., 2006; Ajinkya, Jadhav, & Srivastava, 2013; Chojenta et al., 2014; Faisal-Cury et al., 2009,).

Lastly, many studies have shown that adverse life events and high perceived stress during pregnancy play an important role in the onset of postnatal depression (Abujilban, Abuidhail, Al-Modallal, Hamaideh, & Mosemli, 2014; Bayrampour et al., 2015, Brittain et al., 2015). As such, being exposed to traumatic experiences, such as domestic violence or emotional, physical or sexual abuse, has a considerable impact on a mother's mental health in the postnatal period (Akçalı Aslan et al., 2014, Ali, Azam, Ali, Tabbusum, & Moin, 2012, Brittain et al., 2015; Dibaba, Fantahun, & Hindin, 2013).

3.1.2 Towards a broader understanding of maternal distress. The experience of emotional distress by women as they adapt to their mothering role is of particular interest to this study. Maternal distress is an emerging but not fully developed concept used to describe maternal emotional well-being. No conclusive definition exists. For the purposes of the present study, maternal distress is defined using Ridner’s (2004) definition of psychological distress and is informed by a critical review of the literature. Psychological distress is “a unique, discomforting, emotional state experienced by an individual in response to a specific stressor or demand that results in harm, either temporary or permanent, to the person” (p. 539). Maternal distress is psychological distress and more. It is a state and a process specific to the childbearing period during which a myriad of related symptoms are experienced to varying degrees and of different duration. This thesis argues that distress may be the result of several influencing variables interacting together, which may challenge the mother’s resources for healthy role development and adaptation to motherhood.

As a matter of clarity, I will use the term maternal distress in this thesis, in order to conform to the discourse used to understand women’s experiences. For this study, postpartum

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depression is defined according to the criteria given in the DSM-5. However, in line with previous research, the term maternal distress will refer to psychiatric illness during the postpartum as well as the perceived stress throughout this period. This includes both self-reported accounts of women and through diagnostic criteria of maternal mental health disorders. Moreover, merging the three most prevalent maternal mental health problems during the reproductive period under the 'maternal distress' umbrella may have important implications for a better conceptualization of the undesirable affective states during the reproductive period. This is because it provides a broader benchmark for the identification of numerous possible influences contributing to the experience of maternal distress (Emmanuel & St John, 2010; Rallis, Skouteris, McCabe, & Milgrom, 2014).

3.1.3 Summary. What has been illustrated in the previous sections is how the diagnoses, defined by the DSM-IV, appraise how an individual is positioned and the way in which they make sense of their experiences. Different maternal conditions provide insight into maternal experiences; however, the application of distinct emotional conditions in the postpartum serves to fragment what is, overall, an emotional maternal response. Part of the problem lies in the use of specific terms to label particular conditions that in reality may be part of a broad range of emotional responses that could be termed maternal distress. As suggested by Kruger (2006), a new perspective is needed to explain the experiences of distress in the postnatal period. A suitable way of doing this is through forthcoming studies.

As such, the psychiatric categorization of postpartum depression has been brought into question by illuminating the contradictions in the research that support the validity and usefulness of this diagnosis. However, the goal of this study is not to debate the relevance and validity of maternal mood disturbances as psychiatric diagnoses. It rather sets out to explore women's lived experiences of distress in the transition to motherhood within the context it occurs.

3.2 The lived experience of maternal distress

The previous section outlined the positivist account of the aetiology, measures, and categorization which forms the dominant understanding of maternal distress. This approach has neglected to look at the ways in which maternal distress is constructed within the context it occurs. Motherhood does not exist in a biological vacuum but is situated within a social,

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historical and political context. This inevitably shapes and influences how women experience both the physical and psychological aspects of birth and motherhood.

The following section will examine the research on discourses and ideologies about motherhood and how these ideologies shape a woman's identity as a mother. This is done in order to highlight the context in which women construct themselves as mothers and the context within which diagnoses of mental illnesses in the transition to motherhood occur. Therefore, this section is aimed at foregrounding women's lived experience rather than a clinical perspective. As such, an alternative framework for interpreting women's experiences of maternal distress is provided. This is done to create a more comprehensive understanding of the experience of maternal distress for women as well as healthcare professionals.

In this section, I review research concerned with the wider emotional experiences of distress in the postnatal period. Several themes were identified in the research literature and these themes were included in this review. As such, this review will include literature that relates to 1) the transition to motherhood; 2) the experience of loss in the transition to motherhood; 3) the discrepancy between the expectations and realities of motherhood and; 4) social support. It should be noted that whilst the physical and psychological body are central to women's health, the way in which women experience the postpartum period is always socially and culturally situated. Thus, I have made reference to qualitative literature that serves to illustrate theoretical sensitivity in the researcher (Bryant & Charmaz, 2007; Charmaz, 2006; Creswell, 2007) and includes the cultural and social context wherein the postpartum period is experienced. While most of the literature informing this study originates from a Western context, it is contrasted with literature from a South African perspective.

3.2.1 The transition to motherhood. In order to understand the experience of women who experience distress during early motherhood, it is noteworthy to evaluate what is known about the transition to motherhood when no distress is experienced.

According to Rubin (1961, 1967a, 1967b, 1984), the transition to motherhood involves complex social and cognitive processes which allow for the development of maternal behaviours as well as appropriate adjustments to be made in becoming a mother. These adjustments begin in pregnancy and continue through to the postpartum period. Rubin

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(1984) later identified the concepts of 'maternal identity' and 'maternal behaviour'. 'Maternal identity' is the process of adjustment where women develop a new personality dimension, which in time becomes incorporated into the woman's self-system. This takes place progressively through a series of cognitive activities that are made evident conceptually and behaviourally. 'Maternal behaviour' is a dynamic process resulting from extensive knowledge of her infant, which continues to develop through the relationship with, and feedback, from her infant.

Whilst Rubin's work has been used in several studies, major gaps still exist regarding this developmental process. A series of studies by Mercer (1981, 1985, 1986, 1995) extended Rubin's work to include the period from pregnancy to the first year after childbirth, bringing more clarity to the maternal adaptive processes and adding emphasis to a defined postpartum period. Mercer has reconsidered the notion of maternal role attainment and stresses the progression of preparation, attachment, and skills development and reframing a new 'normal' way of living, starting in pregnancy and continuing on through the first year of their babies life (Mercer, 2004).

Furthermore, Mercer (1981, 1985) proposed that maternal role development involved four stages of role acquisition. These include the anticipatory, formal, informal, and personal identity stage. The anticipatory stage occurs before birth and serves as a time of psychosocial preparation for the maternal role. The formal stage occurs after labour and involves caring for the infant according to the experts' advice and behaviours. The informal stage represents a time when the mother feels comfortable using her own judgment about mothering her infant. The final stage, the personal identity stage, is when the mother reaches a sense of confidence and gratification with the maternal role. According to Mercer (1985), the achievement of this stage usually occurs by four months. Mercer maintained that several factors may influence the development of the maternal role. These may include age, self-concept, personality traits, childrearing attitudes, perceptions of the birth experience, social stress, maternal or infant illness, infant temperament, and other variables such as culture and socioeconomic conditions.

While emphasising maternal role development, both Rubin (1961, 1967a, 1967b, 1984) and Mercer (1981, 1985) neglected the factors that hinder maternal development. In neglecting to discuss maternal development that has gone awry, any substantive effects of

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emotional states such as anxiety or depression were not addressed. Some studies have highlighted that some degree of emotional work before, during, and after childbirth is required (Blum, 2007). This entails a restructuring across a variety of areas in a mother's life. This includes a reorganisation of her relationship with significant others, her body, and sense of self (Blum, 2007).

Other studies have suggested that the transition to motherhood allows for a reorganising of conscious and unconscious aspects of the representation of the self and others. This process may bring up unprocessed experiences, such as experiences of loss and bereavement (Innamorati, Sarracino, & Dazzi, 2010). Stern (1998) contends that as women give birth the mother passes into a new and unique psychic organisation, which was coined the 'motherhood constellation'. This experience has been described as draining, exhausting, and constantly changing by some women while others explain it as burdensome (Spinelli et al., 2015). It would appear, therefore, that despite the pleasure of becoming a mother, the transformation also brings with it what Rubin (1984) described as feelings of tension, anxiety, insecurity, and uncertainty. This may also differ according to context and cultural influence.

Furthermore, Rubin and Mercer's cohort of mothers consisted of white, middle class, and educated North American women attending health care services within a specific geographical area. Findings, therefore, are most probably a context specific portrayal of maternal role development in childbearing women. Recent studies reflect the changing social profile and tension that exists for new mothers. The profile is mirrored in studies that have identified inadequate social support (Corrigan, Kwasky, & Groh, 2015), low income (Goyal, Gay, & Lee, 2010), domestic violence (Dennis & Vigod, 2013) and substance abuse (Carroll Chapman, & Wu, 2013), as prominent variables affecting the transition to motherhood. As such, the work of Rubin and Mercer neglect the experience of some mothers who have a difficult transition and excludes mothers from different social contexts. Studies on the transition to motherhood need to, therefore, examine the scope of women's experiences of distress from a range of perspectives.

3.2.2 The experience of loss in the transition to motherhood. Examining maternal distress within the context of maternal distress, a substantial body of research has associated maternal distress to the changes that occur in a mothers' sense of self (Rubin, 1984; Russell

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& Lincoln, 2016). New mothers are forced to confront massive psychological and social changes, which may be experienced as chaotic, exhausting stressful, frustrating and overwhelming (Edhborg, Friberg, Lundh, & Widstrom, 2005; Mauthner, 1995, 1999; Nicolson, 1999). Moreover, new mothers undergo reconceptualization of their social role, personal identity, individual freedom and interpersonal relationships (Frizelle & Kell, 2010; Laney, Lewis Hall, Anderson, & Willingham, 2015), all of this results in a loss of the known self (Laney et al., 2015). Findings from other qualitative studies on maternal distress have supported this.

Other studies have shown that throughout the postpartum women describe a loss of control over their bodies, a loss of both physical and emotional well-being, and the loss or control of their life as they knew it (Laney et al., 2015; Keating-Lefler & Wilson, 2004; Vik & Hafting, 2012). Shelton and Johnson (2006) further describe changes related to personal domains like autonomy and time, femininity/sexuality and appearance; and to the social domain of occupational identity. The new responsibilities of motherhood combined with fatigue, are challenging to an already established identity. These feelings may increase levels of depression and anxiety (Keeton, Perry-Jenkins, & Sayer, 2008).

Lewis and Nicolson (1998) maintain that women undergo a process of redefinition as they undergo the transition to parenthood and take on the mother identity. This redefinition appears to have many components. New mothers need to renegotiate their social and professional personas within themselves and their community. Loss of identity, especially occupational, has been found to be particularly prevalent for mothers who had worked outside the home before having their baby (Nicolson, 1990, 1999; Mauthner, 2002; Degges-White & Borzumato-Gainey, 2014). As these mothers gave up their paid employment to become full-time mothers, a loss of status and power became prevalent. Hanley and Long (2006) found that among mothers who gave up employment a loss of independence, status and financial freedom featured prominently. They also described the way in which motherhood excluded them from the world of work. This was accompanied by feelings of being confined to the home, where motherhood was associated with a loss of power and status.

Chen, Wang, Chung, Tseng, and Chou (2006) maintain that depression in the puerperium may be contributed to difficulty adjusting to the social and personal changes that

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accompany motherhood. Women must redefine themselves in relation to their children. Indeed, for many mothers motherhood demands sleepless nights, causing anxiety; stress, feelings of being overwhelmed and difficulties with coping. These life events have a lot of meaning to mothers it involves a transformation from a recognized reality to a new reality they are not familiar with (Mercer, 2004). As a result, some women become overwhelmed during this transition because of the multiple simultaneously occurring stressors (Ussher, 2004).

In view of these significant changes, the feminist approach proposes that the experience of loss leads women to review their values, goals, and priorities in different realms; a process that results in a deep transformation and the development of a new identity. According to Lewis and Nicolson (1998), this new identity requires a shedding of their old identity which may evoke a sense of loss. For some women, this sense of loss can be especially daunting. On the basis of this research, Nicolson (1999, 2003) suggests that postnatal depression should be equated to a grieving process rather than an illness.

The transition to motherhood, then, is a process of grieving the losses mothers have encountered and as a result is tasked with renegotiating their lives (Keating-Lefler & Wilson, 2004) Women thus have to negotiate this reorganisation, by accepting their pregnancy, adopting new roles and accepting their new sense of self (Knudson-Martin & Silverstein, 2009). A meta-synthesis of nine qualitative studies describes the transition to motherhood as a 3 step process that emerges from the mother's engagement by which she actively commits herself to the mothering role, caring for her new born, and accepting the presence of her child (Nelson, 2003). The transition to motherhood is a process in which a woman must reconstruct and adapt a new self-concept that is congruent with her newly acquired roles as mother and caregiver of an infant (Darvill, Skirton, & Farrand, 2010; Lawler, Begley, & Lalor, 2015). The mother's engagement allows growth and transformation to occur, but this growth and transformation are dependent on the level of the mother's engagement (Nelson, 2003).

Another element highlighted from this perspective are the restrictions imposed by the cultural context to the natural need for grieving and expressing the sorrow and anger associated with the numerous changes entailed in pregnancy and early motherhood. The ideology of motherhood maintains that it is a joyful and rewarding experience (Choi et al., 2005; Nicolson, 1998; Ussher, 2010). This means that women are socialised to anticipate the

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positive aspects and advantages of motherhood, and the anticipation of these advantages can leave women unprepared for the losses that this transition may bring. However, research has shown that loss is a crucial part of motherhood (Vik & Hafting, 2013; Oakley, 1980). Mauthner (1999) argues that maternal distress occurs when women are "unable to experience, express, and validate their feelings and needs within supportive, accepting, and non-judgmental interpersonal relationships and cultural contexts" (p.148).

3.2.3 The discrepancy between expectations and reality. A second theme which seems to permeate the literature is the disparity between women's expectations of motherhood and how it is experienced it in reality (Choi et al., 2005; Beck, 1993, 1995; Buultjens & Liamputtong, 2007; Nicolson, 1998; Oakley, 1980, 1986). It is important to note that women often experience an increased sense of feeling over-educated but psychologically and socially under-prepared for parenting (Choi et al., 2005).

This discrepancy between the expectations and the reality of motherhood identified in women's experiences implies that there is a tension between participants' lived, embodied experience of being a mother and cultural constructions of being a mother. The research has also noted how contradictory expectations and experiences of motherhood contribute to the development of maternal distress. This has been found in studies regarding the experience of distress in pregnancy and the postpartum (Deave, Johnson, & Ingram, 2008; Staneva & Wittkowski, 2012).

The inconsistency between the expectations and reality of motherhood have been noted in seven areas: labour and delivery, life with their infants, self as mother, relationship with partners, support from their family and friends, life events and physical changes (Degges-White & Borzumato-Gainey, 2014). Parity has also been found to influence the expectations women have. First-time mothers centred their expectations on the image of the "perfect, ideal mother" (Mauthner, 1999). Multiparas, on the other hand, centred their expectations of being able to cope with multiple children.

Expectations centring on birth experiences also seem to be pertinent in the maternal distress literature. The perceptions that natural delivery is the ultimate birthing experience are pervasive in the research literature (George, 2005). Despite receiving a lot of information about the birthing experience, many women continue to have unrealistic expectations and are

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unprepared for the experience. Terry (2014) argues that a difficult birth experience may be a source of distress for women because they may construe the experience as a reflection of their incapability of coping with motherhood. Coates, Ayers, and De Visser (2014) similarly argue that when the expectations of labour are not met during the actual event, a women's self-esteem is severely affected. This contributes to difficulties when assuming the mothering role with self-confidence.

Another area where a discrepancy between the experiences and expectations of motherhood was noted is the notion that mothers would only experience feelings of joy when interacting with their infants. Another facet of this expectation was that mothers would be able to cope with their infants. Wilkins (2006) has found that mothers were concerned about how to care for their babies at home, particularly regarding activities such as soothing, bathing, and clothing. Women describe a progression from difficulties in soothing and caring for the baby to a debilitating sense of incompetence that resulted in a deep despair and detachment from others (Amankwaa, 2003; Kanotra et al., 2007). As already mentioned, the expectations surrounding motherhood for most pregnant women are overwhelmingly positive. These cultural representations of women effortlessly transitioning to motherhood serve to reinforce the dominant myth that women are natural mothers who possess an innate ability to immediately bond with their baby and quickly become a selfless and caring nurturer (Choi et al., 2005).

This can be likened to the studies on breastfeeding where mothers who had expectations of breastfeeding their children, who were unable to breastfeed, felt as though they had failed as mothers. Fox, McMullen, and Newburn (2015) found that breastfeeding was a difficult experience for many of the women in their study because, contrary to their expectations, breastfeeding did not come naturally to them. Many women experience breastfeeding as painful, extremely demanding and stressful.

A general finding in these studies is that women are shocked by the extent of the difficulties they experience when becoming a mother. This incongruity between their expectations may further increase maternal guilt and isolation (Hall & Wittkowski, 2006). Accordingly, some studies (Beck, 2002; Knudson-Martin & Silverstein, 2009; Mauthner, 1999), have found that women's experience of this incongruity has led to an internal crisis. This may be because women base their worth on what society has conditioned them to

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believe is acceptable. When women experience motherhood as incongruent to this, they may question their worth as women and as mothers. This results in feelings of inadequacy, defeat, and isolation, all of which may contribute to and perpetuate distress (Choi et al., 2005; Staneva & Wittkowski, 2012).

Researchers have also illustrated how inaccurate parenting expectations contribute to adjustment difficulties (Harwood, McLean, & Durkin, 2007; Tammentie, Paavilainen, Astedt-Kurki, & Tarkka, 2004; Beck, 2002). This may be because the discrepancy between anticipated and real outcomes makes the acceptance of their new reality especially difficult. Additionally, the negative feelings brought upon by this dissonance may hinder adjustment. Overall these studies conclude early adjustment is strongly related to prenatal expectations.

3.2.4 Social support. Another important facet of maternal expectations that play a role in maternal distress is social support (Stapleton et al., 2012; Ugarriza, Brown, & Chang-Martinez, 2007). Moreover, inconsistent social support has been found to be a strong predictor of distress during the transition to motherhood (Blanchard, Hodgson, Gunn, Jesse, & White, 2009; Stapleton et al., 2012).

Social support is a multi-dimensional construct. It consists of three types of support, which includes emotional support (which consists of comfort and reassurance); instrumental support (which is made up of financial assistance and tangible support); and informational support (consisting of advice and knowledge sharing) (Boothe, Brouwer, Carter-Edwards, & Østbye; 2011; Chojenta, Loxton, & Lucke, 2012; Evans, Donelle, & Hume-Loveland, 2012; Leahy-Warren, McCarthy, & Corcoran, 2012). These sources of support can come from partners, family members, friends or support groups (Deave, et al., 2008; Hanley & Long, 2006).

First-time mothers often look to their own mothers and their relationship for support and education on how to approach the care of their new born, especially when exhaustion sets in (Darvill et al., 2010). Women's remembrance of attachment with their own mother is linked to satisfaction with social support, their own mother-infant attachment, and feelings of competence in caregiving (Huth-Bocks, Levendosky, Bogat, & von Eye, 2004). Similarly, women's partners play a crucial role in encouraging new mothers in their ability to provide for their baby's needs (Darvill et al., 2010). Women who have more prenatal social support

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tend to also have most postnatal support, which is also related to more positive mother-infant bonds (Huth-Bocks et al., 2004).

A variety of sources of social support may be important for improving mental health during the transition to motherhood. However, a woman's spouse or intimate partner has consistently been found, in the research literature, to be the most important source of support (Hopkins & Campbell 2008; Gremigni, Mariani, Marracino, Luigi Tranquilli, & Turi, 2011). As such, support from an intimate partner is a significant protective factor against the development of postpartum depression (Beck 1993, 1995, 2002; Dennis & Letourneau 2007; Dennis & Ross 2006). Women who perceive more social support from their partners during their pregnancy experience lower emotional distress during the postpartum (Stapleton et al., 2012). Additionally, mothers who have experienced postpartum depression are better able to cope with depressive symptoms when they have a supportive partner (Letourneau et al., 2007).

Clearly, partner instrumental support is important to a women's mental health during the transition to motherhood (Corrigan et al., 2015; Rennie Negron, Martin, Almog, Balbierz, & Howell 2013). As such, the lack of instrumental support has been noted in the research literature as particularly deleterious to women's mental health. Women without support note how they are solely responsible for infant care and domestic chores (Parvin, Jones, & Hull, 2004). These multiple roles are considered to be extremely burdensome and demanding (Kurtz Landy, Sword, & Valaitis, 2009; Hanley & Long, 2006). Hoang, Le, and Kilpatrick (2009) found that some women immediately resumed the roles of mother, wife, and housewife after returning from the hospital and as a result had little opportunity to recover from childbirth.

Multiple responsibilities and lack of support appear to be intrinsically linked. Belle and Doucet (2003) coined the term "the stress of caring" to highlight and give credence to the significant demands that are placed on women in society, who are automatically assumed to take responsibility for the well-being of their family members. While some fathers may take on the primary carer role, this is often not the case. The expectation is that mothers are to incorporate the all-encompassing task of childcare with their daily tasks. Generally, fathers take on an assistive role with relatively minimal additional tasks, while the overall caregiving

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becomes the responsibility of the mother. Consequently, mothers often feel alone and overburdened.

Berggren-Clive (2009) contends that when mothers are unable to fulfil their designated gender roles they experience feelings of helplessness. Raymond (2009) found partner support (or lack of it) seemed to contribute largely to the participant's feelings of emotional isolation. Beck (1996) found this led to feelings of inadequacy. The need for support, and feelings of loneliness and isolation were reported by other studies (Rennie Negron et al., 2013).

Interestingly, research has identified that barriers to support mobilization are related to cultural norms. The stigma associated with experiencing distress has been recognized as a barrier to seeking emotional support (Rennie Negron et al., 2013; Dennis & Chung-Lee, 2006). This may be because women who begin to experience the realities of mothering as differing from the expectations thereof often experience a sense of failure as a mother (Ussher, 2006). This can create feelings of emotional distress during the postpartum period (Shelton & Johnson, 2006; Buultjens & Liamputtong, 2007).

3.2.5 The experience of maternal distress in low-income women. The majority of the research literature is based on White, middle-class samples. This gap in the literature is of concern because prevalence rates of maternal distress are higher among women in low-income groups than in other socioeconomic groups (Rich-Edwards et al., 2006).

The core experience of maternal distress in socioeconomically disadvantaged women appears to be in tandem with the experience of women in other socioeconomic classes. Studies have described feelings of loss across multiple dimensions. Additionally, it was found that challenges of having a new baby while recuperating from labour, and at the same time continuing their daily responsibilities, is difficult and overwhelming (Abrams & Curran, 2009, 2011; Dailey & Humphreys, 2011; Kurtz Landy et al., 2009).

However, lack of support and poor living conditions seem to play an especially important role in the experience of maternal distress in low-income women. A majority of socioeconomically disadvantaged women reported a lack of adequate social support. This was related to being raised in families from a low socioeconomic background. In this regard,

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it was found that the friends and family of the mothers were too stressed to provide help. As a result, women from low socioeconomic groups were less likely to receive practical help as well as traditional social support (Kurtz Landy et al., 2009).

It was also noted that mothers experienced distress when they had a complex relationship with the baby's father. These relationships were unstable or non-existent, and sometimes these fathers refused to acknowledge paternity (Richter, Chikovore & Makusha, 2013). In addition, it was found that single mothers experienced stigma related to absent fathers and having to parent alone (Abrams & Curran, 2011).

Abrams and Curran (2009) also found that distressed economic conditions exacerbated the women's symptoms. One identified stressor was related to financial problems involving material deprivation, poor quality housing, struggling with food security, and a difficulty in accessing transportation. Rather than focusing on adapting to the transition to motherhood, women were preoccupied with finding food and shelter for their families.

Accordingly, the research has located the core of postpartum depression in the overwhelming feelings of mothering in situations that are socially and materially stressful. As such, Abrams and Curran (2011) argue that the intersection between postpartum depression and poverty is problematic in so far as poverty poses a challenge to the realization of an idealized mothering image.

3.2.6 The experience of maternal distress in South Africa. In addition to a paucity of studies in the experience of distress in low-income women, there is a paucity of research on the experiences of mothers in South Africa (Kruger, 2006). Furthermore, the impact of race and culture on contemporary motherhood in the South African context has not been adequately researched (Kruger, 2006). In this regard, three pervasive themes on the experience of maternal distress have arisen from the South African literature. This includes the importance of sociocultural context, the role of the dominant mothering ideology in shaping the narratives of mothers and the experience of poverty and motherhood.

Depending on the sub-group motherhood is enacted to varying degrees. A significant finding was that race, political history, gender, and class all have some impact on motherhood (Magwaza, 2003). Daniels (2004) explains that "motherhood is contextualised by the

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interconnection of race, ethnicity, class, and gender" (p. 1). Walker (1995) points out that in South Africa it is common for middle class working women to employ the services of a domestic worker or helper to assist with the physical care of their children, whereas working class women may rely more heavily on the assistance of family members. This is not only determined by the mother's socioeconomic situation but also largely by culture. Western mothers tend to rely more on their nuclear family for assistance, while African mothers make use of extended family networks (Sudarkasa, 2004).

White mothers in South Africa show more Western tendencies where the individual is regarded as an autonomous entity. This is reflected in their individualist mothering practices (Mkhize, 2004) where parenting is located within the nuclear family with a particular emphasis on the mother-child dyad (Sudarkasa, 2004). Within collectivist cultures, individuals are defined in relation to others and understand the self as interdependent with others (Mkhize, 2004). Within Black communities, collectivism results in a co-mothering where the responsibility of motherhood is shared (Arnfred, 2003). The extended family thus form the context for childrearing in most African societies (Sudarkasa, 2004), whereby the inherent contradictions of motherhood are alleviated In this sense, motherhood is perceived as more empowering for Black South African women than their White counterparts (Arnfred, 2003).

While there are clear differences in the current contexts in which Black and White South African women mother, accompanied by different ideas and practices, urbanization and acculturation have led to a changing landscape for motherhood in South Africa. Urbanization has been accompanied by a shift from traditional birthing practices towards more Western practices. In a South African study by Fouche, Heyns, Fourie, Schoon, and Bam (cited in Chadwick, 2006) it was found that for African women, childbirth is increasingly shifting from an integrated, traditional practice towards a medicalized, fragmented process. This is evident in the increase of Black South African women turning to medical professionals for guidance concerning issues related to pregnancy and childbirth rather than to traditional sources of information (Chalmers, 1987). It is likely that this trend could be extrapolated to other aspects of mothering.

Furthermore, increased contact with different cultures can lead to acculturation whereby certain cultural practices are modified or abandoned in favor of other cultural ideals.

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Walker (1995) argues that the overlapping of understanding, common concerns and experiences of women from different backgrounds invalidates separate constructions of Black and White mothers. This is evident in South Africa where Western or White ideas and practices are being assimilated into traditional African ways of life (Mkhize, 2004).

However, it is important to note that the experiences of mothers cannot be homogenised or generalised. Motherhood is multifaceted and complex and this needs to be acknowledged when studying mothers from all different backgrounds. From this statement, it can be inferred that mothers of other racial or class groups would also have an experience of motherhood that is multifaceted and complex. In other words, when conceptualising motherhood it is important to consider the impact that these factors may have on various expressions and experiences of motherhood. It is problematic to isolate the mother from her cultural context.

Some studies have noted how the dominant mothering ideology is prevalent in shaping the narratives of these mothers in the South African context (Frizelle & Kell, 2010; Kruger, 2003, 2006; Magwaza, 2003; Long, 2009; Mamabolo, 2009). What was found in these studies was that mothering occurs largely within a context of gender inequality (Frizelle & Kell, 2010; Jeannes & Shefer, 2004). Women are seen as having the inherent capacity to be mothers because of their gender and they still remain the primary caregivers for their children, despite also working (Mamabolo, 2009; Van Doorene, 2009). Mothers are constructed as secondary to men and parenting is largely the sole responsibility of the mother, thus suggesting that there may be some commonalities of mothering between different racial groups (Frizelle & Hayes, 1999). This serves to reinforce the notion that motherhood is a central aspect of being a woman or being feminine and that a woman only fully becomes a woman when she becomes a mother (Jeannes & Shefer, 2004; Magwaza, 2003; Van Doorene, 2009). The individualization of motherhood in White South African communities, coupled with unequal gender role expectations for mothers and fathers, often results in less satisfying experiences of motherhood (Arnfred, 2003).

These studies have shown not only how culture plays a role in mothering but also how a mothers' socioeconomic situation may impact on the resources drawn upon and the approach to raising children. The experience of most South African mothers is marked by social inequality (Walker, 1995). In line with other studies on the experience of maternal

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distress of women from lower socio-economic statuses, the dimensions of poverty were found to be at the core of maternal distress. This includes food and financial insecurity, interpersonal conflict as well as a general lack of support (Kathree et al., 2014; Lourens & Kruger, 2013). Single mothers relied heavily on their support networks in order to survive (Kathree et al., 2014). Despite this, these supports were often withheld and resulted in feelings of despair and helplessness. As a result, these women often withdrew socially and/or engaged in violent and negligent behaviour with their children (Kathree et al., 2014; Kruger & Lourens, 2015; Kruger et al., 2014).

Ultimately, it does appear as if though mothering in South Africa is particularly gendered. Mothering in South Africa is positioned within a unique socio-political history, categoried by inequality that has greatly influenced the experience of South African mothers (Walker, 1995) resulting in constructions and conditions of motherhood which differ along racial lines in South Africa (Arnfred, 2003). Historically, on both sides of the Apartheid struggle motherhood has been idealised (Long, 2009). Afrikaner mothers and African mothers operate within a nation that is generally a male one (McClintock, 1991). Walker (1995) points out that the traditional African ideology of female deference is reinforced by white capitalist gender ideology. Both belief systems share similar assumptions of female inferiority and domesticity. Twenty years have passed since these findings and cultural values and gender roles may have completely changed, however, Magwaza (2003) states that the experiences from the past still impact in some way on current mothering experiences.

This confirms the notion that motherhood is not a homogeneous construct and that different factors will play different roles in shaping discourses and understandings of motherhood. However, while it is important not to homogenize experiences of motherhood, what is prevalent in these studies is that in South Africa, men still hold positions of power both economically and socially and this impacts on mothers and their experiences (Jeannes & Shefer, 2004). The stark divisions of race and class in South Africa are paralleled by the equally stark division of gender. Compounding this are the internalized ideologies of the ideal all-providing, ever-giving, self-sacrificing mother. This may add more strain to low-income mothers in South Africa as they are likely to receive less support in their mothering, which leaves these women with the sole responsibility of feeding, caring for and raising their children. This occurs in a context where women are naturally dependent on others and cannot survive with support.

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3.2.7 Ideology and maternal distress. Taken together, these studies seem to indicate that the ideology of motherhood and the expectation thereof underlies the experience of maternal distress throughout the transition to motherhood. These cultural expectations of motherhood are used by women as a measure of competence for themselves as a mother (Mercer, 1995; Nelson, 2003).

In line with feminist arguments, recent literature has found that women are less likely to attribute the aetiology of their distress to negative emotions or individuals mental health problems and pathology as it is conceptualized in the biomedical nomenclature (LaFrance, 2007). Instead, women attribute their distress to difficulties around child care, individual and interpersonal difficulties. Within these constraints, it has been found that women link feelings of powerlessness and helplessness to these experiences.

Mothers internalize the cultural ideal of good motherhood and use this as a gauge to develop expectations of themselves as mothers. When mothers find that they are unable to live up to this ideal they perceive this as a sign of inadequacy and failure as both a mother and a woman. As a result, the incongruence with their ideal model of motherhood often leads to self-judgement (Beck, 2002; Knudson-Martin & Silverstein, 2009; Mauthner, 1999). Research shows that many women are tormented by guilt and shame for not fulfilling the expected role of a "good" mother (Buultjens & Liamputtong, 2007; Knudson-Martin & Silverstein, 2009; Røseth et al., 2011). Choi et al. (2005) found that feelings of inadequacy arose when women realized their experiences were different from the societal ideals of motherhood.

As women afflicted with maternal distress often feel guilty and inadequate, a sort of self-silencing occurs (Mauthner, 1995). Mauthner (1999) discovered that women with maternal distress often silence their own voices. Some mothers feared the consequences of talking about what they were feeling, which kept them silent. Others feared burdening their loved ones and being misunderstood, or rejected. Some studies have also found that mothers were more likely to self-silence when they felt that admitting their feelings was a sign of personal inadequacy and failure as a mother (Alici-Evcimen & Sudak, 2003; Choi et al., 2005; Hall & Wittowski, 2006; Knudson-Martin & Silverstein, 2009; MacLellan, 2010; McIntosh, 1993).

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These feelings may be compounded for mothers living in poverty (Abrams & Curran, 2009). Women with already precarious support networks may be reluctant to risk straining relationships on which they heavily depend. This may be even more deleterious for women in poverty as support networks are vital for their survival. This lack of support can exacerbate feelings of inadequacy, further isolating these mothers and preventing them from identifying adequate sources of support.

According to Mauthner (1999), women who suffer from maternal distress are unable to experience their sorrow in a setting which provides empathy through affirming relationships. For instance, if women are ignored or rejected when they do disclose their feelings, women may begin silencing themselves. As a result, women may begin to isolate themselves. Consequently, women with postpartum depression often experience their distress in isolation (Paris & Dubus, 2005; Wardrop & Popadiuk, 2013). Medina and Magnuson (2009) argue that self-silencing may account for the underdetection of maternal distress. This is because women are reluctant to speak about the difficulties they experience because society is so critical about how well a woman performs motherhood (Raymond, 2009; Dennis & Chung-Lee, 2006; McIntosh. 1993; Perfetti et al., 2004).

Mauthner (1999) found that despite women recognizing that the ideology of motherhood was unattainable; most women did not seek out alternative accounts of motherhood. Mauthner (1999) maintained that mothers had difficulty relinquishing these ideals. Instead, it seemed the mothers tried even harder to live up to an impossible ideal and blamed themselves and their own inadequacies when not being able to live up to this ideal (O'Reilly, 2004; Tyano, Keren, Herman, & Cox, 2010).

Clearly, broader social ideals, cultural and socioeconomic contexts permeate what it means to be a mother or to be mothered. Different societies value and institutionalise various types of mothering (Kitzinger, 2004). Women are "exposed to powerful ideologies that impact on their experiences of motherhood, mothering, and mothers" (Kruger, 2006, p. 182). Phoenix, Woollett, and Lloyd (1991), in criticising ideologies and prescriptions for mothering, explain that these prescriptions generally take no account of structural differences between mothers. Mothers and children from working class environments are likely to differ from middle-class mothers in that their children may be denied various goods due to lack of material resources (Phoenix et al., 1991). Phoenix et al. (1991) argue that working class

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mothers' unique experiences are homogenised and left unexplored or misunderstood to a large degree:

> By failing to recognise such issues, current social constructions of normal motherhood do not reflect the realities of working class mothers and children's lives, and this results in any differences between them and middle class mothers being seen as pathological or deviant (p. 18).

As already noted, this gap extends to the South African literature, where the subjective experiences of mothers in South African literature with regards to race, class, and gender and the intersection thereof in the impact on the experiences of mothers is limited (Kruger, 2003). Ultimately the voices of marginalized women as mothers are not being overlooked and an incomplete picture of maternal distress exists.

3.2.8 Summary. Studies mentioned before describe the diverse experiences of maternal distress in different contexts. The negative emotional sequelae of the transition to motherhood are not limited to symptoms typically associated with the dichotomy in the psychiatric nomenclature. This review thus suggests that the diagnosis of depression may not adequately encapsulate women's experiences of distress following childbirth. As such, these studies are in line with the feminist critique of the notion of depression in general.

As qualitative studies have started to delineate women's experiences of maternal distress, the impact of this diagnosis on a woman's sense of self-has emerged as a prominent finding. The description of experiencing grief, loss, isolation, feelings of inadequacy and guilt and an absence of a framework in which to make sense of their experiences, suggests a need for greater knowledge about maternal distress and its effects on women and their families.

Thus far, I have aimed to highlight that despite an increase in interest in maternal distress and women's lived experiences, there continues to be a lack of research in this area, especially in differing contexts. The South African literature indicates that the good mothering ideology also governs understandings of mothering in South Africa. However, what seems to be missing from the South African literature is an investigation of mothering experiences and its multi-layered and complex nature within different contexts in South Africa (Kruger, 2006).

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3.3 Conclusion

This chapter has emphasized the issues of psychiatric definition present in the psychiatric nomenclature. Postpartum depression, the identifying characteristics, prevalence and implications of this diagnosis as defined by the biomedical nomenclature, was introduced. This was done in an effort to provide an understanding of the discourse that frames the understanding of maternal distress. It was argued that the medical construction of maternal distress could problematize the transition to motherhood.

It seems clear that maternal distress should not be considered a unidimensional construct, but must include all of the dimensions that attribute to emotional well-being for women. It should be acknowledged that whilst the physical and psychological body is central to women's health, the way that women experience both their bodies and health care is always socially and culturally situated. Hence, cultural ideals of motherhood and the constructions of the idealized mother; were pressed. This was done by drawing on research that focuses on women's experiences of motherhood where motherhood was experienced as incongruent from the idealized notions of motherhood.

Despite the proliferation in qualitative studies internationally and limited studies in South Africa, it is unclear to what extent current research has achieved a sophisticated and comprehensive understanding of the maternal distress in the transition to motherhood in different contexts. Research on the experience of motherhood is imperative, not merely by obtaining empirical measures of psychological distress but also by interpretation of the subjective experiences of women that underlie this experience. In this way, a more realistic and ethical psychology of motherhood and the distress during this time can emerge. In light of the high prevalence rates of maternal psychiatric illness, this is even more important in the South African context. In order to do this, I implement a qualitative research methodology, informed by a social constructionist theoretical framework. This will be discussed in the following chapter.

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Chapter four: Methodology

The current study forms part of the Women's Mental Health Research Project (WMHRP), which focuses on the emotional experience of motherhood in a low-income semi-rural community in Stellenbosch. Secondary data analysis was performed on the data obtained in the parent study. The following sections present the research design, context of the study, inclusion criteria, recruitment and data collection procedures, and methods of data analysis. This chapter ends with an exploration of issues pertaining to reliability and validity, reflexivity and ethical considerations.

4.1 Parent study

The present study was located in a larger research endeavor, the Women's Mental Health Research Project (WMHRP) which looked at the emotional distress and resilience of low-income women of Colour who live and mother in the Winelands region of the Western Cape in South-Africa. More specifically, this study centered on the motherhood experiences of these women. Participants were recruited at the local clinic during antenatal visits.

The participants were interviewed at four different points: 1) pregnancy; 2) 2 weeks after birth; 3) 2 to 3 months postpartum and; 4) 6 to 8 months postpartum. Extensive open-ended interviews were undertaken to gauge how these women interpreted and gave meaning to what they are experiencing. These in-depth interviews covered a variety of topics (demographic, personal and family history, psychiatric symptomology, coping mechanisms, substance abuse, violence, sexuality and reproductive health issues), but focused more specifically on women's experience of pregnancy, termination of pregnancy, birth, and early motherhood. Approximately 90 women were interviewed over a period of 4 years. Between 2002 and 2005, Psychology Honours students conducted approximately 90 sets of interviews, which amounted to roughly 360 interviews in total.

4.2 Current study

The current study utilized selected components of data that were collected from the Women's Mental Health Research Project. The goal of this study was to describe the experience of maternal distress from the perspective of a group of low-income women in

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South Africa. The second goal of this study was to locate the women's experience within the social context it is told. It was hoped that such an understanding may lead to more effective psychological services to women who suffer from maternal distress (Lourens & Kruger, 2013). As such, a subset of data from the parent study was utilized to fulfill the aims of this study. As a result, the present study is derived from the Women's Mental Health Research Project but the emphasis is more specific, centring on the discourses of motherhood and experiences of maternal distress within one group of women from this community.

4.3 Research design

The goal of this study was to explore and describe the experiences of distress in women who meet the criteria for postpartum depression based on their scores on a self-report measure. In order to achieve this, this study was conducted from a social constructionist epistemological paradigm, through a feminist theoretical lens, located within a qualitative longitudinal method of inquiry (De Vos, Strydom, Fouche, & Delport, 2011).

From the outset of this study, I was aware of the fact that a straightforward analysis of interview data that focused on common experience would not be sufficient to uncover the experiences of motherhood in South Africa. As a young democracy, South Africa is an ideologically complex space while unequal education, poverty, lack of access to healthcare, and violence remain a reality for most South Africans (Charasse-Pouélé & Fournier, 2006). These factors work together to make motherhood a qualitatively different experience for many women. Similarly, psychiatry has historically been a white, male-dominated field and this may exert some influence on the lived experience of motherhood in a different context. Therefore, I understood that my approach to analysis would have to take into account the influence of discourses around motherhood and the structural constraints that exist in the South African society. Drawing from this methodology, the focus of this study was on describing these phenomena, critically unpacking them in relation to the experience of distress, and situating them within context.

In aligning with the social constructionist framework, it is acknowledged that along with the significance of studying narratives in detail, looking beyond what is said permits a supplementary layer of interpretation. In this way, narratives can be set in a broader cultural, historical and social context. According to Burke, Joseph, Pasick, and Barker (2013), actions

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are structured by material and social realities. Moreover, different realities impose different restraints on what is said and done and as a result, influence the construction of phenomena in different contexts.

Social constructionists focus on the process by which meanings are created (Andrews, 2012). Social constructionism regards individuals as integral with social and temporal contexts in specific times and places as well as situated in certain cultural, political and historical milieus. Social constructionism facilitated an understanding of how the subjective experiences of emotional distress are experienced and allowed for the acknowledgment of all the contextual aspects which affect motherhood. For this reason, the study utilizes a social constructionist epistemology.

Social constructionism was chosen for this research as it offered an approach that gave me the tools to add to the existing body of knowledge. It also facilitated an approach that would offer a different understanding of their lives and the knowledge embedded in their experiences as mothers in the context of mental health problems. In addition, I am challenged to focus on their knowledge that was subjugated by ideologies of motherhood and mental ‘illness’ (as discussed in the previous chapters) and subjugated by the oppressive policies and practices that arise from these ideologies.

Consistent with social constructionism, the study was conducted within a feminist theoretical framework. Feminism seeks not only to include women in research but also to deconstruct power (Hesse-Biber & Yaiser, 2004). The feminist theoretical framework provided a lens through which power and the forces that shape women’s lives and the consequences thereof can be understood.

Qualitative research can be characterized as an attempt to scrutinize certain phenomena or to gain a more in-depth understanding of processes, experiences, or meanings located within lived experiences (Charmaz, 2005). Qualitative research is also conducted in an attempt to renew insights, discover new ideas and/or increase knowledge (De Vos et al., 2011). Additionally, qualitative research highlights how things work in different contexts (Austin & Sutton, 2014). This approach was deemed suitable for gaining a better understanding of the nature of the phenomenon under scrutiny as there is a lack of

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information regarding the emotional experiences of maternal distress, both internationally and in South Africa (Coates et al., 2014; Kruger, 2006).

Qualitative research is also important for the study of maternal distress in the South African context. Because research on maternal distress in South Africa is so limited, it is important to gain an in-depth understanding of how South African mothers experience distress during this transition within their particular ecological and cultural context. Learning from the participants how to understand their distress and how they manage change would generate richer information and greater understanding than preselected, quantifiable variables, or a priori ideas (Richards & Morse, 2007). Qualitative methodology is better suited for exploration because it will generate new and unexpected information in unfamiliar territory (Austin & Sutton, 2014; Richards & Morse, 2007).

Lastly, a longitudinal design was utilized as it allowed for investigation within a cohort of participants over time. At the same time, it allows for the examination of changes within and between individual participants (Henwood & Pidgeon, 2011; McLeod & Thomson 2009; Miller, 2005, 2011; Thomson, Kehily, Hadfield, & Sharpe, 2011). A longitudinal component would mirror the period of transition, giving the data collection period a fluidity not usually achieved in once off interviews. The decision was taken to include interviews conducted on three separate occasions: 6-8 weeks postpartum, 2-3 months postpartum and 8-9 postpartum. As the transition to motherhood is an ongoing process, collecting data at different intervals over time is deemed appropriate.

4.4 Research context

This study centers on the emotional experiences of low-income women in a semi-rural community in the Western Cape. The region consists of approximately 5 000 inhabitants, with the majority demographic made up of Afrikaans speaking Coloureds. The region is further inhabited by a minority of White farmers and Xhosa speakers (Visser, 2009).

Categorized as a previously disadvantaged community the area remains economically and socially vulnerable, with 60% of adults unemployed (Kruger et al., 2014). The high unemployment rates have resulted in extreme poverty, with fifty percent of households earning an annual income less than R18 000. This community has a restricted local industry

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and employable skills are limited. As a result, the community is largely dependent on seasonal agricultural labor (Visser, 2009).

The community consists mainly of a primary school, a high school, churches, a municipal clinic, a crèche, and an aftercare center. Recreational and educational upliftment opportunities for adults and children alike are scarce. Additionally, it is plagued by substance abuse, crime and domestic violence (Kruger et al., 2014; Visser, 2009), which is exacerbated by the lack of social infrastructure.

4.5 Procedure

The study utilized data collected in a larger longitudinal study concerned with low-income women's experience of maternal distress. During a four-year period, all pregnant women visiting the local clinic in a low-income semi-rural community were approached to participate in the study. Those who were willing to participate were interviewed by the same interviewer during pregnancy, 6-8 weeks postpartum, 2-3 months postpartum and 8-9 months postpartum. The interviewers were graduate students in psychology (mostly White middle-class women) and were trained by the principal investigator (a clinical psychologist). In addition, the Edinburgh Postnatal Depression Scale (Appendix A), and the Beck Depression Inventory (Appendix B) were administered at the end of each interview. All interviews were subsequently transcribed verbatim and the scores for the each self-report measure were calculated.

4.6 Recruitment

The parent study consisted of a convenience, purposive, voluntary sample of participants recruited through a government-assisted clinic. For the purposes of this study, a multi-stage assessment procedure served to identify potential participants from the parent study's cohort. Eligibility of the participants was ascertained using specified inclusion criteria. Hence, I reviewed the EDPS (see Appendix A) and BDI (see Appendix B) scores for all 93 women. Women who met the inclusion criteria were selected as the final participants.

Inclusion criteria for the current study include:

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(1) Complete data for the self-report assessments for the; 1) 6-8 weeks postpartum, 2) 2-3 month postpartum and; 3) 8-9 months postpartum interviews.

(2) An EDPS score exceeding 9 for the; 1) 6-8 weeks postpartum interviews, 2) 2-3 month postpartum interviews and 3) 8-9 months postpartum interviews or;

(3) A score above 12 for the BDI for the; 1) 6-8 weeks postpartum interviews, 2) 2-3 month postpartum interviews and 3) 8-9 months postpartum interviews.

Two of the inclusion criteria merit further discussion. The second and the third inclusion criteria reflect a larger debate surrounding the boundaries that delimit the cut-off scores for postpartum depression. Thus, the cut-off scores were selected based on research suggesting that a lower cut-off score for the EDPS of 9 is required to adequately detect depressive symptomatology (see Dennis, 2004; Matthey, Henshaw, Elliott, & Barnett, 2006). A cut-off score of 9 for the EDPS has been reported to have a sensitivity of 84-100% and a specificity of 82-88% (Dennis, Merry, Stewart, & Gagnon, 2016). However, the EPDS does not discriminate between levels of depression, thus additional information is required to meet the diagnostic criteria for depression. Several studies have used the Beck Depression Inventory (BDI), in conjunction with the EPDS, for the purposes of assessing the severity of depression in postnatal women (see Miller et al., 2006; Tsai et al., 2013 for a review). The optimal cut-off for the BDI is 12, at which the sensitivity of the scale is 74% and the specificity 83% (Su et al., 2007).

There were complete data sets for 47 women. Of those 47 women, 11 fulfilled criteria 2 and 3, an adequate number of participants for a qualitative study (Ritchie, Lewis, McNaughton Nicholls, & Ormston, 2010).

4.6.1 Measures. Once the complete data sets were established, this study utilized the Edinburg Postnatal Depression Scale (EDPS) and Beck's Depression Inventory (BDI) to identify potential participants. As such, these measures were part of the recruitment process. Those who were identified as being at risk for postpartum depression with these measures were selected to participate in this study.

4.6.1.1 Edinburg Postnatal Depression Scale. The Edinburg Postnatal Depression Scale (Cox, Holden, & Sagovsky, 1987) is a self-report instrument comprised of 10 items designed to detect depression in postpartum women. The EDPS screens for cognitive and

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emotional manifestations of postpartum depression while deliberately excluding the somatic symptoms of depression. The EDPS has been shown to have high sensitivity specificity and predictive power for postpartum depressive symptomatology. Items on the scale are rated on a 4-point Likert scale ranging from 0 to 3.

The EDPS produces a summative score ranging from 0-30, with higher scores indicating an elevated risk for postpartum depression. A cut-off score of ≥ 12 is indicative of depression but a cut-off score between 9 and 12. 5 may be adopted (Lagerberg, Magnusson, & Sundelin, 2011). For the present study, a cut-off score of 9 was used, as recommended by Dennis (2004). The EPDS has an internal consistency reliability of 0.88 and sensitivity of 0.86 (Anderson, 2010; Beck & Driscoll, 2006; Cox et al., 1987). Other studies have estimated the Cronbach's alpha as 0.85 (Adewuya et al., 2006), 0.90 (Adouard, Glangeaud-Freudenthal, & Golse, 2005), 0.79 (Kheirabadi, Maracy, Akbaripur, & Masaeli, 2012), and 0.81 (Eberhard-Gran, Eskild, & Opjordsmoen, 2006).

4.6.1.2 Beck's Depression Inventory. Beck's Depression Inventory (BDI) (Beck, Ward, Mendelson, & Erbaugh, 1961) was constructed in 1961 to measure depression. The BDI consist of 21 items with a 4-point Likert rating and a cut-off of 15 or more is indicative of depression. Scores between 0 and 9 are indicative of minimum symptoms of depression; 10 and 16 are indicative of minor symptoms of depression; 17 and 29 are indicative of average levels of depression, and scores between 30 and 63 are indicative of a major or severe form of depression. It is important to note, however, that cut-off score guidelines maintain that thresholds be adjusted based on the characteristics of the sample, and the purpose of use. The BDI is considered reliable across different populations, with a reported a coefficient alpha of 0.91 and test-retest reliability of 0.96 (Beck, 1996). The BDI is not considered as a suitable measure for the detection of postnatal depressive symptoms because of its reliance on somatic symptoms to measure levels of depression (Boyd, Le, & Somberg, 2005).

Several studies have used the Beck Depression Inventory (BDI), in conjunction with the EPDS, for the purposes of assessing the severity of depression in postnatal women (see Miller et al., 2006; Tsai et al., 2013 for a review). According to Lussier, David, Saucier, and Borgeat (1996), the EPDS and the BDI should be used in conjunction as neither scale is thorough enough on its own. The authors found that these scales are differently attuned to

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different facets of postpartum distress: the EDPS is better at gauging affective disturbances, while the BDI is more sensitive to the breaking down of coping mechanisms. Using only one measure may, therefore, lead to a loss of information about the distinct dimensions of depression.

4.7 Participants

The participants consisted of 11 low-income, coloured women who participated in the parent study. These participants ranged from 17 to 38 years of age, with a mean age of 25. The number of children for each of the participants ranges from 1 to 3, while most of the participants were primiparas. The majority of women indicated that they were unmarried or were single, while some indicated that they were married, engaged or in a relationship. However, the relationship status of many women changed between recruitment and the final interview. In relation to educational level, 8 women reported that they did not finish high school, and 3 reported having completed matric. The demographic questionnaire is presented in Appendix C.

Table 1 provides an outline of the demographic details of the research participants.

Table 1

Demographic Information of Participants

Code name	Age	Parental status	Relationship status	Education	Employment
Alice	27	Multipara	Married	Grade 8	Employed
Bernadette	28	Multipara	Single	Grade 11	Employed
Blondie	17	Primipara	Single	Grade 9	Unemployed
Elize	38	Multipara	Married	Grade 7	Employed
Millicent	19	Primipara	Engaged	Matric	Unemployed
Nina	25	Multipara	Engaged	Grade 8	Unemployed
Pienkie	33	Primipara	Boyfriend	Grade 11	Employed
Robena	21	Primipara	Single	Matric	Employed
Sam	18	Primipara	Boyfriend	Grade 11	Employed
Suzanne	22	Primipara	Boyfriend	Matric	Employed
Wilmien	35	Multipara	Married	Grade 9	Unemployed

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4.8 Data collection

The data analysis focused on understanding the experiences of maternal distress in low-income mothers throughout the transition to motherhood. I took a viewpoint similar to Kruger (2006) who proposed that parenting meanings are enmeshed with social, political and cultural contexts and they cannot be separated from the larger social organization. In order to explore the experience of maternal distress from this viewpoint, data was collected through analyzing transcripts of the participants.

In the parent study, interviews were conducted by the principal investigator and Honours students over a period of four years. These interviews generally lasted anywhere from one hour to 90 minutes and were conducted in the women's homes. The interviews were concerned with gathering in-depth information regarding the emotional experience of motherhood grounded in their lived experiences (see Appendix D for interview schedule). The data analyzed for the current study comprised of verbatim transcripts of semi-structured open-ended interviews conducted with 11 of the 93 participants (who participated in the parent study). More specifically, the dataset consisted of the interviews for each participant at 6-8 weeks postpartum, 2-3 month postpartum and 8-9 months postpartum. As such, all of the interviews that were conducted formed part of the dataset, giving a total of 33 interviews.

The data analysis encompassed a perusal of the interviews in transcription format. This was done by using the grounded theory approach with a specific focus on the constructivist version of this methodology (Charmaz, 2008; Henwood & Pidgeon, 2006). This method merges well with social constructionism.

4.9 Data management

The data were rigorously transcribed verbatim where all verbal utterances were included. Transcription was completed using the guidelines proposed by Silverman (2000). The interview data and transcriptions were stored electronically in a password protected file. Hard copies of transcripts were stored in a locked cabinet. Only my supervisor and members of the research team had access to the data. In addition, participants were given a pseudonym that was linked to their data, and these pseudonyms were used in the current document and will also be used in any future academic outputs, such as conferences and published articles.

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4.10 Data analysis

The data was analyzed using social constructionist grounded theory methodology, a data analytic strategy that is suitable for capturing the meaning of the experience within the context wherein it occurs or exploring the experience of an event or situation within its specific context (Charmaz, 2006). Grounded theory consists of five steps, including coding (open, focused, axial and selective) and comparative analysis. These steps provide a set of systematic procedures for identifying categories and relationships between categories which arise from the data. It is important to note, however, that grounded theory is not a prescriptive methodology and allows a set of flexible guidelines which can be adapted according to the aims of the research.

One challenge during the analysis was my lack of practical experience in qualitative coding techniques. To overcome this hurdle, I initially employed the micro analytic techniques described by Corbin and Strauss (2008). Data-analysis, according to social constructionist grounded theory, began with the initial open and descriptive line-by-line data-coding by naming each line of the data by means of a specific and active descriptive code (Charmaz, 2006, 2008).

Open coding consists of breaking down the data into smaller meaning units in order to identify the core idea of this unit (Strauss & Corbin, 1998). This was done by examining the transcriptions in a line-by-line manner in an effort to create active codes (Charmaz 2005, 2006; Strauss & Corbin 1998). In order to remain close to the data, codes were named using the participant's own words (Charmaz, 2006; Strauss & Corbin, 1998).

Once open coding was complete, focused coding allowed a more nuanced categorization of the data. Focused coding refers to the process of systematically grouping codes into code names and code names into categories or themes (Strauss & Corbin, 1998). Here, codes were linked to create more abstract codes. These codes were then used to explore similarities between the codes. The emergent categories were used to identify which codes were relevant and which were subordinate.

The third stage, axial coding, consists of integrating and refining theory (Strauss & Corbin, 1998). During this stage, the core theme was identified. Thereafter, the core theme

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was related to the subthemes in an effort to identify the central phenomenon (Creswell, 2007). Using memo-writing, categories were defined; their properties explicated, and their relationships highlighted. Data matrices were constructed as a means of visually comparing the data in the following ways: (a) comparing similarities and differences between the codes of each participant; (b) comparing new data with previously defined themes, and (c) comparing a theme with other themes. The objective of this step was to ensure cohesion between themes and/or data saturation (Strauss & Corbin, 1998).

The analysis of the data was guided by feminist social constructionism. Essential to feminist social constructionism is the development of knowledge which can be used to curtail the oppression and exploitation of women (Ussher, 2004). Accordingly, feminist analysis of the data occurred through the identification of issues related to power, politics, culture, class, and gender that have shaped women's lives.

4.11 Reliability and validity

Although reliability and validity are concepts used for testing or evaluating quantitative research, these terms are often extended to qualitative research as well. However, Saville Young (2016) contend that the quality of a study should be evaluated according to its own methodological terms. As a result, many qualitative researchers have developed their own concepts of validity. These concepts are considered to be more suitable for qualitative studies and consist of quality, rigor, and trustworthiness (Saville Young, 2016). As such, the four processes used in this study to ensure quality are sensitivity to context; commitment and rigor; coherence and transparency and impact and importance (Yardley, 2011). The steps taken to follow the above principles are discussed below.

4.11.1 Sensitivity to context. Sensitivity to context is established by an understanding of the relevant empirical and theoretical literature as well as the sociocultural context of the participants (Yardley, 2008). In order to demonstrate sensitivity to the political context in which the research was conducted, an exhaustive review of existent research around maternal distress and poverty the South African context was undertaken. I familiarized myself with current debates surrounding gender, psychopathology, poverty and diagnostic labels. The socio-political context in which the participants were located was also considered.

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4.11.2 Commitment and rigor. Commitment and rigor refer to the validity of results. This is achieved by conducting an analysis that is of sufficient breadth and/or depth (Yardley, 2008). Therefore, extensive engagement with the topic as well as a competency in data collection and analysis needs to be developed and demonstrated (Yardley, 2011).

Commitment to the research process was facilitated by using a reflective journal during data analysis. This enabled an immersion in the data as well as an awareness of implicit assumptions. In order to increase the rigor within the study, transcripts were cross-coded both jointly and separately during a qualitative research group. Discrepancies in the use of codes or their meanings were discussed and reconsidered if necessary.

4.11.3 Coherence and transparency. Transparency refers to the readability and accessibility of the research process (Yardley, 2008). In order to achieve transparency, a systematic description of the research process was provided. Coherence refers to the consistency of the arguments presented in relation to its representativeness of the data (Leung, 2015). Verbatim quotations were provided to demonstrate coherence in the analytic stage of the research process. These quotations enable readers to evaluate the fit between the data, its interpretation and the arguments presented in this thesis (Yardley, 2008).

4.11.4 Impact and importance. Impact and importance refer to the contribution of the research findings (Yardley, 2008). Sharma and Burt (2011) called for studies located in the puerperium period in order to help prevent the misrecognition and misdiagnosis of postpartum depression. The aims of this study were in line with this recommendation. It is also hoped that this study may help to promote a dialogue around the distress experienced during the postpartum period and the treatment thereof.

4.12 Research and reflexivity

In this context, reflexivity will be referred to as the capability to engage in a critical understanding of my own experiences' and circumstances' contribution with regards to the forming of this study. As such, this subsection will consider my epistemological and personal reflexivity. Epistemological reflexivity encompasses a recursive reflection upon the ways in which my own beliefs, values, and interests have shaped this research. Personal reflexivity explores the assumptions that influenced my interpretation of the findings.

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My analysis was influenced by a variety of factors, both external and personal, including the opportunity to undertake a more critical approach to a qualitative piece of research, engaging the voice of low-income women who have experienced maternal distress. More personally, I acknowledge my position as a woman in her 20's who has not experienced motherhood, as an extra-discursive factor, possibly influencing my analysis of the transcriptions.

The decision to use secondary data as a research strategy was informed by a prior literature review which suggested that the Women's Mental Health Research project addressed research questions that were complementary to my own research interests. The Women's Mental Health Research project examined themes of motherhood, poverty, and the impact of socio-cultural constraints on these experiences. My own interests were focused on how normal life experiences could be pathologized by the ever-increasing medicalization of everyday life by the DSM and ICD.

The similarities between the primary and secondary areas of investigation enabled a well-suited fit between the primary dataset and the secondary research question (Long-Sutehall et al., 2011). The qualitative data was obtained from the larger study which contained transcripts of interviews with low-income mothers and their experiences of motherhood.

I approached the primary data with an expectation that the interview transcripts would provide rich information that could generate new ideas for exploring in a subsequent research study of mothers in transition, and gain insight into the lived experience of an understudied population (Kruger, 2006). I was especially interested in the re-use of qualitative longitudinal data because I believed it to be an efficient way to conduct a research study for an inexperienced researcher with access to limited resources.

At times I was touched by the hardships and injustices that colored these women's lives, and I was also frustrated by the apparent barriers these women faced. I was particularly disturbed by one extract which seemed to indicate that the mother had difficulty feeding her baby due to financial constraints.

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I became immersed in the data as I read the interview transcripts and progressed through the data analysis. Similar experiences were reported by Frost and Nolas (2011) where they describe the reactions of researchers conducting secondary analysis to a transcript as developing relationships with the interviewer and interviewee. James (2013) explains how the secondary data researcher makes sense of the transcripts within the context of their own perspectives and in some part, this leads to a co-creation of reality between interviewer and interviewee. This corroborates with my own experience where I found myself developing mental pictures of the interview setting and the people involved. In many instances, I found that the quotations spoke for themselves and revealed the ideologies of motherhood more clearly than I expected.

One major weakness posed by the use of secondary data is the absolute dependence on the written record. There is no opportunity for the secondary analyst to ask supplementary questions, or to clarify answers provided by the research subject.

Overall, I experienced the transcripts as providing rich descriptive information which was emotionally engaging. The analysis of secondary data offered valuable insights into an exasperating experience and saved unnecessary intrusion into people's private lives (Whiteside, Mills, & McCalman, 2012).

4.13 Ethical Considerations

This section describes the measures that were taken to ensure the protection of participants' rights during this research study. Informed consent, confidentiality, and fidelity are ethical concerns central to archival data analysis.

In the case of archival data analysis, informed consent cannot be presumed. The onus rests on the researcher to discern whether the re-use of data will violate the initial agreement made between the primary researcher and the participant. The basis for interpretation regarding the degree of informed consent relies on the fit between the original research question(s) and the secondary research question (Carusi & Jirokta, 2009). In the original study, participants may have volunteered to share their experience about a phenomenon for an identified purpose. Thus a radical departure from the originally identified purpose of the research violates the conditions under which consent was obtained.

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In relation to the parent study, the scope of this research study was deemed sufficiently related to the specific conditions of the original consent (see Appendix E). Therefore, a decree was made that the consent gained in the primary research was suitable to carry out the proposed study. Additionally, this study was approved by the Departmental Ethics Screening Committee (DESC) at Stellenbosch University. Further ethical issues are outlined below.

Confidentiality was maintained by using code-names, chosen by participants themselves. Thus, all interview data in the study were personified, and all names and other identity cues subsequently removed to ensure anonymity. Small portions of the transcripts, rather than entire transcripts, were used in the report. Throughout the study, all electronic data were kept in secure storage, which was only accessible to the research team.

4.13 Conclusion

This chapter has sought to give a detailed account of the research process and the methodological approach chosen. As has been discussed, social constructivist grounded theory and qualitative longitudinal methods of inquiry are the main vehicles through which the research questions were explored. The data were collected through analysis of the transcripts from the interviews that were conducted throughout the postpartum period. The findings from the analysis of participants' experiences of distress in the transition to motherhood are presented in the next chapter.

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Chapter five: Results and discussion

This study aimed to explore the experiences of distress in the transition to motherhood in a group of low-income women. These experiences are explored in the current chapter. In this regard, seven major categories and 21 subcategories emerged from the analysis conducted on the data. The categories are provided in Table 2.

These findings suggest that the experience of postpartum distress in a low-income context is complex and multi-layered. Without exception, the women in this study situated their experience of postpartum distress within the material and social circumstances of their lives, immediately foregrounding the context within which the women mother. While the participants shared the stories of their unique lives as women, it was apparent that there were definite similarities among their experiences. Regardless of how the mothers described their distress, their experiences are recursively gendered.

As such, these accounts encompass not only the embodiment of what maternal distress feels like, but also the cultural, social, political, economic, and interpersonal realities within which the participants' mother. Accordingly, the attempt to integrate idealized notions of femininity with their personal experiences appears to be at the core of this distress. The following seven categories that emerged from the data are presented under the following categories and subcategories:

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Table 2

Outline of Categories and Subcategories

Categories	Subcategories
The mothers	Alice
	Elize
	Bernadette
	Suzanne
	Wilmien
	Nina
	Sam
	Millicent
	Pienkie
	Blondie
	Robena
The expectations and reality of motherhood	Infant care
	Adjusting to the realities of motherhood
	Overwhelming responsibility
Caregiving overload	Role strain
	The loneliness of motherhood
Dysfunctional interpersonal relationships	Betrayal and infidelity
	Interpersonal partner violence
Mothering in poverty	
The physical body and motherhood	Birth related distress
	Breastfeeding
	The postpartum body
The silencing of the self	

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In line with feminist social constructionist methodology, the aim of this chapter was to provide an overview of the experience of maternal distress as it is embedded in the material and social lives of the participants. As such, I provided an analysis of the emotional experience of maternal distress through the gendered and institutionalized practices within society that structure the everyday experiences of low-income mothers.

In order to achieve this, the first section of this chapter serves to introduce each of the participants and present their uniquely authored stories. This serves to introduce the reader to each of the participants and to offer an overall perspective into the participants' stories. Next, a description of each category and its subcategories will be discussed with direct quotes to support them. This is also done to make participants' voices audible. While customs dictate a separate data analysis chapter from the discussion of research findings when using a feminist social constructionist analysis as a methodology, this separation becomes less distinct as describing data, explaining and contextualizing it, are significantly interlinked (De Vos et al., 2005).

5.1 The mothers

More than simply introducing the participants, this section allows the unique stories of each of the mothers to be heard and presents the differences and the similarities of their experiences. It also provides a holistic picture of the experience of the transition to motherhood as these individual mothers perceive it. These stories show that while there may be a similar thread to each of the stories that were told, there are also critical differences in each mothers' experience of motherhood.

5.1.1 Alice. Alice's EDPS scores were 9 at her first interview, 11 at the second and 16 at the last interview. Her BDI scores were 18 at her first interview, 18 at the second and 19 at her last interview.

Alice was 27 years old at the time of the interviews. She had two daughters and was expecting her third child, a boy. Alice, her husband and children live on a farm where both Alice and her husband are general workers. Alice gave birth in Stellenbosch Hospital, and despite wanting to have her husband with her, he was not allowed in the delivery room.

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While very excited about the new baby, Alice was very worried about the extra financial strain that the new baby would bring as the family was already struggling financially.

> Interviewer: What do you think is a perfect or ideal birth? How would that be?
> Alice: How would it be? Or how was it?
> Interviewer: Yes, how do you think it has to be? How would your birth be if it was perfect?
> Alice: I thought it was perfect except that the father wasn't there.

5.1.2 Elize. Elize's EDPS scores were 17 at her first interview, 18 at the second and 18 at the last interview. Her BDI scores were 33 at her first interview, 29 at the second and 28 at her last interview.

Elize was 38 years old at the time of the interviews. She was expecting her third baby, a girl. Elize is married and lives with her husband, three children and her mother. They reside on a farm, where Elize works as a farm worker. Elize was the sole provider for her family as her husband would often spend his money on alcohol. The lack of instrumental and financial support from her husband often caused Elize distress.

> Elize: And as old as she is now, she's already 6 months old. I haven't been able to buy her anything, not a dress or shirt or anything. I've only ever received things from other people.

5.1.3 Bernadette. Bernadette's EDPS scores were 9 at her first interview, 21 at the second and 16 at the last interview. Her BDI scores were 12 at her first interview, 21 at the second and 12 at her last interview.

Bernadette was 28 years old at the time of the interviews and had full time employment at a guesthouse. This was her second baby. During her interviews she unveiled that she had lost her first baby, a little girl, 9 months after her birth. Bernadette lived with her mother and two brothers, whom she is very close with. By her third interview, the father of Bernadette's baby had left her for her another woman. This caused a lot of distress for Bernadette.

> Bernadette: The only thing that I wanted was that he would be there, but he wasn't. I have forgiven him for that as well. It doesn't help to cry and moan about it. My friends and my family support me. I really wanted him to be there, but

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> more than that my friends and family were there for me. That was the most important thing I wanted, but it didn't happen that he was there.

5.1.4 Suzanne. Suzanne's EDPS scores were 10 at her first interview, 9 at the second and 9 at the last interview. Her BDI scores were 16 at her first interview, 18 at the second and 14 at her last interview.

Suzanne was 22 years old at the time of the interviews, and expecting her first baby. She was working as a waitress at a wine farm. Suzanne lives with her mother but spends most of her time with her boyfriend. She describes herself as someone who is very social, but also someone who is very private. Her appearance was important to her and she had spent a lot of time making sure she looked attractive. The changes to her body and her lifestyle had been difficult for her to accept.

> Interviewer: The role of your friends? Do they still come regularly?
> Suzanne: They come sometimes – less than usual.
> Interviewer: Less than usual. Would you say it bothers you?
> Suzanne: Sometimes it bothers me, but also not really. Okay yes it bothers me – I go out with them less often. I do fewer things with them; I am at home with the baby most of the time, so it does bother me a little, but not so much.
> Interviewer: Hm.
> Suzanne: Sometimes I'll think, I could've gone out, but now I have to stay.

5.1.5 Wilmien. Wilmien's EDPS scores were 20 at her first interview, 15 at the second and 12 at the last interview. Her BDI scores were 13 at her first interview, 14 at the second and 19 at her last interview.

Wilmien was 35 years old at the time of the interviews. She was employed as a farmworker, but stopped working after the birth of her baby. She lives with her husband, children and elderly father. Even though she had had two children previously, Wilmien often felt unhandy when caring for her third baby, as there had been a 6-year gap between her second and third child. While Wilmien described herself as blessed to have another baby, her narratives were often overshadowed by the resentment she felt towards her husband. This was compounded by her husband's drug abuse which not only made him even more emotionally and physically unavailable, but also abusive.

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> Wilmien: He's just naughty, this man, because the help that he has to give me, he doesn't give. And then I am responsible for the whole household and the children and he does not help me. If I can say, okay do this then I don't have to do it, but I still have to always keep doing it. You get so full that, uh, a depression builds up. Now uhm, at night he, when he comes from work, he just comes from work then he goes out with friends. Then he lies down, and when he lies down, he orders me around, he wants coffee now and he wants his food. Now that is what stresses me out, because, if he helps me then I can continue going forward, but he breaks my spirit he really breaks it down.

5.1.6 Nina. Nina's EDPS scores were 9 at her first interview, 16 at the second and 26 at the last interview. Her BDI scores were 13 at her first interview, 12 at the second and 22 at her last interview.

Nina was 25 years old and unemployed at the time of the interviews. This was her second baby, as she already had a 5-year old son. She lives in a house with her mother, father, sister, niece, nephew and her children. From the outset, Nina emphasised the importance of having her partner be active in the baby's life. Her son's father had left her soon after his birth which was clearly devastating for Nina. She often noted how she struggled to provide for her son without the assistance of a father and how difficult it had been to raise a baby alone. As a result Nina desperately wanted to get married. Her boyfriend was described as being very caring and supportive during the first few weeks of the baby's life. However he became more distant as the baby got older. This preoccupied Nina's narrative significantly.

> Interviewer: How are things different now that you have a new child?
> Nina: Uhm. What's different is that Justin's father was there a lot, but he didn't like to work. He would be with his child the whole day without going to work. And her dad loves to work but he gives more attention to his friends than to her.

5.1.7 Sam. Sam's EDPS scores were 9 at her first interview, 13 at the second and 15 at the last interview. Her BDI scores were 14 at her first interview, 12 at the second and 12 at her last interview.

At the time of the interviews, Sam was 18 years old and worked at a laundromat. She lives with her mother, brother, two sisters and her baby. Unlike many of the participants, Sam's boyfriend had stayed with her throughout the interviews and provided much needed support. Despite this, finances were a constant struggle for the couple, as Sam struggled to find work. What became apparent from the interviews was that her boyfriend simply did not

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have the money to support Sam and her baby, but often giving the very little that he had. Initially Sam had difficulty with caring for her baby, which caused her some distress.

> Sam: I don't feel, how can I say, I don't have that pressure that I had.
> Interviewer: Is it? What type of pressure are you talking about?
> Sam: Well, to tell you the truth, she was too busy, and in the morning I became anxious and I don't know what to do. I did everything, but she did not want to stop crying. Later on she stopped crying and slept.

5.1.8 Millicent. Millicent's EDPS scores were 13 at her first interview, 20 at the second and 19 at the last interview. Her BDI scores were 12 at her first interview, 24 at the second and 23 at her last interview.

Millicent was 19 years old at the time of the interviews, and worked in a factory. She was expecting her first baby. Millicent lived with her father and four brothers. Millicent describes herself as an anxious, shy and self-conscious person. Millicent's family was not happy about her pregnancy and had hoped she would enjoy career opportunities they themselves had been denied and motherhood was perceived as a potential threat to these ambitions for her. Millicent often felt inadequate as a parent. Caring for her baby was difficult, and she was constantly worried about his health.

> Interviewer: Are you worried when he coughs?
> Millicent: Yes, it looks like he is going to choke.
> Interviewer: And you are worried that he won't be able to breathe when he is sleeping?
> Millicent: Yes, I never sleep. At night I never sleep because I am so worried about him.

5.1.9 Pienkie. Pienkie's EDPS scores were 22 at her first interview, 21 at the second and 26 at the last interview. Her BDI scores were 41 at her first interview, 20 at the second and 52 at her last interview.

At the time of the interviews, Pienkie was a 33-year old waitress. Pienkie reported feeling very unhappy because she was still living with her family and desperately wanted to get a place of her own. She expressed a lot of resentment towards her family, who often infantilized her but also expected of her to be the breadwinner. As with her family, Pienkie had a complex relationship with her boyfriend. She reported that he was often unfaithful and

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had been abusive on more than one occasion. Her precarious interpersonal relationships often left Pienkie unhappy and she maintained that she cried often. Pienkie had planned on having a baby and after three miscarriages she was very happy to be a mother. However, towards the end of her interviews Pienkie expressed regret at having a baby. Her family was often critical of her parenting, and her boyfriend had left her for another woman. This was a bitter reminder of her own childhood, where her father had left her mother soon after she was born. This had a profound psychological impact on Pienkie.

Pienkie: I am not sad anymore. Not sad at all anymore. I just feel hard.

5.1.10 Blondie. Blondie's EDPS scores were 11 at her first interview, 9 at the second and 9 at the last interview. Her BDI scores were 17 at her first interview, 26 at the second and 24 at her last interview.

Blondie was 17 years old at the time of the interviews, and had just completed grade 9. While Blondie was well supported by her mother and siblings; she expressed a strong dislike towards her father whom she claimed was often abusive. She also struggled to get the financial support she needed from her ex-boyfriend. As a result Blondie had to resort to working full-time as well as being the sole carer for her baby, which often left her exhausted. Blondie often lamented the fact that she ended up being the sole carer for her baby.

Blondie: He must support me. And I mean, you don't have to go through that situation alone.
Interviewer: Mmm.
Blondie: Because it takes two to tango.
Interviewer: Mmm.
Blondie: You can't suffer alone, I mean after the child is born or while you are still pregnant, you just have to suffer alone, what's the child going to wear, how am I going to support my child.

5.1.11 Robena. Robena's EDPS scores were 15 at her first interview, 17 at the second and 15 at the last interview. Her BDI scores were 12 at her first interview, 16 at the second and 18 at her last interview.

Robena was 21 years old at the time of the interviews and worked as a reserve policewoman. This is her first baby, although she reported experiencing a miscarriage in her adolescence. She lived with her mother but reported that she had a very strenuous

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relationship with her which was often conflictual with very little communication. She also maintained that her pregnancy had exacerbated the problem, as tensions seemed to increase after the pregnancy. The father of her baby left her for another woman, which left Robena feeling hurt and betrayed. Robena's mother and her ex-boyfriend also experienced a strained relationship which made it difficult for Robena to garner any financial support from him.

> Robena: Practically, she doesn't want me to accept anything from him. No money, nothing…anything that he sends, she sends back to him.
> Interviewer: So she's very bitter towards him?
> Robena: He's not allowed to come here at all.
> Interviewer: Really? But you and your mom's relationship?
> Robena: She doesn't hold anything against my baby. Sometimes I notice there's…she still has something against me, or she blames me and other times, she'll try to hurt me with words.
> Interviewer: Have you talked about it? Is it something that has come up?
> Robena: It is difficult to speak to my mother about it. She doesn't like it. We don't have the ability to communicate efficiently. We can talk about other things, but we don't talk about problems between us. Because…I, I will accept it more easily if I…
> Interviewer: Talk it out?
> Robena: Yes, but she has been this way since I was a child, well she was the mom, the older one, we can't tell her if she's wrong. We can't give our opinions. It's been like this for years. And when we do it, she gets angry. She's angry at us and she's angry at her husband. And then she'll start talking, but she won't talk about the tihng she's angry about.

5.1.12 Summary. These stories provide a brief impression of the narratives that the mothers told in the interviews. The intention of these stories is to provide an overall understanding of their circumstances. What is striking in the presentation of the stories is just how unique each mother's experience is, despite the similarities in the stories. While many of the stories shared some aspects, each mother faces challenges that are specific to her own circumstances. It also suggests that motherhood is highly influenced and dependent on the contexts in which mothers mother.

5.2 The expectations and the reality of motherhood

The birth of a child can be seen to provide a 'turning point' crucially the anticipation of the baby becomes the experience of the baby. This category is characterized by a sense of unpreparedness for life with a baby. Implicit in the mothers' accounts was the major incongruence between the realities of becoming a parent and their suppositions of what

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motherhood would be like. Every aspect of the mothers' lives was encroached upon and even when the mothers had time for themselves, it was always constrained by the baby's needs. The relentlessness demands of infant care evoked in them a sense of loss when they reflected upon how much their lives had changed. The impactful nature of social and historical norms on the mother's transition into parenthood further assist in describing the post-expectant period for these mothers. In this regard, three themes were identified: infant care; adjusting to the realities of motherhood; and overwhelming responsibility.

5.2.1 Infant care. Many of the women identified a dissonance between their expectations of what motherhood entailed and the reality of being a parent. The participants' days filled with a new routine. They had new skills to learn and they were also learning how to care for their babies. For a lot of participants caring for a baby is heavy and demanding work. For Millicent not knowing what to do affect her profoundly. She describes how helpless she feels when her baby cries.

> Millicent: And when he starts to cry, I get, on the one hand you also want to cry, because you don't know what's wrong with him, where the pain is. You can't really help, because they're still too small to talk or to tell you where the problem is.

Similarly, Blondie found her baby's crying utterly bewildering and invariably causing her to feel inadequate.

> Blondie: Sometimes I feel I am stupid, I don't know what to do; I don't know what's wrong with the child.
> .

Other participants spoke of being impatient and becoming angry with their infants.

> Sam: Well, sometimes I get angry but then I say, okay don't, you don't have to get angry. But later, at night she will want her candle. She wants a candle with her the whole time, and then I have to wait until she falls asleep.
>
> Blondie: She makes me angry sometimes.
> Interviewer: Yeah?
> Blondie: With the continuous crying, sometimes I want to change her or if, I try to burp her.

Interestingly, despite having two children Wilmien stated that she had forgotten how to take care of such a small baby.

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> Wilmien: It feels very clumsy, very clumsy work. You forget… sometimes how to handle your child, especially when they're still so small. Then you have to start teaching them from scratch and you don't know how, so…yes, it's difficult work.

For the participants in this study, being a mother encompassed a range of emotions from joy to resentment, anger and frustration. Clearly, some mothers in this study were especially impacted by crying and fussiness. Research has indicated that mothers are more affected by crying and fussiness due to their own feelings of inadequacy and incompetence when it comes to caring for their infants (Ellet, Appleton, & Sloan, 2009). Indeed, Leung et al. (2005) found that mothers often felt inadequate and frustrated because they considered themselves to be incompetent mothers. These findings are reflected in this study where feelings of inadequacy are exacerbated by crying and fussiness, which is reinforced by their inability to soothe their babies.

Motherhood as an institution includes tremendous responsibilities. The myth of motherhood perpetuates the notion that motherhood is a natural transition easily assimilated into women's everyday lives (Haynes, 2007). These representations reinforce the dominant myth that motherhood is instinctual, that all women possess an inborn aptitude to immediately take care of an infant (Choi et al., 2005) and that caring for an infant is easy and effortless. These expectations might also contribute to difficulty in creating realistic expectations of what motherhood might be like, which may cause distress in the face of challenging situations experienced when caring for their infants.

Most participants did not naturally and effortlessly slip into motherhood. As a result, these mothers felt unprepared and under-resourced when it came to motherhood and caring for their babies. This lack of preparation might make taking care of an infant particularly difficult. Research has demonstrated that individuals who are more aware of the many ways having a child will impact their life experience a less difficult transition. Accordingly, mothers who are less prepared and have less prior experience on which to develop expectations may have more difficulty in the transition to motherhood (Lazarus & Roussouw, 2015). Implicit here is the notion that mothering is natural and easy as perpetuated by the myth of motherhood. As such women enter into motherhood with strong expectations of themselves as mothers, their babies, and the mothering role

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5.2.2 Adjusting to the realities of motherhood. Many of the women identified a dissonance between their expectations of what motherhood entailed and the reality of being a parent. Mothers experienced difficulties when confronted with a different reality than what they had anticipated. Some women felt they were unprepared for the constant demands made on their time, attention and fortitude by the new baby. Robena explains what she expected motherhood to look like.

> Robena: I told myself at least I would still be able to do this or do that, when he goes to sleep, but when I planned to do a specific thing it almost looks like he doesn't want to go to sleep.

Later, she elaborates on the expectations she had of her baby. Interestingly, she finds a bigger baby to be a negative thing – it is usually the other way around. At this stage this baby was only a few weeks old. It might be an indication that the responsibility for caring for her child was too big.

> Robena: I thought that, I could easily leave him with others because I am someone who talks to other people easily and so on. I accepted that he won't be difficult when I leave him with other people but that's not the case now.
> Robena: And, how can I say, I didn't expect that he would be so big. I expected him to be a small baby, and that I would be able to cuddle him for a long time. He is too big.

Similarly, Millicent speaks about how she didn't anticipate the difficulty of childcare.

> Millicent: Yes, on the one hand. I didn't know that it would go like this, because every couple of hours he wakes up with gas that I have to burp and sometimes it's difficult to get out, because they say the gas sits under his shoulders and in the back. I have to rub. Sometimes it doesn't come out easily. Then you have to comfort him the whole night, and keep burping him.

Many of the women identified a dissonance between their expectations of what motherhood entailed and the reality of being a parent. Mothers experienced difficulties when confronted with a different reality than what they had anticipated. This discrepancy has been noted in the literature on maternal distress (Tammentie et al., 2004; Westall & Liamputtong, 2011). This difference between myth and reality (expectations and experience), can leave a mother feeling bewildered by her experience, leading to feelings of being trapped, desperation, and extreme guilt (Choi et al., 2005). Miller (2005, 2007) argues that the

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unpreparedness of the reality encompassing motherhood leads to mothers feeling ambivalent about their mothering role as well as about their baby.

Stadlen (2011) describes the dissonance between the mother's expectations and her experience as 'nurture shock'. Accordingly, research conducted by Read, Crockett, and Mason (2012), found the gap between mothers' expectations and the reality of motherhood contributed to a sense of shock. They maintain that the ideology around good motherhood may create this gap because new mothers are misinformed on the reality of what motherhood is like. These findings were reflected in this study where the women entered into motherhood with strong expectations of themselves as mothers, their babies, and the mothering role. As a result the mothers did not realise that motherhood would be so dissimilar from their expectations and were in a state of confusion about how different the lived experience was.

5.2.3 Overwhelming responsibility. This subcategory centres on how much life changed for mothers once their babies have arrived. Coming home meant adjusting to the new realities and responsibilities of caring for a new-born as well as getting back to their old responsibilities. Some women described how they were unable to find any time for themselves in the wake of the baby's demandingness while still running a household. This perpetual responsibility led to feelings of ambivalence towards motherhood. Robena found the change in routine particularly difficult. She expresses the contradictory feelings produced by the mothering experience.

> Robena: It's fun, but it's a big responsibility.
> Robena: You as a person have a routine that you've been caught up in your whole life and now all of it has to change again, because of the baby.

While adjusting to their new lives, many mothers noted that they were also losing the freedom to have an active social life. The curtailing of her freedom is especially difficult for Robena to cope with.

> Robena: There's no more… I can't go to my friends anymore, when I feel like it or like I used to do before the baby was here. I can't just leave when I feel like leaving like when I was young, not that I was young (laughs) but when I wasn't a mother yet.

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The babies took over every part of the women's lives. Robena describes how she found herself entirely preoccupied with her baby. Even when she is not busy with him she thinks about him.

> Robena: The time I have to bathe and maybe sit in front of the TV, without him, but actually there's no time that I can live without him, he's there every minute of the day. If I am not busy with him I am thinking of him (laughs). There's something about him that keeps me busy.

Millicent speaks about how responsible she feels for her baby. She realizes the added reality that life as she knew it is essentially over. With the birth of her baby, she is faced with a new lifestyle.

> Millicent: I feel responsible. Very responsible.

> Millicent: If you have a baby, your life is not the same anymore. It's a big change.

Pienkie notes how the increased responsibility increased her stress.

> Pienkie: Yes, I have a lot more stress now, I have more stress. Like I said to you, a girl has to make hundred percent sure that she wants a baby.
> Interviewer: Yes.
> Pienkie: For the things that you go through.

For mothers in this study, having a baby is marked by a series of complex adjustments in addition to a loss of living in a way the mothers previously understood it. At the time of the interviews most of the mothers were trying to make sense of and come to terms with the enormity of the changes in their lives. Every moment of the day and much of the night is caught up with caring for their babies. Even if physically separate from their infants the women's thoughts constantly returned to their babies. The all-encompassing nature of childcare left some women desperately trying to hold onto a sense of their selves, and their lives prior to giving birth. The mothers described how they felt confined - physically, emotionally and socially. Having children was invariably at odds with having any undisturbed time, space or privacy to enjoy activities previously taken for granted. As such there was a loss of previous routines and autonomy. This led to feelings of ambivalence.

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These findings are in line with previous research that maintains the transition to motherhood entails a change in lifestyle that is different in almost every aspect (Stadlen, 2005). Tremendous changes occur in the mother's world as there is the surrendering of personal autonomy and identity as well as a re-defining of the mother's interpersonal relationships (Laney et al., 2015). This new identity requires a reconstruction of the old non-mother identity which may evoke a sense of loss for the woman (Lewis & Nicholson, 1998). Shelton and Johnson (2006) found that the magnitude of this change was challenging for new mothers as they had not expected the enormity of it. Accordingly, Buultjens and Liamputtong (2007) contend that adapting to the changes that comes with motherhood is challenging to cope with because the changes are so extreme.

5.2.4 Summary. The main tenet of this category revolves around the changes that have occurred in the new mother's life. Life now revolves around her baby and the usual routines of her life are no longer possible. Every moment of the day and much of the night is caught up with responding to their often inscrutable baby, who remains a mysterious bundle of needs. The baby consumes all the mothers' time and thoughts which makes assimilating her new identity particularly difficult. Entering this new world feels like a shock to some new mothers. This is experienced as an anxiety provoking experience because there is no familiarity to hold on to.

The mother is now tasked with adjusting to her new life. Consequently, she experiences a sense of loss over her autonomy and identity. This new life is not one that she prepared for. The expectations she had before the birth are incongruent with the reality of the mother's new life and identity. New skills are needed and the new mother isn't able to fall back on or build from previous experiences. As the process is experienced as extremely difficult, the mothers question themselves and their abilities. Accordingly, there is a process of re-evaluation of the expectations the mother had of herself, and her abilities. Expectations the mother might have about the type of mother she might be, or how the baby would fit into her life are completely overturned. For the majority this was experienced as bewildering.

The mothers used terms like "joy", "blessed" and "happy to describe their experience of motherhood. However the same descriptions are fraught with feelings "exhaustion", "shock", and "unpreparedness". This reflects the recurrent theme of how the reality of

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motherhood was experienced as vastly different from what the mothers had anticipated. Therefore early motherhood was experienced as a disconcerting time for the mothers as they undertook new tasks and for which she has not been able to fully prepare for while trying to reconceptualise their old identities.

The assumption is that women's expectations of parenthood are influenced by dominant discourses of motherhood. These expectations were threaded and reinforced throughout by the dominant discourses centered on motherhood (Miller, 2007), which were internalized to create a myth of how motherhood should be. When these expectations are incongruent with reality, significant difficulties in adapting to actual situations can occur (Lawrence, Nylen, & Cobb, 2007). As a result, these women felt increasingly unprepared and overwhelmed with new motherhood. They experienced significant feelings of loss as their lives became consumed by mothering.

These findings confirm Stadlen's (2005) view, who maintains that the lack of emphasis on the emotional preparation for motherhood suggests that it is considered less significant than the care of babies. She contends that if mothers are emotionally supported, the adjustment to motherhood will be less difficult. The category also illustrates a lack of discourse on the actual experience of motherhood. Indeed, Choi et al. (2005) found that despite a 9 month pregnancy most women remained unprepared and became overwhelmed by the veracities of motherhood.

5.3 Caregiving overload

Caregiving overload was a primary experience for most participants and was described as occurring in some form by all participants. It encompassed two aspects. Support emerged as critical element for the new mothers, not only in terms of financial assistance or assistance with childcare but adjustment to motherhood as well. Mothers in this study undertook the bulk of domestic tasks and had the sole responsibility of taking care of the children. Male partners seemed to not be involved in childcare or domestic work, thus perpetuating a gendered division of labor. While some of the fathers continued to provide financial assistance, many new mothers were left to raise their babies alone. Most consistently, mothers associated their emotional distress to their perceived lack of assistance with childcare and parenting demands. The women in this study found themselves unhappy,

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overwhelmed and alone. This was compounded by a never-ending exhaustion from which there seemed to be no respite.

5.3.1 Role strain. The majority of mothers spoke consistently about the emotional distress they experienced in trying to balance the responsibilities of caring for a new baby; taking responsibility for the other children; meeting the expectations of the male partner; housework; and inadequate sleep. Mothers felt they shouldered this overwhelming responsibility alone. This heavy responsibility left Millicent feeling bewildered with having to constantly monitor her baby.

> Interviewer: He can put anything in his mouth and you are just careful about it.
> Millicent: And let's just say, you're busy with your thoughts and then you have to look out for him, you can't really leave him alone, so he's at the stage now where he just, how you can you put it, just picks up things and put it in his mouth.

The perpetual responsibility left Millicent exhausted. The lack of sleep left Millicent with insufficient energy to attend to both her needs and the needs of her baby and as a result neglected her own needs.

> Millicent: And how long does he sleep, and I am so happy when he sleeps, because there might be a load of laundry waiting.
> Interviewer: Yes.
> Millicent: Uhm and nappies, or something else to do.
> Interviewer: Yes:
> Millicent: And I have to look after myself as well (laughs). I can't just look after him, I have lots of things.
> Interviewer: Yes, OK so the expectations just get more and more.
> Millicent: Yes.

Similarly, Wilmien denotes how the difficulty of caring for a baby has not eased. The mother's rarely rested, even when the babies slept during the day. Instead they tried to complete all the outstanding household chores. Wilmien describes the exhaustion associated with mothering a baby.

> Wilmien: He wets himself and you have to change him, he gets difficult and starts crying, then you know there's something wrong, and you just have to get up.
> Interviewer: Get up, yes. So it makes you incredibly…
> Wilmien: It exhausts you yes and…it really is yes, exhausting, because then you have to give your attention to the older children as a mother. It's a very big responsibility (laughs).

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> Wilmien: After teething it is difficult, he keeps crying and…moans and stays up nights. It exhausts your body, and the next day when you have to work again, you feel so powerless.

Similarly, Elize illustrates how she is expected to take care of everyone in her household's needs. Elize recalls how her own needs are of so little importance that they were all but forgotten.

> Elize: Sometimes it's very difficult, because a lot of times I get so discouraged, if I think of all the work. When I tell my oldest son to do something for me and he doesn't and I come home from work, and the father sits back and watches TV and we are both there, and maybe I'm busy with the baby, then I maybe take too long to make coffee and then he just asks me "Am I not getting coffee tonight?" I then lose my temper.
> Interviewer: Really?
> Elize: Yes, he can get up and make his own coffee. He sees the work... they do nothing. They just want to always sit down and I have to run from morning til night.

Some of the mothers had to return to work due to the financial strain of having a baby in the house. For many mothers incorporating a full-time job into an already busy life led to a significant amount of strain. Blondie describes the relentless demands of working a full-time job and being the sole carer of her baby.

> Blondie: It means a lot. Sometimes it feels as if your head will break when you think of all the things you have to do.
> Interviewer: Okay.
> Blondie: And every night I must unpack, I must unpack her bag and then I have to put in other clothes, clean clothes and clean layers. And sometimes we work late, eleven, until eleven o'clock, and then I maybe get home at quarter past eleven. And then I have to put clean clothes, I still have to wash nappies, still have to wash clothes; I have to put in her food for tomorrow.
> Interviewer: Mmm.
> Blondie: I still have to think of myself as well, because I have to make sure my work clothes are clean and I have to make sure that I put in food for myself as well.

Most consistently, mothers associated their emotional distress with their perceived lack of assistance with childcare and parenting demands. Mothers in this study undertook the bulk of domestic tasks and had the sole responsibility of taking care of the children. Here Wilmien describes how she has found herself unhappy, overwhelmed and alone. This was compounded by feelings of exhaustion.

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> Wilmien: You feel hurt. When he comes from work and he takes some of the work for him. Now I can do what I want again. What I couldn't do, I can now continue with. He stays tired. He is always tired when he comes from work.
> Interviewer: And you are you tired as well?
> Wilmien: I am also tired at night, but I can't say that I am tired; I just have to continue with my work.
> Wilmien: Sometimes he isn't there, and then the woman is alone, because she has other obligations as well. And it doesn't weigh down, the scale doesn't weigh down, it's difficult.

The findings above seem to allude to the fact that it was not unusual for all the duties related to parenting, cooking, cleaning, caring (for children, partners and extended family members), as well as income-generation and household financial management, to fall entirely upon one woman. As a result, the women neglected themselves and their own needs.

Each of these excerpts implies a sense of being overwhelmed by a multitude of duties and responsibilities, which collectively, left little time for the women to take care of their own needs. There seemed never enough time to eat, let alone find moments for relaxation. Several of the women described their feelings of despair and helplessness as they carried on for long periods of time with the burdens of mothering in difficult circumstances with very little chance for respite. These findings are reflected in the literature where it was found that mothers were desperate for respite from the unyielding demands of motherhood. Consequently, the children's needs often took precedence over the mothers' own emotional well-being (Abrams & Curran, 2009).

Role overload emerged as another important dimension where it was found that mothers felt that they lacked the sufficient resources, including the time and energy needed to meet the demands of all their roles. Role overload often leads to an inability to meet role expectations, which leads to role strain (Goode, 1960). Sociocultural conceptions of motherhood emphasize the expectations of motherhood where the mother is expected to be able to do it all. In addition, a higher degree of role strain is associated with the lower degree of maternal identity, or positive maternal self-evaluation (Lee & Kwon, 2006). This indicates that a mother who has developed a negative evaluation of herself in the maternal role will be less able to successfully manage the competing demands and obligations of family and caregiving/work roles. In addition, social support acts as a buffer against role strain but also may facilitate the transition to motherhood and a maternal identity.

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Research has alluded to the importance of support in the postpartum. Social support becomes especially important as the mother has an increase in responsibilities. Osborne (2004) found that mother's perceptions of support from her husband are related to maternal behaviour. The more the mother perceived she had support from husband, the more apt she was at becoming involved with the infant when they were together and the less she felt she needed to be in the presence of the infant at all times. The support of family and friends can assist the mother with tasks, as well as provide a time for rest (Ugarriza, 2002). LaFrance (2009) found that women in heterosexual couple relationships were able to maintain self-care practices which facilitate their wellbeing.

The reality is that mothers are still primarily responsible for household chores and childcare. As such women in this study received very little support from their partners. Mauthner (1999) contends that there are different expectation of men and women. For instance, men's limited involvement in the home is seen as acceptable, and to some extend expected. On the other hand, women are expected to responsible for the children and the housework.

It has been found that this is particularly true of low-income South African populations, in which the women are expected to carry many of the responsibilities of family life without support (Lesch & Engelbrecht, 2011). Several international and South African studies commented on the lack of father involvement in childcare among diverse cultural and racial groups (Ally-Schmidt, 2005; Manning, Stewart, & Smock, 2003; Morrell & Richter, 2006). These studies attributed the lack of father involvement in childcare to high rates of paternal absence among South African fathers (Richter et al., 2013), maternal gatekeeping (Fagan, 2003), the relationship status between mother and father (Tach, Mincy, & Edin, 2010), poverty and a lack of resources (Morrell & Richter, 2006), and the endorsement of traditional gender role ideologies (Roopnarine, Krishnakumar, & Xu, 2009).

As the mothers in this study attempt to navigate the landscape of their daily lifeworld, they are neither provided with the resources to do so successfully, nor to successfully negate the conflicting and overloaded demands of their multiple obligations. As such, the social milieu in which these women find themselves may negatively impact maternal adjustment for these mothers in that without any support, the mothers are unable to attain a positive maternal identity.

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5.3.2 The loneliness of motherhood. The mothers often spoke of the love they felt for the fathers of their children and their hopes to "be a family" together. While Nina receives financial support from the father of her baby, she also wants a father for her baby.

> Nina: I told him I won't do it alone. Financially he helps me, but he has be a father to her.

The realisation that this would not be the case clearly hurt the young women, with their narratives often implying a sense of heartbreak. Nina reflected on what the support she needed looked like.

> Nina: Sometimes... I have my cousins – I have four cousins who had babies this year. I had mine first, two had theirs, and there is one more. And now their children's fathers help them a lot. Walk with the children and help with feeding them – anything... and I have to do everything alone without the father.

Many of the women in this study received no emotional support from their ex boyfriends, and minimal financial support. Shockingly, Sam relates how difficult it is to provide for her daughter.

> Sam: To tell the truth, he gives money, but sometimes there's no food.
> Interviewer: Oh shame.
> Sam: That makes me angry. Now he says he is going to give less, and then I say I don't want less, I want the money that you always gave her.

Blondie speaks about the frustration of not giving her child a better life. Without the financial support of her baby's father, she is unable to provide this.

> Blondie: But I need the normal things, and, I just need a bit of support, and more money, so that I can give her a better life than I had and so forth.

Blondie is angry at the fact that she is left to raise her baby alone. She wants her baby to have a father.

> Blondie: It's just that he doesn't, he has to help me, man. It isn't just me that wanted her, the baby. He must help her.

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For the mothers in this study, the father's lack of support was devastating. The challenges of motherhood were exacerbated by the lack of physical, emotional and financial support from the fathers of their babies. Often the challenges were associated with the financial burden of being solely responsible for their child as well as the difficultly associated with not having the economic resources to adequately provide for their children. The cycle of strain caused feelings of desperation and disappointment during a time when support is particularly important.

Social support is a multidimensional construct, consisting of different types of support. These consist of informational support which consists of advice and guidance, instrumental support which consists of practical or material support or assistance with tasks and emotional support which consists of expressions of caring and appreciation. While all forms of support is necessary for maternal and infant health (World Health Organisation, 2007), many studies have shown the considerable importance of instrumental support. In this regard, instrumental support has shown to ameliorate maternal mental health as well as facilitate the transition to motherhood (Schachman, Lee, & Lederma, 2004). This is reflected in the findings of this study, where the mothers have emphasized the importance of support with infant care and financial support.

In addition, research has shown how expectations of support may be important in the evaluation of perceived support. Expectation of support pertaining to motherhood is often influenced by powerful cultural images of happy families (Choi et al., 2005). As such, women usually have highly optimistic expectations of the impact of a new infant on their relationships (Hoffenaar, van Balen, & Hermanns, 2010). This was reflected in the study where implicit in the mothers' narratives were images of motherhood which centred on supportive partners and happy families. Many women find themselves in situations that challenge the ideas they have about motherhood. The realisation that they would not live up to their expectations clearly led to feelings of disappointment and heartbreak.

Consequently, it is clear that without the instrumental or financial support of the father, the brunt of childcare is seen as the mother's responsibility and that she is ultimately alone with this responsibility. The inability to provide for their children was experienced as extremely stresful for the participants of this study. As a result the women in this study felt a sense of responsibility, juxtaposed with a sense of helplessness.

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5.3.3 Summary. Although most participants stressed the importance of support from their partners during the postpartum period, many did not actually have such support. Most of the women in this study have experienced a change of status in their relationships during this transition, changing from being in a relationship, to being the sole caregiver of their children. Mothering alone entails hard work, with relentless responsibilities, constant demands on their time, emotional and physical energy, as well as struggles with other roles and relationships (Balaji et al., 2007). Most of the women who participated in this study assumed an inordinate number of roles and responsibilities in their everyday lives.

Furthermore, many of the mothers had difficulty in garnering the support they needed to take care of their babies, both instrumentally and financially. As a result the women in this study consistently spoke about the difficulties they experienced in trying to balance the responsibilities of housework in addition to childcare, and in some cases even employment. In addition, the constant stress the mothers were put under in tandem with a lack of support impacted the mothers' already precarious mothering identities in that it prevented the mothers from feeling fulfilled in their roles. This is because many of the mothers had expectations of what life would be like once their baby arrived and afterwards struggled to reconcile their expectations of their support system with the actual amount of support they received

5.4 Dysfunctional interpersonal relationships

Dysfunctional interpersonal relationships featured as another prominent finding in this study. Some of the women in this study experienced maltreatment from their significant others either by infidelity or abusive behaviours. These precarious situations often left mothers feeling hurt and deceived, and as a result feature prominently in their experience of distress. As such, this section consists of two themes; betrayal and infidelity and intimate partner violence.

5.4.1 Betrayal and infidelity. A recurring theme throughout the study was the lack of support many women felt they had. Seven of the participants reported that their intimate relationships had ended soon after the birth of their babies. Bernadette, whose partner left her soon after she got pregnant, describes her experience.

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> Bernadette: To be honest, yes. It's difficult. The worst is that I found out that her father is seeing someone…and, it was difficult for me, she was just… I always asked why now, and everything.

In addition to dealing with responsibilities of their new born, some of the women had to deal with the rejection or loss of their relationships with a partner. Pienkie found out about her partner's infidelity soon after she gave birth. Once the infidelity was brought to light, Pienkie experienced a severe sense of deceit and betrayal.

> Interviewer: Are you saying that he was with other women?
> Pienkie: When I gave birth.
> Interviewer: And how did you feel about it?
> Pienkie: Very disappointed, and cried a lot, I cried a lot.

Compounding her sadness, Pienkie describes how this connects to her childhood experiences. Her boyfriend's infidelity serves a bitter reminder of her own childhood: In this sense, she not only situated her emotional experiences within her current realities but also connected it to the fact that her father abandoned her when she was an infant.

> Pienkie: If I am honest with you, my child is getting raised like I was raised. I was three months old when my grandmother took me in. My own father took someone else.

For Robena, it is hard to reconcile that a man that would get her pregnant would betray her. She explains how much confusion and hurt this causes her.

> Robena: Oh, even now still, I still think about him a lot. Because I loved him very much, so I could forgive him. But it still bothers me that he did it. Because he wanted me pregnant so that I could be the mother of his child, but he didn't have enough respect for me to be faithful.

Robena's situation is compounded by the fact her baby resembled his father. This led to feelings of ambivalence towards her baby and added to her feelings of distress.

> Robena: Yes a lot. I can actually say that not a day passes, and now especially since he's here it's even more difficult, because when I look at him, I can see something of his father in him.

For the women in this study, the betrayal by their partners led to feelings of extreme unhappiness, sadness and anger. They describe how they felt alone, abandoned and betrayed.

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Research has noted that the experience of betrayal goes beyond a cognitive awareness of the betrayal and is felt at a deep, visceral level. Accordingly, pain is one of the first and most acute emotional reactions upon discovering betrayal (Leary, Twenge, & Quinlivan, 2006). Other researchers have noted how betrayal from a romantic partner affects one's sense of self-worth and needs for emotional security (De Stefano & Oala, 2008). Humiliation or the perception that one has been treated disrespectfully may intensify the severity and painfulness of the experience (Guerrero & Bachman, 2010).

In addition to dealing with responsibilities of their babies, some of the women had to deal with the loss of their relationships with a partner. The consequences of this may be particularly dramatic and long-lasting, especially for new mothers. Bowlby (1980) has maintained the importance of resolving a loss in order for healthy adaptation to occur. In this regard, it has been found that in association with unresolved loss, mothers reported more negative perceptions of parenting, which affects maternal psychological adjustment.

As mentioned previously, Leary et al. (2006) noted that experiencing infidelity may shatter long-held assumptions about the meaning of commitment, perceptions of the partner and views of the self, with the severity of the reaction being associated with the strength of those assumptions. Similarly, Blow, and Hartnett (2005) found that of betrayed wives experienced significant damage to their confidence and self-esteem. This may be especially true in that women's value often remains at least partly dependent upon their ability to attract and hold male attention, and women who fail to do so are readily positioned as abject—as the sad spinster, unwanted woman, and representation of failed femininity (Berscheid & Regan, 2016; Reynolds & Wetherell, 2003;).

Lesch and Engelbrecht (2011) found that among the stressors that low-income couples typically have to contend with were issues around fidelity. However, it could also be possible that the women in this study were severely affected by the infidelity of their partners because it meant the shattering of long held expectations of family life and motherhood. Choi et al. (2005) found that women's expectations of motherhood were influenced by powerful cultural images of happy families and that once they had their children were faced with the realization that this was not the case.

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5.4.2 Intimate partner violence. In the narratives told by participants, themes of violence and abuse in intimate relationships came out strongly. The participants had been exposed to varying levels of physical violence in their intimate relationships. Elize recounts an incident of interpersonal partner violence.

> Elize: He just unravelled and while I was making my grocery list on Friday night, I just felt him hitting me on my mouth, my jaw got hurt. And I just thought of one thing, because just before that I had boiled water for the baby's bottle. I took that water, and he realized, so he followed me and took my chair, to throw at me, but I took the kettle with the boiled water, and I threw it at him. The water hurt him; he got a fright and made so much noise that my sister-in-law came running to see what was going on. Then I told her that I burned him. It is the only way that I could defend myself.

Being in an abusive relationship led to feelings of shame and embarrassment for the women in this study. Wilmien describes the profound psychological and emotional effects of the physical violence.

> Interviewer: Has he ever used violence?
> Wilmien: Yes, uhh he, yes, in the beginning he drank then I had to leave, and then I had to sit outside with the child.
> Wilmien: It's not nice because it's cold and I mean there's people everywhere around you and if they see that what was going on ... they see what's happening.

Pienkie recalls a time where her boyfriend slapped her. She elaborates on the disappointment she feels at his behaviour.

> Interviewer: But has he ever hit you?
> Pinky: Once
> Interviewer: What happened?
> Pinky: He slapped me. He slapped me Friday (laughs).
> Pinky: I feel very unhappy; all of the guys that I've gone out with, no one have ever done this to me and him of all people. And everyone warned me against him.

For the women in this study, shame, social stigma and sadness featured prominently in their experience of intimate partner violence. These findings are reflected in the other studies that have explored the effects of interpersonal partner violence. Women who have experienced interpersonal partner violence report increased levels of depression, anxiety, posttraumatic stress disorder and shame (Kendall-Tackett, 2007; Kornfeld, Bair-Merrit, Frosch, & Solomon, 2012; Kothari et al., 2016). Additionally, poorer health outcomes are

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related to higher rates of interpersonal partner violence (Kothari et al., 2016). The most common mental health outcome for victims is depression, especially in the postpartum period (Beydoun et al., 2014).

Furthermore, it appeared that the effects of intimate partner violence and postpartum distress were additive, with the stress, powerlessness, and isolation of intimate partner violence magnifying the stress, powerlessness, and isolation of postpartum distress. Studies indicate that there is a reciprocal relationship between interpersonal partner violence and postpartum distress. Experiencing interpersonal partner violence during pregnancy or in the postpartum increases the odds of developing postpartum depression three-fold (Cerulli, Talbot, Tang, & Chaudron, 2011) At the same time, experiencing postpartum depression increases women's risk for abuse by an intimate partner (Cerulli et al., 2011; Howard, Oram, Galley, Trevillion, & Feder, 2013; Trabold, Waldrop, Nochajski, & Cerulli, 2013). As such, the effects of the two conditions may interact and compound each other, as women must who must live with both as they attempt to manage their situations and their emotional well-being.

It has been reported that one in three South African women has experienced abuse at some point in their relationships (Jewkes, Sikwewiya, Morrell, & Dunkle 2011). Norms accepting of intimate partner violence may contribute to the increased perpetration of interpersonal partner violence. Recent research has suggested that the patriarchal nature of South African society contributes to this problem (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Wood, Lambert, & Jewkes 2008; Seedat, Van Niekerk, Jewkes, Suffla, & Ratele, 2009). As such, instances of violence can often be attributed to a patriarchal society and strict gender roles. Furthermore, recent ethnographic research with young men in South Africa proposes that female obedience and control of women are key elements in current constructions of masculinity and that violence is used as a strategy to secure respect and control (Wood et al., 2008). Thus interpersonal partner violence is best understood as both a reflection and embodiment of gendered social and cultural context.

5.4.3 Summary. The mothers' in this study spoke about their distress by drawing on specific examples of infidelity and violent incidences in their intimate relationships. Dysfunctional interpersonal relationships have been shown to significantly affect mental health and more significantly, contribute to the development of depressive symptoms (Du Rocher Schudlich, Papp, & Cummings, 2011; Jack, 1991; Lesch & Engelbrecht, 2011). It has

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also been found that low-income couples experience more distress related to relationships than couples from other socioeconomic classes (Beam et al., 2011; Rehman, Gollan, & Mortimer, 2008; Lesch & Engelbrecht, 2011). This may be because traditional gender roles are particularly dominant in these settings (Shefer et al., 2008, as cited in Lesch & Engelbrecht, 2011). From this position, the maltreatment of women is part of a continuum of violence against women with infidelity and intimate partner violence being alternative manifestations of gender inequality. This is complicated by the participants' low socio-economic status and inability to take care of their families by themselves.

5.5 Mothering in poverty

A substantial and understudied dimension of mothering is the access to economic resources and its influences on mothers' experiences of distress. Several women in the sample were not able to work, or decided to stay home to look after their children. This caused significant financial difficulties for the household. Alice underscores the direness of her financial situation in that they barely have enough money for the basics.

> Interviewer: So financially are there are things that bothers you? Do you have concerns about it?
> Alice: I am worried about it, yes. The things that you need, just the basic necessities worry me.

Some of the participants with multiple children worried about managing an additional child while already struggling to make ends meet. Many women were worried about not being able to meet the basic needs of their children, such as food, clothing and school fees. In this regard, Wilmien describes how she worries that having another child will contribute to more financial strain.

> Wilmien: Yes, my needs ... I have him now. And then there's the other two. And now the money...
> Interviewer: The money that you?
> Wilmien: I am worried because I mean the school fees are a lot. I cannot cope with two in high school and ... and the other one now.

Similarly, Alice shares her worries about how the new baby is stretching the household's resources. She describes how rising prices might make it difficult for her to afford the basic necessities of caring for a baby

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Alice: I think about the child's basic needs.
Heidi: The first little one?
Alice: Everything was cheaper.
Heidi: Really?
Alice: Yes. Everything gets more expensive every day.

Participants significantly conveyed feelings of worry and anxiety in relation to their financial hardships. Rather than being able to focus on recuperating from childbearing, establishing infant feeding, and adapting to the new baby and changes in family life, women were also forced to be preoccupied with activities to provide the basics of food and shelter for their families. A large body of literature supports a connection between economic deficit, and depression (Belle & Doucet, 2003; Martin et al., 2006), as well as postpartum depression (Katz, Hessler & Annest, 2007).

It has been noted how the poverty limits the women's ability to meet her own and her children's material needs (Wright, Noble, Ntshongwana, Neves, & Barnes, 2014). Similarly, in this study, it was found that the ideal of the all-providing, self-sacrificing mother, which the women strived to be, was an ideal these women could not live up to, given their context. Kruger and Lourens (2016) points out that neoliberal discourse of self-sufficiency in solving one's own problems translates into women's feelings of guilt and shame when they fail to meet their children's needs. Ultimately, the tension between low-income women's constructions of ideal motherhood and their inability to meet these ideals due to poverty-related constraints mean that providing for children is not only a daily struggle but also a marker of personal failure for the women (Raphael-Leff 2010; Kruger & Lourens, 2016; Beck & Indman, 2005).

In keeping with this perceived interrelationship between poverty and depression, being a "good mother" in this context means providing for the family's financial needs. As such, mothers framed their financial struggles as an additional threat to an already compromised maternal self or at the very least mothers viewed their distressed economic conditions as exacerbating their symptoms.

5.5.1 Summary. The conditions of poverty, the experience of depression, and the intersections between the two are problematic in so far as they pose a challenge to the realization of an idealized mothering image. Thus, for these low-income mothers, poverty

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contributed to a sense of inadequacy as a mother and added an additional threat to their sense of maternal aptitude. In other words, mothers' experiences of postpartum distress could not be extricated from the reality of their challenging life conditions.

5.6 The physical body and motherhood

This section discusses the participant's experiences of labour and childbirth, breastfeeding, and the postpartum body. Some mothers in this study faced a variety of challenges associated with the physical experiences of motherhood. Many women reported feeling dismayed that their expectations were not met with regards to these physical aspects of childbearing.

5.6.1 Birth-related distress. In their postpartum interviews, the mothers described how their experiences of labour contrasted sharply with what they had expected. One of the most predominant sentiments expressed by women this study is that labour and birth can be traumatic experiences for the labouring women. Almost all of participants reported their labour experience as very traumatic. For these women, childbirth was characterized as a difficult, physically exhausting, intense, demanding, and painful experience. Millicent describes how labour was nothing like she had imagined and experienced it as much harder than she thought it would be.

> Millicent: I thought that everyone's just trying to scare you and…I didn't know it will be that bad. It was just a different, the pain, it can drive you crazy.
> Interviewer: Yes.
> Millicent: You can climb the roof or the walls. Just want to walk, jump off the stairs!

Their physical and emotional unpreparedness was evident from the participants expressed doubts about and fears of their abilities to cope with childbirth. Blondie felt that the pain was so severe that she would not make it through labour.

> Blondie: And, I felt like I will never be able to get through it. I couldn't take it anymore!

Suzanne describes an extremely painful experience. Significantly, the experience of labour and birth was strongly related to encountering death.

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> Suzanne: Giving birth I will tell you is really painful, uh, I almost died.
> Interviewer: Shame.
> Suzanne: It's really painful, yes. You can't tell someone how painful it is. You have to go through it yourself, but it is, I was, with one foot in the grave, it's really painful.

Nina describes her birth as extremely painful, but childbirth was easier and quicker than the first time around.

> Nina: Pain is something to talk about it (laugh)! Lots of pain, but the birth was easy. It wasn't difficult like it was with Justin. Within 5 minutes I was done (laughs).

Interestingly, despite already having given birth twice, Wilmien noted that childbirth was just as painful as the before.

> Wilmien: The birth at the beginning was very difficult; I had a lot of pain.
> Wilmien: I have, I felt it was another experience, it's been a long time since I've given birth, I felt like telling them not again (laughs).
> Wilmien: Because it's very painful, the pain is too bad, it was really painful yes.

Unanticipated complications resulted in experiences for which women did not feel prepared. Suzanne recalls not anticipating that giving birth would be as painful as it was. For Suzanne, the pain was exacerbated by her episiotomy. She recalls feeling saddened by the experience.

> Suzanne: I was very sad because I didn't know the pain would be so bad, I was cut.

Expectations are often determined by culture and the socio-economic context in which women live. Millicent attributes her expectations of childhood to a reliance on a poster in a clinic.

> Millicent: How can I put it, most of the time at the clinic, there are those posters that show how a normal birth happens and how a Caesarean section is given. And so I thought I want to give birth normally. And I thought it would probably be like this and feel like that.

Despite some of the negative and painful experiences of labour, almost all the participants emphasized that childbirth was the plight of every woman.

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Suzanne: I guess it's natural; every woman has to go through it.

Millicent: Everyone talks, but everyone has to go through it, every woman has to go through it.

The experience of labour for these mothers was not as they had anticipated. Even in the case of multiparous women, childbirth was more painful than what was expected. Some of the mothers in this study also commented on their dissatisfaction and unhappy experiences with the nurses in the labor ward. Some described being treated insensitively or were shouted at. Robena recounts her experience.

Robena: But the one that helped me give birth, the nurse that helped me, she was very rude. She did, did….how can I put it, she didn't have patience. The fact that I was in pain, she told me not to give birth like a savage. Because every time the pain came, I screamed, and it was a scream that I, it just went on, it went on the whole time. And no, then she said I must not give birth like a savage.

Blondie recounts witnessing verbal harassment of another mother on the labour ward. Witnessing this event was particularly distressful for Blondie.

Blondie: Just like, "Yes, open your bum, I didn't tell you to open your legs when you slept with a man."
Interviewer: Mmm.
Blondie: It, it actually hurts me a little, I mean with a lot of women, it touches them, man. It hurts them, I mean emotionally. That is painful.

For some women in this study, the pain of childbirth and its process was experienced as frightening, painful, unmanageable, and too demanding. Feelings of being overwhelmed was central to this experience, as women experienced panic, anxiety and/or fear over whether they would able to cope with the intensity of the pain. This finding has been reported in similar studies where women described feeling anxious, fearful and distressed during labour (Baston, Rijnders, Green, & Buitendijk, 2008; Cheyne, Dowding, & Hundley, 2006).

Their psychological and emotional distress seemed to be related to fear, anxiety, vulnerability, and loss of control over the labour processes. Women interviewed in the present study experienced childbirth as a time of increased vulnerability. One participant, for instance, likened her childbirth experience to dying. This may allude to the incredible

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feelings of vulnerability and loss of control women experience during childbirth. Experiencing a loss of control during labour has important implications for the psychological wellbeing and adjustment to motherhood (Ayers & Pickering, 2005; Cook, 2012).

Pain during childbirth is a unique phenomenon because of its association with a normative physiological occurrence (Walsh, 2012). While every woman experiences pain during labour (Sawyer et al., 2010), the experience of pain is influenced by a range of factors. The complexities of pain during labour have been described by in numerous studies. The multi-dimensional nature of labour involves intense emotional, physical, psychological and spiritual elements that play a critical role in a woman's experience of this event (Bryanton, Gagnon, Johnston, & Hatem, 2008; Cipolletta & Balasso, 2011; Goodman, Mackey, & Tavakoli, 2004).

Additionally, caregiving by medical personnel contributed significantly to women's perceptions of childbirth. The abuse of women by nurses in maternity units has been documented internationally but remains a precarious problem in South Africa (Kruger & Schoombee, 2009; Thomson & Downe, 2008). The findings of Kruger and Schoombee (2009) were reflected in this study where the women reported that both physical, as well as emotional support was lacking. The women experienced the hospital as an environment where others yielded control over them which left them feeling vulnerable and powerless (Baillie, 2009). In this study, this contributed to the women's experiences of postpartum distress.

Studies have repeatedly found that traumatic birth is associated with unaccommodating, disrespectful and abusive care by healthcare workers (Elmir, Schmied, Wilkes, & Jackson, 2010). Traumatic birth has been associated with long-term negative sequelae, postpartum distress and disrupted relationships with infants and partners (Elmir et al., 2010). If a woman feels neglected, discounted, or abused during labour, she may feel too angry, too inadequate, or too frightened to focus on the next stage of motherhood (Mannava, Durrant, Fisher, Chersich, & Luchters, 2015).

5.6.2 Breastfeeding. Amongst the mothers, breastfeeding provoked feelings of either satisfaction or distress. The ideologies surrounding breastfeeding and the idea of 'breast is best' were strongly linked to women's choice to breastfeed and the satisfaction they received

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from it. Some women found breastfeeding pleasurable. Elize describes how providing her baby with the ideal source of food was rewarding for her.

> Interviewer: Do you enjoy that she drinks from you?
> Elize: Yes I am quite happy because I always wanted to do it, because wherever you go in a clinic, they say that breast milk is best.

Similarly, Suzanne describes being happy that she was able to breastfeed her baby. She describes this satisfaction as being rooted in the idea that breastfeeding is healthy

> Suzanne: Probably because everyone says it's healthy and because I read everywhere that it is healthy and yeah, that's why I am doing it.

In contrast, Millicent describes her difficulties with breastfeeding. Her experience is primarily organized around the discomfort she experienced. Millicent describes feeling so much discomfort, that the pain she felt during breastfeeding reduced her to tears. Despite this extreme discomfort she continued to breastfeed as she believed it was the best for the baby.

> Millicent: Yes. At the beginning it was how can one put it, breastfeeding was very painful. Especially the Monday when they brought him to me, the Monday afternoon.
> Interviewer: Yes.
> Millicent: Then he had to drink from me and started sucking, it was very painful, a shooting pain through your breasts. Your nipples are very sensitive
> Interviewer: Painful.
> Millicent: And now he sucks and oh, it's very painful. I almost started crying. Now sometimes, then it starts to get sore, then they say he must drink until it heals.
> Interviewer: So he must just continue?
> Millicent: Yes.
> Interviewer: And you just have to push through?
> Millicent: You just have to push through, yes.

Sam was unable to breastfeed because of an insufficient milk supply. She describes reluctantly bottle feeding her baby. Below Sam describes her disappointment and feelings of guilt.

> Sam: For me, sometimes when I give her the bottle…I feel guilty because I actually wanted to breastfeed her, but I can't help that my milk is not right for her.

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Breastfeeding was a focal point for mothers in this study, either providing satisfaction or intense distress. The women in this study described feeling upset at their inability to breastfeed which was at odds with the experience they had expected. Where they associated breastfeeding with a natural and taken-for-granted function of maternal bodies, when breastfeeding challenges arose among the participants, they labelled themselves, their breast milk or their bodies as inadequate. Infant feeding decisions are tremendously value-laden. Stern (1998) argues that culture plays a major part in forming the motherhood constellation. The socially constructed ideology of motherhood also determines attitudes toward breastfeeding. The majority of participants recognized the expectations around breastfeeding.

Not all mothers are able to breastfeed their babies (U.S. Department of Health and Human Services, 2011). Mothers who were unable to breastfeed their babies spoke of feeling pressured. Some mothers were even inclined to endure discomfort in order to conform to the good mothering ideology. The pressure to breastfeed arises out of internalized societal expectation, which gives rise to guilt and disappointment. Deleterious feelings associated with the inability to breastfeed demonstrate a perceived failure arising from notions of "bad mothering." Ultimately women want to do what is best for their babies and be good mothers and because breastfeeding is such a laden cultural value, new mothers often experience extreme emotions with regards to breastfeeding.

5.6.3 The postpartum body. For some of the women, the physical changes to their bodies during and after childbirth were a source of unhappiness. For Robena the changes brought on by pregnancy have changed her body in a negative manner, citing weight gain as the primary reason.

> Interviewer: Good and uhm, now I want to ask you, the changes that happened in your body, and, how do you handle it, how do you feel about it?
> Robena: I feel that my body changed in a bad way and this weight that I gained.

For Blondie, her experience of her postpartum body is a negative one. She expresses her unhappiness about the physical changes to her body. More adamantly, Blondie feels she can no longer wear the clothes she wants to because of weight gain and stretch marks.

> Blondie: I just feel, wow, I messed up my body, sometimes it feels like that.
> Interviewer: Is it?

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> Blondie: Because now it has stretch marks and, and you can't wear the bikinis that you want to wear anymore that you always wore and so on. You can't actually wear the clothes that you wanted to wear.

Similarly, Wilmien speaks about how her weight changes make her feel unhappy. For Wilmien, her post-baby weight makes her feel uncomfortable.

> Interviewer: And now, your body…it changed a lot right? Before you fell pregnant and got bigger and later gave birth ….is your body the same as before the birth or not?
> Wilmien: No…you're fatter.
> Interviewer: Are you fatter? How do you feel about it?
> Wilmien: Uncomfortable.

For some of the women in this study, the physical changes to their bodies after childbirth were a source of unhappiness. The postpartum body changes so drastically that it appears to affect the mother's self-esteem. Additionally, implicit in the mothers' narrative there seems to be a struggle of regaining the lost self while having to deal with the reality of having a changed body. This finding appears to be consistent with other studies that where it was found that women are more likely to be dissatisfied with their bodies in the postpartum period (Clark, Skouteris, Wertheim, Paxton, & Milgrom, 2009; Hodgkinson, Smith, & Wittkowski, 2014; Nash, 2015; Patel, Lee, Wheatcrof, Barnes, & Stein, 2005).

Mothers who were not prepared for these body changes expressed dissatisfaction with motherhood. This can be likened to the literature on physical recovery following child birth and women's unrealistic expectations of this process (Coates et al., 2014). Generally, women do not anticipate that pregnancy and childbirth would place such dramatic physical demands on their bodies.

The dissatisfaction with the weight gain makes society's focus on and expectations for women's bodies obvious. Grogan (2008) argues that society expects a fit and toned body type that portrays a sense of self-control. Thinness remains the ultimate ideal of female attractiveness. All postpartum women have body ideals and body expectations that influence their body image. However, women who hold more rigid ideals and unrealistic expectations for their postpartum figures are at risk for higher levels of body dissatisfaction (Walker, Timmerman, Kim, & Sterling, 2002). Individuals with high levels of body dissatisfaction are

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at risk for developing body image disturbances, which can affect a person's mental health (Delinsky, 2011).

5.6.4 Summary. Based on the presented experiences, the physical experiences of motherhood is an important component of the distress mothers' experience. New mothers experience a number of psychological and physical changes over the first year of postpartum. Women's experiences and expectations of their bodies during childbirth, the postpartum and breastfeeding are mediated by varying cultural standards and ideals (Kruger, 2005). When these expectations are not met, women become disappointed at their inability to meet this ideal.

5.7 The silencing of the self

An interesting finding in this study was how the women dealt with their emotions. Bereft of legitimate ways of understanding and expressing their distress, women often spoke of hiding it instead. Despite feeling like she is going to burst, Millicent decides to silence herself.

> Millicent: Sometimes I feel that I can completely burst open.
> Interviewer: Yes.
> Millicent: I can't, how can you put it, tell them now that…
> Interviewer: Yes.
> Millicent: I can't behave like that.
> Interviewer: Yes.
> Millicent: Keep your mouth shut, and be the lesser and just go on, don't worry about what they are going to say.

Later on, Millicent described finding solace in isolation, stating a strong preference to be on her own. Millicent describes how she feels ostracized in her own home. Instead of confronting her family members, she prefers to shut herself inside her room.

> Millicent: Very fake and um I, let's just say by now I know them, they are very fake, that's why I don't communicate with them very often.

Bernadette is afraid that people won't like her anymore so she decides she has to sort herself out. Implicit in her account is expectations regarding how women should handle conflict.

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> Bernadette: I don't want to be like that anymore because people know I am impatient and then nobody will like me anymore. So I want to change myself and I told myself I will get myself together and leave my attitude behind.

Later on she attributes her irritability to the fact that her daughter's father betrayed her. She explains that the anger she feels is compounded by the fact that she does not speak about it to other people, but rather keeping it inside.

> Bernadette: The reason why I am so impatient is because of the things that happened between me and her father. It affects me and I don't talk about it and that's why I got so impatient

Robena gives a vivid description of her feelings of responsibility and guilt regarding her ambivalent feelings about motherhood. She frames motherhood as her responsibility alone, which means she cannot complain to others.

> Robena: Because I can't, how do you explain these things to other people, then it looks like, I just keep complaining, and then you're actually complaining about things you created yourself. And nobody else, it's nobody else's fault that I have a child, or that I have a responsibility now, or that I have to take care of him and give out money for him, money that I could've spent on myself or something like that. It's my fault, I made the mistake.

Taking responsibility for being distressed, and thus expecting to be blamed or criticised for their distress, may provide one explanation for why the mothers were reluctant to talk about their distress. Blame or criticism was not just a private expectation; some women gave accounts of situations where they felt judged by their partners or families. Here Millicent talked about her partner's questioning her child care practices.

> Millicent: Yes, they, they it is like that, they expect that everything is perfect and that kind of thing.
> Millicent: Milli, um did Campbell, has Campbell had a bath yet. I say, yes you can see it for yourself (laughs).
> Interviewer: Yes. So he keeps asking if everything is alright.
> Millicent: Yes, and he does know that I will look after the child; he must know me by now.
> Interviewer: Yes.
> Millicent: Just that.
> Interviewer: So how, how do you feel when he asks you that?
> Millicent: I feel irritated because he knows I will do it.
> Interviewer: Yes.

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Millicent: And he knows I will look after my child, but he asks that unnecessarily.

Many of the mothers acknowledged how socially unacceptable it was to express what they were feeling. This was especially prominent with regards to their feelings of being a new mother, their anger but also relational experiences and their disappointments in relationships. By approaching women's accounts from a discursive perspective, the reasons behind women's self-silencing came into view as the result of an interlocking set of discourses that require women to behave in circumscribed ways and then deny their pain. This silence is clearly informed by wider cultural expectations of the good mother but also of the good woman (Jeannes & Shefer, 2004), which dictate that good women are in control, composed and self-sacrificing (Jack, 1991; Newman, Fuqua, Gray, & Simpson, 2006).

This engenders a powerful imperative of personal responsibility for coping without complaint. Millar (2014) refers to this as relational autonomy. This autonomy refers to the importance of being able to deal with problems, which creates a sense of responsibility for sustaining the social world (Millar 2014). Peacock, Bissell, and Owen (2014) frame this discourse as an imperative where everything is deemed to be the responsibility of the woman, who is expected to be able to manage any situation. Underlying this discourse is the notion that acknowledging the need for help is seen as weak and unacceptable. Consistent with this, in studies of stigma, it has been identified that stigma was linked to ideas about people being responsible for causation and/or continuation of their distress (Boardman et al., 2011). So for the mothers to take responsibility for the distress they feel because she 'chose motherhood' or 'cannot act like this' would expose her to this risk of being stigmatised. This is a further reason for her to not express her feelings of distress openly.

Unfortunately, the power of social acceptance is strong and in order to conform to these societal norms, women actively suppress their own thoughts and feelings and adopt an attitude of agreement and compliance or self-silencing (Jack, 1991). Self-silencing, the restriction of self-expression, is further propagated by a gendered society (Jack, 1991). Buultjens and Liamputtong (2007) argue that the myth of motherhood stipulates that mothering is solely a happy experience. If a woman experiences unhappiness or feelings of depression, she is challenging the fundamental societal understanding of motherhood as well as womanhood. Furthermore, women's self-silencing can be attributed to the societal belief that women possess an inherent responsibility to care for those around them (Jack, 1991).

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According to Winstanley (2001), these ideologies are powerful enough to condition women into striving to fulfil their given roles. “To fall from grace, to deny this model, is to be an outsider, un-natural and despised. It can become powerful enough to silence alternative experiences” (Winstanley, 2001, p. 12).

This process of devaluation and inhibition of one’s own feelings and opinions results in a fall in self-esteem and feelings of a loss of self (Jack & Dill, 1992), which heightens feelings of distress. One consequence of this is that women may internalize feelings which perpetuate a negative experience of motherhood. This results in an externalized self-perception, which refers to a tendency to judge or evaluate the self by external standards as well as or putting the needs of close others before the self. Paradoxically, women who already feel isolated and alone, now further isolate themselves as they feel guilty about their negative feelings.

5.7.1. Summary. Women are under strong pressure to conform to societal norms and feminine ideals prescribing silence. In conforming to these roles, women actively suppress their own thoughts and feelings if these are in conflict with their idealized versions of womanhood and motherhood. In this sense, the ideology of motherhood emerges as an expression of power relations and therefore has the power to negate the telling of counter experiences.

To the extent that silencing, as lack or loss of voice, is a gendered phenomenon which characterizes women’s experience, self-silencing might indeed pose a greater threat to women’s personal and relational well-being, as numerous researchers have proposed. Theorists concerned with self-silencing argue that lack of voice has negative consequences or correlates, involving low self-worth and a loss of self (Ahrens, 2006; Jack, 1991). This echoes this study’s findings in that mothers feared invalidation from others and as a result actively silenced and isolated themselves.

5.8 Conclusion

This study aimed to explore the experiences of distress in the transition to motherhood in a group of low-income women. What became apparent in trying to provide some interpretation of these experiences is the contrast between the women's stories when relating

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their experiences but also the evident similarities. What is also marked is the need to consider women's birth and postnatal experiences as a whole, and the complex interplay of women's individual physical, social, cultural and personal biographic realities.

These accounts clearly illuminate a multi-faceted image of maternal distress. For women in this study, the root of their distress lay in three key areas: their interpersonal situation, their psychological situation and their experience of motherhood. At the core of all of these factors was a profound difficulty in accepting the reality of their changed lives. The women had expected motherhood to be different. They had not expected so little support and so much conflict with the significant people in their lives; they had not expected to feel a grave sense of loss of who they were before having a child and of what their lives had been - they had not expected childbirth and mothering to be so challenging. Their thwarted expectations, in the final analysis, contributed most significantly to their postnatal distress.

Furthermore, insight into maternal distress that emerges from women's narratives appears to enable the conclusions that whilst women's accounts depict an individualised biography, they are underpinned by perceived failures to meet the idealised cultural and societal depictions that surround childbirth. There is no one consistent causative factor which characterises the experience of maternal distress. The level of maternal distress is perhaps mediated by personal resources, but is more clearly located in women's abilities to perform and perceive themselves as `good mothers'. In the words of Stoppard (2000): ”One consequence of a life lived at the intersection between what is culturally expected and what is materially feasible is the set of subjective and embodied experiences which are called depression” (p. 212). Herein lays the essence of maternal distress for this group of low-income mothers.

Although each theme was presented categorically, it is acknowledged that the deeply complex and intertwined nature of each of these themes remains recognised and appreciated. Likewise, it is recognized that each theme warrants a far greater depth of discussion than was possible here. In sacrificing depth of analysis, the current chapter was able to achieve its aim of presenting a broad overview of the experience of maternal distress in the context it occurs in one group of low income South African women. A comprehensive summary of the collected findings will be presented in the following and final chapter of this research project.

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Chapter six: Conclusion

This study aimed to get greater insight into the experience of maternal distress in a group of low-income women. This section presents a summary of the aims and main findings of this study. In addition, the study's limitations are discussed and recommendations are made for future research.

6.1 Aim and Objectives of the Study

A review of the research on maternal distress indicates a lack of research on postpartum disorders in the South African context. This is surprising given the exceedingly high prevalence rates of postpartum depression in South Africa (Cooper et al., 2009; Madu & Roos, 2006). As such, this study aimed to bring the experience of maternal distress to the fore, by focusing on low-income women who met the criteria for postpartum depression (given their scores on self-report measures). The study was built on the assumption that the medicalization of motherhood fails to capture low-income women's experiences of distress, and further serves to pathologize women while obscuring how the social context might influence and shape these experiences.

The primary goal of the study was therefore to explore the experiences of maternal distress. In order to achieve this, selected components of data that were collected from a larger study, the Women's Mental Health Research Project, were analyzed. Theoretically, the study was informed by feminist social constructionism, which gives credence to women's experiences within their social and political contexts (Røseth et al., 2011; Schlimme, 2013). In line with feminist social constructionism, social constructionist grounded theory was used to analyze the data.

Numerous interconnected thoughts, feelings, and behaviors were revealed in the data. The women always situated their experience of postpartum distress within the material and social circumstances of their lives. Mothering in a low-income environment is a complex process presenting numerous obstacles. As illustrated throughout this study, maternal distress is closely associated with the socially constructed ideals and expectations of motherhood. Although the experiences of maternal distress were sometimes recounted differently, there are also some important similarities in the ways mothers construct the meaning of their

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experiences. This study, therefore, highlights the complexity of maternal distress and the interplay of the socio-political context of the experiences of distress.

6.2 Summary of findings

This study's explorations of women's experiences of maternal distress in the transition to motherhood allowed a more multifaceted representation to emerge than that which is currently offered by diagnostic systems. The women situated their distress in their complex relationships and life events.

6.2.1 The participant's stories. The women's biographies were intended to help to generate an understanding of how context impact on psychological health and experience through subjective collective experiences. These stories showcase the mother's frequently difficult and challenging lives, punctuated by their changing relationship statuses, socioeconomic circumstances and contextual influences. For these women motherhood remains a central aspect of womanhood, but is also characterised by an intrinsic hardships. Through close analysis, it was possible to see the connections between the social contexts, ideologies of motherhood, and imperfect social relationships.

Whilst individual biographies clearly became an important and illuminating aspect of analysis, they were not initially the primary interest. What became apparent, however, is that women's psychological health was best understood when it was seen in the wider context of women's whole experience. Some of that wider context was inevitably lost in the necessity of breaking up the whole into categories which could then be compared and integrated. However the qualitative comparative analysis attempted to be faithful to women's unique biographies throughout as well as to their shared characteristics and identities.

6.2.2 The expectations and reality of motherhood. The transition to motherhood plunged the women in this study into a period of discontinuity where much that was familiar prior to giving birth was obscured by a sense of chaotic disorganisation and intense emotional responses to new, unforeseen experiences. The presence of a totally dependent infant demands the mother to be totally child centred. As such the mothering role is a significantly more physically-emotionally-demanding role than what the women were expecting.

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Since the moment of birth the baby was always on the mother's mind, already the child was more present to her than she would have considered possible. Instead, it was as if though the mother's life was no longer familiar and she could not escape from being a mother whether she was physically present to the baby or not. Interwoven with this was an unsettling sense of loss - of her past life, of her non-pregnant identity, of her freedom and a growing awareness of the relentless responsibility and enduring interdependence that motherhood represented.

Learning to mother was a prominent cause of distress. The lack of knowledge about infant care was further compounded by uncertainty, confusion and feelings of inadequacy. A clash between the expectations of motherhood and the reality of caring for a baby was evident. Furthermore, the transition to motherhood involved a shift from women being solely responsible for themselves to being responsible for a vulnerable new baby. For many women, the postpartum period is the first time in their adult life that they do not feel as competent as they are used to feeling and at the same time as they take on a profound responsibility.

All of this encumbers a shock. Part of the shock is experiencing a mismatch between the mother's expectations and her experience. Again, the role that societal discourses around \`parenting' and \`traditional gendered roles' play is inherently forceful in women's adaptation to a \`real mother'. Postnatal events build on this level of emotional vulnerability, which appears to manifest in perceived failures to adequately fulfil \`good mother', \`gendered parenting' and \`domestic labourer' roles, which perpetuates the descent into significant psychological distress.

However, the mothers in this study did not question their beliefs about motherhood. Instead, they used these beliefs as a yardstick for measuring their own competence and adequacy in the mothering role. As a result they experienced themselves as inadequate mothers. Implicitly, their performance as mothers had failed to live up to the "genuine" and "true" motherhood that women should experience.

6.2.3 Caregiving overload. It is clear in the vivid and expressive accounts that many of these feelings are enduring. It was not unusual for all the duties related to parenting, cooking, cleaning, caring (for children, partners and extended family members), as well as income-generation and household financial management, to fall entirely upon one woman.

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These narratives display some women's distress at a loss of personal identity, as they feel constrained by gendered parenting roles, which create both distress and resentment towards their partners. This is characterised by the responsibility for a dependant that relies almost exclusively on the biological mother, being self-sacrificing and accountable.

An interesting insight which was raised by the women was their realisation of the extent to which their lives had changed since the birth of their baby and the extent to which their partner's lives had not. Thus complexity is added by `contemporary notions of fathers' as active parents. Yet the reality was in stark contrast as narratives of uninvolved and unsupportive fathers came to the fore. The general experience of women in this study was that of disappointment in their partner's unwillingness to provide emotional, practical and financial support.

For the mothers in this study, the father’s lack of support was devastating. Women’s continuing reference to deficiencies in care and support suggests that these absences can indeed have a lasting effect for women. These narratives illuminate how women feel unsupported and candidly demonstrate how these feelings can endure in the postnatal period. For these mothers, a lack of support plays a fundamental role in creating difficulties in the adjustment to motherhood but also conflicts with their need to be perceived as an `ideal modern family'

6.2.4 Dysfunctional interpersonal relationships. The difficult, frustrating and abusive relationships with their intimate partners or the fathers of their children appeared to affect the mothers substantially. These dysfunctional relationships contributed to their experiences of distress by making them feel unsupported, misunderstood and emotionally isolated. The sequelae of the intimate partner violence and infidelity these women suffered appear compounded by the multiple stressors they faced. In addition to dealing with responsibilities of a baby, some of the women had to deal with the rejection or loss of their relationships with a partner or frequent violent occurences.

Again, women sought to locate themselves locate themselves as part of a fulfilled and loving family, based on cultural depictions of `an ideal modem family life'. Lesch and Engelbrecht (2011) found that among the stressors that low-income couples typically have to contend with were; issues around fidelity and intimate partner violence. It could also be

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possible that the women in this study were severely affected by the infidelity and violence because it meant the shattering of long held expectations of family life and motherhood, but also their own feelings of self-worth.

Instances of maltreatment cannot be regarded as merely isolated events in the lives of individual women, but as one consequence of living as women in patriarchal society. With men accorded more value and power than women, they are situated in a web of interlocking ideological and institutional forces that secure their dominance across political, economic and social spheres, including those of family and interpersonal relations (Lafrance, 2009). Thus, individual violence is best understood as both a reflection and embodiment of gendered social and cultural contexts and nowhere is men's power over women more tangibly exerted than through violence.

6.2.5 Mothering in poverty. The challenges of motherhood were exacerbated by the lack of physical, emotional and financial support from the fathers of their babies. Often these challenges were associated with the financial burden of raising a child with very little financial support (if at all) and the difficultly associated with not having the resources to adequately provide for her child. Consequently, their worlds were very grim. They were badly resourced, both materially and psychologically. As a result the mothers' attention to their child's developmental needs often came secondary to satisfaction of basic needs, such as hunger.

Underlying participant's narratives was the notion of the ideal woman and mother, who is all-providing, ever-giving, self-sacrificing. However, the women could not live up to this ideal given their context. This echoed the findings of Youngleson (2006) who found that the juxtaposition between low-income mothers' constructions of ideal motherhood and their inability to meet these ideals due to their poverty-laden context, led to feelings of inadequacy, psychological distress, and desperation.

6.2.6 The physical body and motherhood. Finding motherhood much more difficult than it is represented significantly impacted the experience of motherhood. This becomes apparent in the narratives of childbirth, where the mothers experience a violation of their expectations of labour as natural and easy. Labour and delivery were clearly described by most participants as traumatic. The women found themselves faced with the terror of

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unbearable pain during labour which was frightening and unmanageable. Some wondered if their own bodies were strong enough to deliver their child. Other women expressed a felt sense of the possibility of death. This finding is significant in terms of highlighting the potential vulnerability of women during labour.

Women clearly perceive nurses as fundamental to both reassuring and facilitating their childbirth experience. Failure to provide women with individualised and adequate levels of support left them lacking confidence in the ability to care for their babies and infused with feelings of guilt and failure. Coates et al. (2014) argue that a difficult birth experience can contribute to postpartum distress in new mothers because the experience can be interpreted as a reflection of the women's incompetence in dealing with the demands of motherhood and essentially, being failures as mothers. In essence, these mothers are thrust into motherhood with a compromised self-esteem, vulnerable, alone and in a state of disorder. It seems apparent that for the women in this study who experience childbirth in an emotionally vulnerable state enter the postnatal period in the same way.

The demanding and dichotomous ideology prescribed by intensive mothering frequently resulted in feelings of guilt, inadequacy, and ambivalence towards the experience of motherhood for mothers who attempted to adhere to the expectations of this model. Again, this ideology comes to the fore in women's experiences of breastfeeding, where mothers who were unable to breastfeed their babies spoke of feeling pressured. Some mothers were even inclined to endure continued discomfort in order to demonstrate their allegiance to breastfeeding. Deleterious feelings associated with the inability to breastfeed demonstrate a perceived failure arising from notions of "bad mothering."

Furthermore, women's experiences of their bodies during the postpartum are mediated by their interactions with institutions and discourses (Kruger, 2005). The dissatisfaction the mothers experienced with their changed bodies brings to the fore society's focus on expectations of mothers and women. These feminine ideals reflect wider social values and gender constructions which women cannot actually meet, but against which they are judged and judge themselves as failing. It appears that following birth women feel expected to make an immediate return to non-pregnant women, but this is not possible. Her body now becomes a symbol of another ideal she fails to meet, and a sense of lost beauty is added to her experience.

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6.2.7 The silencing of the self. The notion of self-silencing (Jack, 1993; Jack & Ali, 2010) also came to the fore in this study as women's distress emerged as an emblematic act of the powerlessness they feel. Thus women silence their feelings of disappointment and anger and in turn their true selves in their intimate and social relationships. Many of the mothers acknowledged how socially unacceptable it was to express what they were feeling. This was especially prominent with regards to their feelings of being a new mother but also their interpersonal experiences and their disappointments in these relationships.

Self-silencing is informed by cultural expectations of the good mother but also of the good woman (Jeannes & Shefer, 2005). These constructions dictate that the ideal woman is composed; in control and self-sacrificing in relationships. Consequently, women engage in self-silencing behaviours in order to conform to these ideals (Jack, 1991; Newman et al., 2006). Paradoxically, women who already feel isolated and alone, now further isolate themselves as they feel guilty about their negative feelings.

6.2.8 Conclusion. The data clearly confirms that mothering and fathering are gendered (Magwaza, 2003), racialized, shaped by class and culture (Shears, 2007) and can therefore not be analysed in isolation from its context (Kruger, 2006). The findings of this study were not entirely unique. Causal models of maternal distress do include biological, interpersonal and psychological explanations. However, what was different about the findings of this research was that unlike the traditional models, no single aetiological factor could account for their distress after childbirth. Their attributions were interlinked and multidimensional. Their accounts were enhanced by their own insights, and the meaning they attached to those insights, so that the whole picture that was painted was multi-layered and complex. As such, this study has provided a different view and can be used to gain a more inclusive understanding of the meaning of maternal distress. These findings are consistent with studies exploring the lived experience of postpartum distress in other countries (Abrams & Curran, 2009; Beck, 2002; Choi et al., 2005; Mauthner, 1999; Nicolson, 1999; Tammentie et al., 2004), and expand upon the findings of similar investigations in South Africa (Frizelle & Hays, 1999; Frizelle & Kell, 2010; Jeannes & Shefer, 2004; Kathree et al., 2014; Long, 2009; Magwaza, 2003).

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6.3 Limitations

One limitation regarding this study is the homogeneity of the sample. This study consisted of a small number of low-income women, all of whom were living in the same sub-district of the Western Cape Province of South Africa. Additionally, the women participating in this study were from the same racial, socioeconomic and cultural group. The extent to which this sample is representative of women from similar contexts is thus limited. This was deemed acceptable as the goal of this study was not to generalize the findings. Instead, the aim of this study was to understand the experience of maternal distress in one group of women within a particular context.

Also, while the social constructionist theoretical framework of this study acknowledges the influence of subjectivity and inter-subjectivity, it is possible that other researchers would have recognized different categories from the data. While it is recognised that my own subjectivity as a white woman in her 20's who has not experienced motherhood has affected the research process, it is a limitation of this study that its scope did not allow for a more comprehensive examination of how my subjectivity impacted on all aspects of the research process. Tied to this concern is the ability of white researchers, when studying women from other races, to reflect more critically on their ethnocentric assumptions about gender relations and identity (Walker, 1995) and to be aware of their differences and how this may impact upon the research process. Being a researcher whose background is different to that of the participants in terms of race, culture and class, thus emerges as a limitation in this study. However, it should be noted that every effort has been made to reflect the findings of this study in an honest and accurate way. It is hoped that the views which have been interpreted and presented in this research project are as accurate as the women who participated in this research project would have wished.

A third limitation arose out of the secondary nature of the research study. Secondary data analysis was performed by means of analysing the transcriptions obtained in the parent study. There are limitations to relying on transcripts as the sole source of data (Markle, West, & Rich, 2011). Transcribing spoken words inevitably loses data as the tangible event or emotive response is translated into written language. Thus transcription can result in the loss of nonverbal communication, energy, and dynamics from the interviews. As such nonverbal

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gestures were impossible to incorporate as evidence of emergent themes because they did not transfer directly into the transcripts. Interpretation that commences during transcription phase has important implications for the research findings and conclusions (Markle et al., 2011). In the future, perhaps it is best to use video recording, in addition to audio, from which nonverbal communication can be coded. This would be especially useful for populations who communicate a great deal of meaning through nonverbal channels.

6.3.1 Implications for future research in recognition of limitations. The present study has identified several aspects that warrant further investigation and clarification. The paucity of research in the area of maternal distress has recently been acknowledged with more studies beginning to explore the experiences of maternal distress (e.g. Beck, 1993, 2002; Hall, 2006; Homewood, Tweed, Cee, & Crossley, 2009; Nicolson, 1999; Wardrop & Popaduik, 2013). These studies focus on women's lived experience of postpartum depression, as well as experiences of professional care and stigma of this diagnosis. Despite this, it seems that studies centered on the systems within which women exist are still rare (Doucet, Letourneau, & Blackmore, 2012).

As mentioned above, the findings of this study cannot be generalized. Research has indicated that mothering is affected by social-cultural variables. Mothering in the context of poverty, same sex parenting, single parenting and other contexts that are generally ignored by literature needs to be explored. It would, therefore, be important to design a study that would compare the experience of maternal distress in various races, socioeconomic and cultural groups within the South African context. This is necessary to increase the understanding of women’s illness experiences in the context of their social and cultural positioning.

Future research could include the experiences of women who do not qualify for a diagnosis of postpartum depression. This would provide crucial information regarding the contrasts between expectations and experience, and if these experiences are exclusive to mothers with postpartum depression. It would be important to explore the experience of this group of women and to compare it with the experience of other groups.

6.3.2 Implications for future research in recognition of the findings of this study. In terms of prominent findings in this study, the emotional tone of motherhood seems to be informed by experiences in childbirth. One-third of all births has been characterized as

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traumatic and can be a strong predictive factor for postpartum distress (Giannandrea, 2013). As such, further research is needed to explore women's birth expectations. Equally important would be to investigate strategies mothers use to process these unsatisfying experiences prior to experiencing significant distress.

The difficult relationships women experienced with their partners were another prominent theme in this study. In many cases, the mothers felt unsupported and received very little instrumental support. It would be interesting to explore the partners' perspective on the experience and the process that they went through. The relational components of maternal distress might also be better understood by contrasting the experience of women versus those of the men. Also, the relational processes occurring during the transition to parenthood may be better understood by comparing the women's points of view with those of the men.

From the findings of this study, an interesting question of coping and resilience arose. This is a ripe area for future exploration. While it is important to recognize the power of discourses that shape women's subjectivities, it is equally important to explore how such discourses are negotiated and resisted. As such, future studies could explore how women are actively resisting dominant discourses on mothering and how this resistance is grounded in women's personal contexts.

6.4 Implications for practice and policy

The findings of this study can facilitate the practice of professionals and the enactment of policy and programs geared towards mothers. Perhaps the most important guideline for practitioners is to become critical of the assumptions regarding maternal distress and the ideology of motherhood. Thus, practitioners and policymakers should shift their attention from the current biomedical focus towards an integrated understanding of postpartum distress. An integrative framework can contribute towards different understandings of the multifaceted problem that is maternal distress. Furthermore, acknowledging how social context and gendered power relations affect women's experiences of motherhood can facilitate the efficiency of prevention and intervention efforts. For example, if low-income women are not primarily experiencing sadness, but rather problematic interpersonal relationships, then detection and intervention strategies are misdirected.

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The provision of information at clinics could construct knowledge about the difficulties of motherhood, something that was found in this study as unavailable. As such, stakeholders in antenatal care of low-income women could encourage a less authoritarian attitude by acknowledging the difficulties of motherhood (Engqvist, Ferszt, Åhlin, & Nilsson, 2011). If services are to respond to and support mothers before a crisis there needs to be an open dialogue with women encouraging discussion of their mental distress and mothering and how these impact on each other.

Promoting realistic expectations about motherhood indicates, however, that there is opportunity for healthcare workers to intervene even earlier, for example prenatally, and offer strategies to support expectant mothers. It is likely that that early intervention would at least decrease the dissonance that is often experienced between idealised notions of motherhood and the everyday reality of these experiences. Including the vast emotional experiences mothers have as a normal reaction to the upheaval of the mothering role, should be an integral part of such a program.

Furthmore, intervening prenatally allows for the incorporation of preventative strategies when identifying risk factors for maternal distress. Identifying potential risk factors at this stage may decrease the probability of distress reaching a level of severity that would necessitate secondary or even tertiary intervention. For instance, a lack of support has been demonstrated to significantly contribute to the feelings of distress in mothers (Choi et al., 2005). Therefore, evaluating the nature of mothers's support systems, as well as providing opportunities for additional support after childbirth, may be significant in the prevention of maternal distress.

It is acknowledged that assimilating additional antenatal and postnatal service provision will necessitate addition resources, and will require changes within the South African health system. However, the identification and intervention of problems at an early stage would save both time and resources. This is especially important in the context of the South-African health services that are persistently stretched to the limit.

6.5 Concluding thoughts

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This study aimed to capture the experience of maternal distress in one group of low-income South African women. This allowed for the positioning of maternal distress within a wider frame of sociocultural context. The sociocultural context could not be discussed in more detail due to the limited scope of the thesis. However, within this approach maternal distress can be used as a springboard for dimensions of life such as emotions, motherhood, cultural contexts, and the dominant ideologies that colour these institutions.

These narratives strongly signified aspects of women's lives beyond the biomedical understanding of illnesses, revealing the complex backdrops of women's everyday existence. Consequnently, it is possible conceptualize maternal distress at the level of the individual; in terms of reproductive histories, or the availability of support networks and financial resources. However, maternal distress also constitutes a commentary on phenomena occurring at an institutional level; such as ideologies of motherhood and gender or the increasing authority of biomedicine as a model of normativity (Tapias, 2015).

Recognizing women's own experiences of maternal distress demonstrate how these processes (the individual and the institutional) become connected (Kleinman, 1992, 2006) and impact upon the individual. This enables the inclusion of more diverse and complex sets of meanings into our understanding of this phenomenon. In such an understanding, maternal distress can be understood as an expression of a contradictory set of systems.

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Appendix A

Edinburgh Postnatal Depression Scale

Name: ___________________________________ Date: ____________________________

Number of days after birth: ____

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

In the past 7 days:

1. I have been able to laugh and see the funny side of things

    As much as I always could

    Not quite so much now

    Definitely not so much now

    Not at all

2. I have looked forward to things

    As much as I ever did

    Rather less than I used to

    Definitely less than I used to

    Hardly at all

3. I have blamed myself unnecessarily when things went wrong

    Yes, most of the time

    Yes, some of the time

    Not very often

    No, never

4. I have been anxious or worried for no good reason

    No, not at all

    Hardly ever

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Yes, sometimes

Yes, very often

5. I have felt scared or panicky for no very good reason

Yes, quite a lot

Yes, sometimes

No, not much

No, not at all

6. Things have been getting on top of me

Yes, most of the time I haven't been able to cope at all

Yes, sometimes I haven't been coping as well as usual

No, most of the time I have coped quite well

No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping

Yes, most of the time

Yes, sometimes

Not very often

No, not at all

8. I have felt sad or miserable

Yes, most of the time

Yes, quite often

Not very often

No, not at all

9. I have been so unhappy that I have been crying

Yes, most of the time

Yes, quite often

Only occasionally

No, never

10. The thought of harming myself has occurred to me

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Yes, quite often

Sometimes

Hardly ever

Never

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Appendix B

Beck Depression Inventory

Op hierdie vraelys is daar groepe stellings. Lees elke groep stellings noukeurig deur. Kies dan uit elke groep die een stelling wat die beste beskryf hoe jy die afgelope week, insluitende vandag, gevoel het. Trek 'n sirkel om die nommer van die stelling wat jy kies. As meer as een stelling in die groep van toepassing is, omsirkel elke een wat van toepassing is. Maak seker dat jy alle stellings in die groep lees voordat jy jou keuse maak.

1. 0 Ek voel nie swaarmoedig of terneergedruk nie.
   1 Ek voel swaarmoedig of terneergedruk.
   2 Ek is gedurig swaarmoedig of terneergedruk en kan die gevoel nie afskud nie.
   3 Ek is so swaarmoedig of ongelukkig dat ek dit nie kan verduur nie.

2. 0 Ek is nie besonder pessimisties of ontmoedig deur die toekoms nie.
   1 Ek voel ontmoedig oor die toekoms.
   2 Ek voel ek het niks om na uit te sien nie.
   3 Ek voel die toekoms is hopeloos en dat dinge nie kan verbeter nie.

3. 0 Ek voel nie soos 'n mislukking nie.
   1 Ek voel ek het meer as die gewone mens misluk.
   2 As ek op my lewe terugkyk, sien ek net mislukkings.
   3 Ek voel ek is 'n algehele mislukking as 'n mens.

4. 0 Ek kry soveel bevrediging soos voorheen uit dinge
   1 Ek geniet dinge nie soos gewoonlik nie..
   2 Ek kry nie werklik bevrediging uit enigiets meer nie.
   3 Ek is ontevrede of verveeld met alles.

5. 0 Ek voel nie besonder skuldig nie
   1 Ek voel 'n groot deel van die tyd skuldig.
   2 Ek voel die meeste van die tyd taamlik skuldig.
   3 Ek voel altyd skuldig.

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6. 0 Ek voel nie ek word gestraf nie.
   1 Ek voel ek mag gestraf word.
   2 Ek verwag om gestraf te word.
   3 Ek voel ek word gestraf.

7. 0 Ek voel nie teleurgesteld in myself nie.
   1 Ek is teleurgesteld in myself.
   2 Ek het 'n teensin in myself.
   3 Ek haat myself.

8. 0 Ek voel nie ek is slegter as enigiemand anders nie.
   1 Ek is krities teenoor myself oor my swakhede of foute.
   2 Ek blameer myself altyd vir my foute.
   3 Ek blameer myself vir alle slegte dinge wat gebeur.

9. 0 Ek het geen gedagtes aan selfmoord nie.
   1 Ek dink aan selfmoord, maar sal dit nie uitvoer nie.
   2 Ek wil myself graag om die lewe bring.
   3 Ek sal selfmoord pleeg as ek die kans kry.

10. Ek huil nie meer as gewoonlik nie.
    1 Ek huil nou meer as gewoonlik.
    2 Ek huil nou gedurig.
    3 Ek kon vroeër huil, maar nou kan ek nie al wil ek ook.

11. 0 Ek is nie nou meer geïrriteerd as gewoonlik nie.
    1 Ek word makliker ergerlik of geïrriteerd as voorheen.
    2 Ek voel nou gedurig geïrriteerd.
    3 Ek word glad nie geïrriteer deur dinge wat my gewoonlik geïrriteer het nie.

12. 0 Ek het nie belangstelling in ander mense verloor nie.
    1 Ek stel minder belang in ander mense as voorheen.
    2 Ek het die meeste van my belangstelling in ander mense verloor.

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3 Ek het al my belangstelling in ander mense verloor.

13. 0 Ek neem besluite net so goed soos gewoonlik.
    1 Ek stel meer uit om besluite te neem as voorheen.
    2 Ek neem besluite moeiliker as voorheen.
    3 Ek kan glad nie besluite neem nie.

14. 0 Ek voel nie dat ek slegter as gewoonlik lyk nie.
    1 Ek is bekommerd daaroor dat ek oud of onaantreklik lyk
    2 Ek voel daar is blywende veranderinge in my voorkoms wat my onaantrekilik laat lyk.
    3 Ek glo ek lyk lelik.

15. 0 Ek kan net so goed soos tevore werk
    1 Dit vereis meer inspanning om te begin om iets te doen.
    2 Ek moet myself forseer om enigiets te doen.
    3 Ek kan geen werk doen nie.

16. 0 Ek slaap so goed soos gewoonlik.
    1 Ek slaap nie so goed soos gewoonlik nie.
    2 Ek word 1-2 ure vroeër wakker en sukkel om weer aan die slaap te raak.
    3 Ek word etlike ure vroeër as gewoonlik wakker en kan nie weer slaap nie.

17. 0 Ek word nie moeër as gewoonlik nie.
    1 Ek word makliker moeg as gewoonlik.
    2 Ek word moeg van omtrent enigiets wat ek doen.
    3 Ek is te moeg om enigiets te doen.

18. 0 My eetlus is nie slegter as gewoonlik nie.
    1 My eetlus is nie so goed as wat dit was nie.
    2 My eetlus is baie slegter.
    3 Ek het glad geen eetlus meer nie.

19. 0 Ek het nie onlangs veel, indien enige, gewig verloor nie.

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1 Ek het meer as 2.5 kg verloor.

2 Ek het meer as 5 kg verloor.

3 Ek het meer as 7.5 kg verloor.

20. 0 Ek is nie meer bekommerd oor my gesondheid as gewoonlik nie.

1 Ek is bekommerd oor liggaamlike probleme soos pyne of 'n omgekeerde maag of hardlywigheid.

2 Ek is baie bekommerd oor liggaamlike probleme en dit is moeilik om aan iets anders te dink.

3 Ek is so bekommerd oor my liggaamlike probleme dat ek aan niks anders kan dink nie.

21. 0 Ek het nie onlangs enige veranderinge in my belangstelling in seks opgemerk nie.

1 Ek stel minder in seks belang as gewoonlik.

2 Ek stel nou baie minder in seks belang.

3 Ek het heeltemal belangstelling in seks verloor.

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Appendix C

DEMOGRAPHIC DETAILS

Respondent number: ______________________ Codename: _______________

Language: ____________________________ Age: ____________________

1. Household

Composition of Household: ____

____

Relationship status (In relationship? Live together? How long?): ___________________

____

Children (gender and age): ____

____

2. Work

Work (type/ fulltime/part time/ unemployed):

Self: ____

Partner (man/boyfriend): ____

Parents: ____

3. Income

Self: _____________ Partner: ________________ Household: ___________

4. Literacy

Comfortably read and write: _____________ Schooled to standard: ______________

5. Religion

Religious affiliation: _________________ Actively involved: ________________

6. Accomodation

Years in Kylemore: _____________

No. of rooms in house: ___________ No. of bedrooms in house: __________

With whom do you sleep in a bedroom? ___________________________________

Is there a bathroom in the house? __________ Is there electricity in the house? ________

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IDENTIFISERING VORM

Volle naam: ____

Kodenaam: _______________________ Respondentnommer: ________________________

Geboortedatum: ____

Adres: ____

____

Telefoonnommer: ____

Alternatiewe kontak nommer: ____

Huistaal: ____

Verwagte datum van geboorte (due date): __________________________________

Datum van werwing: ____

Naam van werwer: ____

Onderhoudskedule:

	Onderhoud 1 (swangerskap)	Onderhoud 2 (3 dae na geboorte)	Onderhoud 3 (3 maande na geboorte)	Onderhoud 4 (6 maande na geboorte)	Opvolg
Datum:					
Tyd					
Plek					
Onderhoudvoerder					

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Appendix D

UNSTRUCTURED INTERVIEW 1

(PREGNANCY)

- You are now X months pregnant. How are you today? How do you feel emotionally/physically?

- Tell me about the day you found out you were pregnant.
  - Story: where, when, how, who?
  - Feelings: surprised, heartbroken, excited, ambivalent, anxious, strange, guilty, disappointed, proud, emotional, worried, ashamed, denial

- What did you do after you found out?
  - Told someone (who, why, what was there reaction)

- What is it like being pregnant? How have things changed and stayed the same?
  - Feelings now:

surprised, heartbroken, excited, ambivalent, anxious, guilty, disappointed, proud, emotional, worried, ashamed, denial, scared, calm, irritated, tense, depressed, energetic, tired, alone, lonely

-Feelings about fetus (baby):

Negative (hope for miscarriage, abortion, adoption, hides fact that pregnant, denies, impulse to hurt baby), scared, excited, angry

-Attitude/feelings/reaction of others:

Partner (who, married/unmarried), family (mother, father, own children, others), friends (ask about female friends), work (colleagues and boss), church, school

Judgmental, supportive, excited, proud, worried

- Changes i.t.o body and sexuality

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Physical symptoms (breasts, larger body, digestive system – constipation, nausea, indigestion –etc), more aware of body, feelings about feminine changes, vulnerable, powerful, more/ less attractive more/less sexual feelings, more/less sexually active

- Changes i.t.o work? Changes i.t.o. identity
    - Changes i.t.o. lifestyle?
    - Do you feel like a mother, do you feel more like a woman

- What bothers you now that you are pregnant? With what do you struggle?

- Have your needs changed now that you are pregnant? What do you feel you need?
    - From others?
    - From health services (doctors, nurses, clinic)
    - From community

- What type of care have you already received? How do you feel about it? Has it helped?
    - Information: who, where, when, how, what?
    - Procedures: checkups, sonars, genetic tests, other tests, experience thereof
    - Special treatment from the people in your life

- How do you feel about the birth, what do you think about it, what are your expectations?
    - What have you been told/ by whom?
    - Role of doctors, nurses, partner, others?
    - How do you think it should be (ideal birth)?
    - Are you scared for the birth/ are you looking forward to it?
    - How do you feel about medical interventions (natural birth, pain killers)

- How do you feel about becoming a mother? What do you expect?

- What is a good mother? Do you know anybody who is a good mother? Was your mother a good mother?

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UNSTRUCTURED INTERVIEW 2

(1-5 days after birth)

- How do you feel now? A lot has happened…
- Tell me about the birth?
    - Story: How did it begin – where, when, who was there

      Did you know what was happening?

      How did you know?

      What did you do?

      Did you tell anyone?

- ASK DETAIL OF BIRTH ITSELF
    - Feelings: surprised, heart sore, excited, ambivalent, strange, anxious, guilty, disappointed, proud, emotional, worried, ashamed
- How do you feel about the birth, what did you expect, did it live up to your expectations?
    - What were you told about it/ By whom?
    - Role of doctors, nurses, partner, other?
    - How did you think it should be (ideals if there is)
- Medical intervention, natural birth, pain killers, hospital, after the birth?
- Breast feeding
- What did you do just after the birth?
    - Tell somebody (who, why, what was your reaction)
- What is it like to have a baby? How did things change or stay the same?
    - Feelings now:

      Surprised, heartsore, excited, ambivalent, anxious, guilty, disappointed, proud, emotional, worried, shy, denial, scare, calm, irritated, tense, depressive, energized, tired, lonely, alone

    - Feelings about baby:

      Negative, positive, happy, love, scared, excited, angry, heartsore
- Attitude/feelings/actions of others:
    - Judgmental, supportive, excited,
- Changes in relationships with other

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Partner (who, married/unmarried), family (mother, father, own, children, others), friends (ask esp. about friends), work (employers, colleagues), church

- Changes In body and with regard to sexuality
    - Physical symptoms, more aware of body, vulnerable, powerful, more/less attractive, more/less sexual feelings, more/less sexually active
- Changes i.t.o. work?
- Changes i.t.o. identity?
- Do you feel like a mother, do you feel more like a women?
- Change i.t.o lifestyle:
    - Substances, sex, social activity, physical activity, exercise, eat, sleep, dress
- What bothers you now that you have a baby?
- Have your needs changed now that you have a baby? What do you feel you need? With what do you struggle?
    - From others?
    - From health services (doctors, nurses, clinics)?
    - From community
- What type of care have you already received and how do you feel about it?
    - Information

    Who, where, when, how, what

    - Procedures

    After birth

    - Special treatment from people in your life

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UNSTRUCTURED INTERVIEW 3

(3 months after the birth)

- How do you feel now? A lot has happened…
- How do you feel now when you think back about the birth, what did you expect from it, how did it fulfil your expectations?
  - What were you told about it / By whom?
  - Role of the doctors, nurses, partner, others?
  - How do you think it is supposed to be (idea if there is one)
- Breastfeeding
  - Do you breastfeed?
  - Why / Why not?
  - Do you enjoy it?
  - For how long are you going to continue to breastfeed?
  - When will you stop
- How does it feel now, after a few months, having a baby? How have things changed and stayed the same?
  - Feelings now:

    Surprised, heartsore, excited, ambivalent, anxious, guilty, disappointed, proud, emotional, worried, shy, denial, scare, calm, irritated, tense, depressive, energized, tired, lonely, alone

  - Feelings about baby: Negative, positive, happy, love, scared, excited, angry, heartsore
  - Attitude / Feelings / Behaviour of others - Partner (who,married/unmarried), family (Mother, father,own, children, others),friends (especially ask about female friends); work (employers and colleagues) church: Judgemental, supportive, excited, reserved, proud, worried
  - Changes in terms of relationships with others - Partner (who, married/unmarried), family (Mother, father,own, children, others),friends (especially ask about female friends); work (employers and colleagues) church:

    Closer / further, Trust

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- Changes in terms of body and sexuality

  Physical symptoms, more aware of body, feelings about female changes, vulnerable, stronger/powerful, more or less attractive, more or less desirable, how do others feel, more / less sexual feelings, more / less sexually active

- Changes in terms of work?
- Changes in terms of identity?
- Do you feel like a mother, do you feel more womanly?
- Changes in lifestyle::

  Substances, sex, social activities, physical activities, exercise, appetite, sleep, clothing attire

- Now that the baby is older, are there things that bother you?
- Have your needs changed now that you have a baby? What do you feel that you need? With what do you struggle?
  - In terms of others
  - In terms of health services (doctors, nurses, clinics)
  - In terms of the community/Van gemeenskap
- What types of care have you already received and how do you feel about it?
  - Information:

    Who, where, when, how, what

  - Procedures: after birth
  - Special treatment from the people in your life
- At which stage did you begin to start thinking about yourself as a mother?
- What does it mean to be a mother?
- Is there such a thing as a good and a bad mother? What is that?
- What is nice about being a mother?
- What is bad about being a mother?
- Has being a mother affected your relationship with others?
- How were things different with your last child compared to your first child?

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UNSTRUCTURED INTERVIEW 4

(6 months after the birth)

- How do you feel now after having a baby for a few months? How have things changed and how have they stayed the same?
  - Feelings now:

    Surprised, heartsore, excited, ambivalent, anxious, guilty, disappointed, proud, emotional, worried, shy, denial, scare, calm, irritated, tense, depressive, energized, tired, lonely, alone
  - Feelings about baby:

    Negative, positive, happy, love, scared, excited, angry, heartsore
  - Attitude / Feelings / Behaviour of others - Partner (who,married/unmarried), family (Mother, father,own, children, others),friends (especially ask about female friends); work (employers and colleagues) church:

    Judgemental, supportive, excited, reserved, proud, worried
  - Changes in terms of relationships with others - Partner (who, married/unmarried), family (Mother, father,own, children, others),friends (especially ask about female friends); work (employers and colleagues) church:

    Closer / further, Trust
  - Changes in terms of body and sexuality

    Physical symptoms, more aware of body, feelings about female changes, vulnerable, stronger/powerful, more or less attractive, more or less desirable, how do others feel, more / less sexual feelings, more / less sexually active
  - Changes in terms of work
  - Changes in terms of identity
  - Do you feel like a mother, do you feel more womanly?
  - Changes in lifestyle::

    Substances, sex, social activities, physical activities, exercise, appetite, sleep, clothing attire

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- Now that the baby is older, are there things that bother you?
- Have your needs changed now that you have a baby? What do you feel that you need? With what do you struggle?
  - In terms of others
  - In terms of health services (doctors, nurses, clinics)
  - In terms of the community
- What types of care have you already received and how do you feel about it?
  - Information:

    Who, where, when, how, what

  - Procedures: after birth
  - Special treatment from the people in your life
- If you now think back about the whole experience, pregnancy, birth and motherhood, is there something that you would have wanted to be different?
- At which stage did you begin to start thinking about yourself as a mother?
- What does it mean to be a mother?
- Is there such a thing as a good and a bad mother? What is that?
- What is nice about being a mother?
- What is bad about being a mother?
- Has being a mother affected your relationship with others?
  - Father of your child, your other, family, friends
- How were things different with your last child compared to your first child?
- Breastfeeding
  - Do you breastfeed
  - Why / Why not
  - Do you enjoy it?
  - For how long are you going to continue to breastfeed?
  - When will you stop
- How do you feel now when you think back about the birth, what did you expect from it, how did it fulfil your expectations?
  - What were you told about it / By whom
  - Role of the doctors, nurses, partner, others
  - How do you think it is supposed to be (idea if there is one)

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- How were the interviews? How do you feel about them?
- Are you prepared to allow us to contact you in a year’s time for a follow-up interview?
- If you move, will you inform us of your new address?

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Appendix E

VORM VIR OORWOë TOESTEMMING

Beste Deelnemer

Hiermee wil ons u graag versoek om deel te neem aan 'n naarvorsingstudie wat ondersoek instel na hoe vroue swangerskap, geboorte en moederskap ervaar. Ons stel daarin belang om meer te verstaan oor moontlike positiewe en negatiewe aspekte van hierdie ervaring en watter faktore daartoe bydra. Ons hoop dat hierdie navorsing sal bydra tot meer effektiewe sielkundige ondersteuning van swanger vroue en moeders.

Indien u bereid is om aan hierdie studie deel te neem, sal ons graag vier onderhoude met u wil voer. Die onderhoud sal tussen een en twee ure duur. Die onderhoud sal op band opgeneem word. Vroulike narvorsers, wat senior studente in Sielkunde is, sal die onderhoud voer. Die onderhoud sal gevoer word of by u woonplek of by die Departement Sielkunde aan die Universiteit van Stellenbosch, of enige ander plek wat vir u geskik is, op 'n tyd wat u pas.

Tydens die onderhoud sal vrae gestel word oor u ervarings van swangerskap, geboorte en moederskap. Ons sal vrae vra oor watter impak hierdie ervarings op u en u verhoudings en werk gehad het. Ons wil met ander woorde verstaan hoe dit vir u is om verwagtend te wees en hoe dit vir u is om 'n moeder te wees.

Ons vertrou dat die onderhoud interessant en nuttig sal wees vir elkeen wat aan hierdie studie deelneem. Sommige van die vrae wat gestel word, sal egter hoogs persoonlik wees, en kan onaangename herinneringe oproep. U moet asseblief kennis neem dat die onderhoud te enige tyd kan beëindig, en dat u tydens die onderhoud kan weier om spesifieke vrae te beantwoord. Deelnemers het die vryheid om hulle deelname te enige tyd te beëindig. Indien u van die studie ontrek, kan u vra dat al die data wat oor u versamel is, dit sluit die bandopnames en die transkripsies van die bande in, vernietig word, en dit sal gedoen word.

Om die vertroulikheid van die narvorsingsmateriaal te verseker, sal geen name op die onderhoude of vorms geplaas word nie. Elke deelnemer sal gevra word om 'n kodenaam te kies, en daar sal 'n lys saamgestel word om aan te toon watter deelnemer met watter kodenaam ooreenstem. Die lys sal in ‘n toegesluite kas in 'n kantoor by die Departement Sielkunde gebêre word. Slegs lede van die narvorsingspan sal toegang hê

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tot enige van die data, wat die bande en die transkripsies insluit. Dit sal ook in die reeds genoemde toegsluite kas bewaar word. Alle inligting sal dus vertroulik gehou word

Verslae oor die studie, dit sluit enige gepubliseerde werk in, sal nie enige ware name noem nie. Beskrywings van alle persone sal verbloem word sodat hulle nie herkenbaar sal wees vir enigiemand anders wat die studie lees nie. Daarom sal geen stuk inligting wat deur die studie versamel is op enige manier met enige spesifieke persoon of familie kan verbind word nie. Aangesien sodanige inligting oor lewens van vroue so waardevol is, sal die bande bewaar word solank as wat die navorser navorsing op hierdie terrein voortsit. Sodra die navorser hierdie studie voltooi, sal die bande vernietig word, tesame met met die lys wat die name en kodename bevat.

Indien u vind dat die vrae wat tydens die navorsingsonderhoud gestel word, pynlike of onaangename herinneringe oproep, en u sou met iemand oor u gevoelens wou praaat, het ons 'n lys hulpdienste wat u kan kontak. Ons kan u ook help om hulp te kry indien ons tydens die onderhoud agterkom dat u sielkundige ondersteuning verlang.

Indien u daarin belangstel om aan hierdie studie deel te neem, lees asseblief die volgende verklaring en teken hieronder.

Ek begryp dat deelname aan hierdie studie vrywillig is, en is bewus van die moontlike risiko's, voordele, en ongerief verbonde aan my deelname. Ek aanvaar dat ek vrylik vrae kan vra, kan weier om vrae te beantwoord, en dat ek 'n sessie te eniger tyd kan beëindig. Ek begryp ook dat indien ek enige vrae of probleme het wat hierdie narvorsing betref, ek die hoofondersoeker, Dr. Lou-Marie Kruger by 808-3460, kan bel.

_________________________ ___________

Handtekening van deelnemer | Datum

_________________________________ ___________

Handtekening van ondershoudvoerder | Datum