

Perceived barriers to perinatal mental health care utilization: A qualitative study.

by

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SUMMARY

The topic of perinatal depression (i.e. depression during and after pregnancy) remains a subject of continued research interest, as a broad literature body reports that a large proportion of women suffering from this mental disorder do not receive appropriate treatment. This is worrisome, firstly, because mental health treatment is often readily available to the public and at no cost. Secondly, untreated perinatal depression not only holds dangerous consequences for the mother but also for the infant and the rest of the family. It is therefore important to identify those factors that act as barriers to mental health care utilization for perinatal depression.

Although this is a persistent problem within the South African context, to date, little is known about the barriers to the utilization of available mental health services experienced among pregnant South African women. For this reason, the Perinatal Mental Health Project (PMHP) aims to provide mental health services at the same location where women receive obstetric services. However, despite their efforts, the number of women who decline available treatment is still of great concern.

The present study offers a unique perspective on counselling for perinatal depression appointment-keeping barriers as it provides a holistic view of these barriers that exist not only within the women but also in their multi-levelled environments. Secondly, it addresses the problem of nonattendance to mental health care treatment offered by the PMHP and consequently also addresses the gap in South African research on the topic.

The sample for this study was selected from PMHP files of those patients who failed to attend scheduled counselling appointments. The participants included in this study were selected by means of purposeful sampling to participate in face-to-face and telephonic semi-structured interviews. Participants were assured of confidentiality and anonymity. The semi-

structured interviews were audio-recorded and transcribed after which transcriptions were entered into MS Word for textual analysis. Transcriptions were thematically analysed. The main themes that emerged from the present study included individual-related barriers, social-related barriers, institution-related barriers, community-related barriers and poverty-related barriers.

The results of the present study reflect the motivations for depressive pregnant women to decline available and free mental health services provided by the PMHP, according to five main themes. These themes were then discussed according to Bronfenbrenner's (1977; 1979) Ecological Systems Theory, which categorised the main themes identified according to the different systems operating within the patient's environment, i.e. the individual-, micro-, meso-, exo-, and macrosystem. The individual system comprised the individual-related barriers, which included poor mental health, and ambivalent feelings toward the pregnancy. The microsystem comprised the social-related barriers, which included low social support and self-help strategies. Community-related barriers were considered within the mesosystem of the patient's ecological environment, with stigma and pity as sub-barrier. The exosystem comprised the institution-related barriers, including referral protocol barriers, lack of information provided by the nurses, and nurses' attitudes as experienced by participants. Lastly, poverty-related barriers were considered within the macrosystem, with financial life hardship, constant child-care demands, and transportation barriers as sub-barriers.

The significance of this study lies in the original perspective offered on mental health care appointment-keeping behaviour within the South African context. Future research could, in addition to conducting interviews with hospital patients, include health care professionals and focus groups as this will allow for triangulation of the perspectives of all significant players. Also, having identified the problems and concerns with regards to attending

counselling appointments, future research direction may be aimed at creating interventions designed to reduce the identified barriers to mental health care service use.

OPSOMMING

Perinatale depressie (d.w.s. depressie voor en na swangerskap) bly 'n onderwerp van voortdurende navorsings belang, aangesien 'n breë navorsingsveld aandui dat 'n groot proporsie van vroue wat aan hierdie geestesversteuring lei, nie die gepaste behandeling ontvang nie. Dit is kommerwekkend, eerstens, aangesien behandeling vir geestesgesondheid meestal openlik verkrygbaar is aan almal sonder enige koste. Tweedens, onbehandelde perinatale depressie hou nie slegs gevaarlike gevolge vir die moeder in nie, maar ook vir die baba en die res van die gesin. Dit is daarom belangrik om daardie faktore te identifiseer wat as hindernisse optree tot geestesgesondheid sorg diensgebruik vir perinatale depressie.

Alhoewel dit 'n voortdurende probleem binne die Suid-Afrikaanse konteks is, is daar tot op hede geen navorsing wat hindernisse tot gebruik van beskikbare geestesgesondheidsdienste bekend gemaak nie, veral wat ervaar word onder swanger Suid-Afrikaanse vroue nie. Vir hierdie rede, beoog die Perinatal Geestesgesondheid Projek (Perinatal Mental Health Project - PMHP) om geestesgesondheidsdienste te lewer by dieselfde plek waar vroue verloskundige dienste kan ontvang. Nietemin, ten spyte van hul pogings, is die getal vroue wat beskikbare behandeling van die hand wys steeds van groot kommer.

Dié studie bied 'n unieke perspektief op hindernisse tot berading vir perinatale depressie afspraak-ooreenkoms gedrag, aangesien dit 'n algehele uitkyk bied op hindernisse wat nie slegs binne die vrou bestaan nie, maar ook in hul veelvlakkige omgewings bestaan. Tweedens, spreek dit die probleem van nie-bywoning van geestesgesondheidsbehandelingsdienste wat aangebied word deur die PMHP aan en gevolglik ook die gaping wat binne Suid-Afrikaanse navorsing rakende dié onderwerp bestaan.

Die steekproef vir die studie was gekies van PMHP lêers van daardie pasiënte wat nie hul geskeduleerde terapie afsprake bygewoon het nie. Die deelnemers ingesluit in die studie

is deur middel van doelgerigte-steekproefneming geselekteer om aan aangesig-tot-aangesig of telefoniese semi-gestruktureerde onderhoude deel te neem. Deelnemers is van hul vertroulikheid en anonimiteit van die proses verseker. Die semi-gestruktureerde onderhoude was oudio-opgeneem en transkripsies is daarvan gemaak, waarna die transkripsies in MS Word gelaai is vir tekstuele analise. Transkripsies is tematies geanaliseer. Die hoofemas wat na vore gekom het, sluit in individuele-verwante hindernisse, sosiale-verwante hindernisse, institusie-verwante hindernisse, gemeenskapsverwante hindernisse en armoede-verwante hindernisse.

Resultate van dié studie reflekteer die motiverings van depressiewe swanger vroue om beskikbare en gratis geestesgesondheidsdienste wat verskaf is deur die PMHP van die hand te wys, volgens die vyf hoofemas. Hierdie temas is toe volgens Bronfenbrenner (1972) se Ekologiese Sisteemteorie verdeel in die verskillende sisteme teenwoordig in die pasiënt se omgewing, naamlik die individuele-, mikro-, meso-, ekso-, en makrosisteem. Die individuele sisteem het die individuele-verwante hindernisse ingesluit, wat swak geestesgesondheid, en teenstrydige gevoelens teenoor die swangerskap omvat het. Die mikrosisteem het die sosiale-verwante hindernisse ingesluit, wat swak sosiale ondersteuning, en self-help strategieë omvat het. Gemeenskapsverwante hindernisse is binne die mesosisteem van die pasiënt se ekologiese omgewing beskou, en het stigma en jammerte as sub-hindernisse ingesluit. Die eksosisteem het die institusie-verwante hindernisse ingesluit, wat verwysing protokol hindernisse, gebrek aan inligting verskaf deur die verpleegsters, en verpleegsters se houdings soos ervaar deur die deelnemers omvat het. Laastens is die armoede-verwante hindernisse binne die makrosisteem beskou, en het finansiële lewens swaarkry, konstante kindersorg eise, en vervoer-verwante struikelblokke as sub-hindernisse ingesluit het.

Die belang van dié studie lê in die oorspronklike perspektief van geestesgesondheidsbehandeling dienste afspraak-ooreenkoms gedrag binne die Suid-

Afrikaanse konteks, wat aangebied is. Toekomstige navorsing kan, bykomend tot die voer van onderhoude met hospitaal pasiënte, fokus daarop om gesondheidsorg kenners en fokus groepe in te sluit, aangesien dit die triangulasie van perspektiewe moontlik maak van al die belangrike rolspelers. Ook, aangesien die probleem en bekommernisse rakende bywoning van terapie afsprake reeds geïdentifiseer is, mag toekomstige navorsing in die rigting beweeg met die doel om intervensies te omskep wat beoog om die geïdentifiseerde hindernisse tot geestesgesondheidsorg diensgebruik te verminder.

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Chapter 1: Introduction

1.1 Introduction and Rationale for the Present Study

Traditionally, pregnancy has been linked to great excitement and joy and has therefore been said to act as a barrier to mental illness and depression (Buist, 2000). However, recent research opposes this notion as it becomes more and more apparent that pregnancy and childbirth represents a period of great vulnerability to become mentally ill (Ryan, Milis & Misri, 2005). This is especially true when referring to perinatal depression (Rochat, Tomlinson, Bärnighausen, Newell & Stein, 2011; Stocky & Lynch, 2000).

Perinatal depression is depression during and after pregnancy. This mental illness shows symptoms similar to depression unrelated to pregnancy and childbirth, however the content of these symptoms tend to focus on mothering (DSM-IV-TR, 2000; Remick, 2002). Perinatal depression not only holds dangerous consequences for the mother when it goes untreated, but also for the infant and the rest of the family (Alder, Fink, Bitzer, Hösli, & Holzgreve, 2007; Bonari et al., 2004). Depression during pregnancy can compromise the birth outcome (Orr, James & Blackmore Prince, 2005); and depression after pregnancy can have deleterious consequences for the mother–infant relationship and for further childhood development (McLearn, Minkovitz, Strobino, Marks & Hou, 2006).

Statistics related to antenatal depression in the broad literature are comparable to that of South African populations, and varies from 13% to 51% depending on the demographic characteristics of the population studied and the type of screening instrument used (Sleath, West, Tudor, Perreira, King & Morrissey 2005). A meta-analysis of 59 studies found that 13% of women will experience postpartum depression within the first 12 weeks after giving birth, regardless of their culture (O'Hara & Swain, 1996). However, due to the underreported nature of perinatal depression, these estimates are likely to be conservative (Murray, Woolgar, Murray & Cooper, 2003). These figures are therefore worrisome as research shows that the

majority of these women who experience perinatal depression are unlikely to receive any treatment (Flynn, O'Mahen, Massey & Marcus, 2006; Smith et al., 2006).

At the United Nations Summit on Millennium Development Goals (MDGs) it was emphasized that the least amount of progress has been made on improving maternal health (i.e. the fifth MDG) compared to any other MDG (The World Bank Group, 2013). Consequently, it has been found that one in three women living in poverty in South Africa will suffer from a pregnancy-related mental health problem (PMHP, 2012). In rural Kwazulu-Natal 41% of women have depression (Rochat et al., 2006), comparable to the 47% rate of antenatal depression in the same area (Rochat et al., 2011). The antenatal depression prevalence rate in two peri-urban Cape Town settlements have been found to be a slightly lower (39%) than that of Kwazulu-Natal (Hartley et al., 2011).

In light of the high antenatal prevalence rates amongst the South African female population living in poverty, the Perinatal Mental Health Project (PMHP) was founded in 2002. The aim of the PMHP is to address mental illness among pregnant or post-natal girls and women who come from communities in the Western Cape that are adversely affected by poverty, violence, abuse and HIV/AIDS. The extreme life hardship faced by this group of women on a daily basis is exacerbated by their lack of social support. The PMHP firstly aims to provide mental health services at the same location where these women receive obstetric services. It further strives to, together with the Department of Health, equip the public health sector with those skills and tools needed to provide accessible and affordable maternal mental health services. This aim is achieved through advocacy, teaching and training, and research (PMHP, 2012). However, despite their efforts, the proportion of women who decline available mental health treatment is still of great concern. To date, little is known about barriers to the use of available mental health services experienced among pregnant South African women.

1.2 Need for the Present Study

Based on the preceding argument, the purpose of my research is to identify and understand the motivations for depressive pregnant women to decline available and free mental health services provided at Mowbray Maternal Hospital (MMH) by the PMHP. There is currently a need to identify what the barriers are to service utilization, in order to extend health care to those women who are not accessing available mental health services. Identifying these barriers may lead to an improvement of the PMHP services, in that these barriers may be accounted for and planned against, which may improve access for those women who are currently not utilizing these services.

1.3 Overview of the Chapters

Chapter 2 provides an overview of perinatal depression, the risk factors related to perinatal depression, the consequences of untreated perinatal depression, barriers to service utilization in the case of perinatal depression, and a theoretical framework. Chapter 3 describes the method that was used for the present study, including context, participants profiles, sampling strategy, procedure, analysis, reflexivity, ethical procedures and significance of the study. Chapter 4 includes the findings of the present study together with a discussion of it. Theory is also incorporated to explain the results. The chapter is concluded with a discussion of the limitations of the study, recommendations for future research, what the present study impact is and the final conclusion.

Chapter 2: Literature Review

In the following chapter I will firstly discuss perinatal depression according to its two components, namely antenatal and perinatal depression. I will then examine the risk factors related to perinatal depression and the consequences of untreated perinatal depression. An extensive overview of studies that have explored the barriers to service utilization in the case of perinatal depression is then presented. The chapter closes with the theoretical paradigm in which the study is located.

2.1 Perinatal Depression

Perinatal depression can be described as major and/or minor depressive episodes that occur either during pregnancy, i.e. antenatal depression, or within the first twelve months after birth, i.e. postpartum depression. Gotlib, Whiffen, Mount, Milne, and Cordy (1989) were among the first researchers to suggest that antenatal and postpartum depression exist along a continuum. However, perinatal depression is often researched according to its two separate subcomponents – antenatal and postpartum depression.

Although research has found that depressive symptoms appear more frequently during pregnancy than after birth (Evans, Heron, Francomb, Oke & Golding, 2001), postpartum depression has been studied more extensively than antenatal depression (Rochat et al., 2011; Ryan et al., 2005). Antenatal depression has been identified as the leading cause of complications related to childbirth, whereas postpartum depression has been identified as the leading cause of maternal morbidity (O'Hara & Swain, 1996).

During the first trimester of pregnancy it is particularly difficult to diagnose depression due to an overlap between somatic and behavioural symptoms related to pregnancy and symptoms related to depression. Commonly, women who become pregnant experience changes in appetite or weight, sleep patterns, energy levels and sometimes concentration.

Comparably, symptoms related to a depressive disorder also include alterations in appetite or weight, fatigue, disruptions in sleep patterns, difficulty concentrating and psychomotor retardation. For this reason, it is argued that the overlap between normative pregnancy experiences and symptoms of depression make it difficult to diagnose a pregnant woman with depression (Klein, 1995). However, the prevalence rate of depression rises in the second and third trimester, consequently making it somewhat easier to diagnose depression during these periods (Ryan et al., 2005; Bennett, Einarson, Taddio, Koren & Einarson, 2004).

The onset of postpartum depression typically starts within four weeks after delivery and has to be continuously present for at least a two-week period. Symptoms related to the disorder must at least include either a depressed mood or a loss of pleasure or interest. Additionally, five or more of the following symptoms should be present: depressed mood most of the day; reduced interest in pleasure or interest in most activities; significant weight loss; insomnia or hypersomnia most of the day; psychomotor agitation or retardation for most of the day; fatigue or loss of energy for most of the day; feelings of worthlessness or guilt; weakened ability to concentrate; or recurring thoughts of death, suicide ideation, or a suicide attempt. These symptoms have to interfere significantly with everyday functioning for the diagnosis to be made. Although the symptoms of postpartum depression do not differ from that of depression that is unrelated to childbirth, the content of these symptoms tend to focus on childcare – for example, the mother may experience feelings of guilt about failing as a mother (Abrams, Dornig & Curran; 2011; DSM-IV-TR, 2000; Remick, 2002).

2.2 Risk Factors for Perinatal Depression

Depression develops due to an interaction between biological, psychological, and social attributing factors. Such factors place the person at an increased risk to develop a certain disorder, such as perinatal depression, compared to any other randomly selected person. Risk

factors hardly exist in singular form, but rather interact in complex ways, making intervention more troublesome (Mrazek & Haggerty, 1994, as cited in NHMRC, 2000). Early intervention could prevent on-going depression. It is therefore important to identify those factors that place certain pregnant women at a greater predisposition to develop depression during pregnancy than others (Ryan et al., 2005). These risk factors will be reported according to the two subcomponents of perinatal depression in the following sections.

2.2.1 Risk factors for antenatal depression.

Risk factors identified in the literature for antenatal depression include maternal age, both younger than 26 years and older than 40 years (Hartley et al., 2011; Milgrom et al., 2008). Reasons provided for increased risk at a younger age include the presence of factors such as drug abuse, unplanned pregnancy, and low levels of support (Barnett, Duggan, Wilson & Joffe, 1995). Research also show that adolescent mothers are twice as likely to avoid seeking prenatal care during their first three trimesters than their counterparts who are in their twenties. Additionally, those who do seek prenatal care are more likely to miss a greater number of appointments (Mercer, Hackly & Bostrom, 1983). Factors such as increased maternal anxiety and trouble adjusting to parenthood, place older mothers at risk of developing depression during pregnancy (Dennerstein, Lehert & Riphagen, 1989).

Other important risk factors for antenatal depression include: low socio-economic status (Beeghly et al., 2003; Hartley et al., 2011), with low education level as a subcomponent (Marcus, Flynn, Blow & Barry, 2003); history of depression (Leigh & Milgrom, 2004; Robertson, Grace, Wallington & Stewart, 2004); previous perinatal loss, through miscarriage or abortion (Price, 2008; Rubertsson, Waldenstrom & Wickberg, 2003); history of childhood violence and abuse (Martin, Casaneuva, Harris-Britt, Kupper & Cloutier,

2006; Rodgers, Lang, Twamley & Stein, 2004); and limited social support and/or being single (Da Costa, Larouche, Dritsa & Brender, 2000; Hartley et al., 2011).

2.2.2. Risk factors for postpartum depression.

Previously, antenatal depression and postpartum depression have been seen as distinct mental health concerns. However, recently it has been proposed that both conditions exist on a continuum with its onset during pregnancy (Austin, 2004). Supporting this idea is the fact that antenatal depression and anxiety has been identified as the greatest risk factors for postpartum depression (Beck, 1996; Milgrom et al., 2008; O'Hara & Swain, 1996; Robertson et al., 2004; Rochat et al., 2011); and has been found to increase the odds of poor postpartum mental health by more than 11 times (Witt et al., 2011). Additionally, Leigh and Milgrom (2008) have found that antenatal depression acts as the main mediator between postnatal depression and other risk factors.

There are numerous other biological, psychiatric, medical, personal, and socio-demographic risk factors for postpartum depression that have been identified in research. However, the main factors repeatedly found and emphasized in the literature, are a history of depression, major life events, and low social support (Beck, 2001; Leigh & Milgrom, 2008; Milgrom et al., 2008; Pope, 2000; Robertson et al., 2004).

Firstly, a personal and familial history of major and minor depression has been identified as a significant risk factor for postpartum depression (Pope, 2000). There is a significant body of research that indicates that the recurrence of depressive symptoms is more likely to appear during the vulnerable period after birth in women with a history of psychopathology, compared to women with no such history (Beck, 2001; Johnstone, Boyce, Hickey, Morris-Yatees & Harris, 2001; Milgrom et al., 2008; O'Hara & Swain, 1996; Robertson et al., 2004).

Secondly, apart from the fact that pregnancy and birth by themselves can both be identified as stressful and transitional life experiences (Holmes & Rahe, 1967), other events that may cause major life stress and increase the risk of developing depression after delivery, include: moving; unemployment; separation or divorce; intimate partner violence or the death of a loved one (Robertson, et al., 2004). Also, stresses experienced after birth, such as health or behavioural problems of the infant, may have an impact on maternal depression (O'Hara & Swain, 1996).

Lastly, adequate support from social networks, including friends, family, and spouse, has been identified as a major protective factor to developing postpartum depression (Brugha, 1998; Milgrom et al., 2008; Pope, 2000). Important aspects of social support that play a role in protecting the mother from developing depression include instrumental support, such as financial assistance and physical help with tasks, and emotional support, such as manifestations of caring (Robertson et al., 2004). Furthermore, the marital relationship can be seen as another subcomponent of social support, as research has found that marital difficulties and intimate partner violence experienced after birth could lead to depression, as the mother may feel even more isolated then (Beck, 2001; Jewkes, Dunkle, Nduna & Shai, 2010; O'Hara & Swain, 1996; Witt et al., 2011).

Other less significant risk factors for the development of postpartum depression include, low self-esteem (Ritter, Hobfoll, Lavin, Cameron & Hulsizer, 2000), negative cognitive style (Leigh & Milgrom, 2008), low income (Patel, Rodrigues & DeSouza, 2002), and obstetric complications (Pope, 2000; Witt et al., 2011).

2.3 Effects of Untreated Perinatal Depression

Untreated depression experienced during and after pregnancy, holds deleterious potential health consequences related to the mother, child, and family. These consequences may affect

the mother-infant relationship and child development, may cause obstetric complications, and may lead to problematic social and health behaviour of the mother.

2.3.1 Mother-infant attachment and child development.

Cooper et al. (1999) found a significant correlation between maternal mood and mother-infant interactions. This correlation suggested that problematic long-term cognitive and socio-emotional development of the child stems from an early-impaired mother-infant relationship, caused by perinatal depression (Grace, Evindar & Stewart, 2003; Lyons-Ruth, Wolfe & Lyubchik, 2000; Murray & Cooper, 1997; Murray, Fiori-Cowley, Hooper & Cooper, 1996).

One such example of impaired socio-emotional development is that the mother's depressed behaviour, i.e. withdrawal, disengagement, and hostility, has been found to result in a depressed style of interaction or passive coping (as opposed to active coping) in the infant. In this way the infants appear to "mirror the behaviour of their [depressed] mothers" (Field, 2002, p. 28). Other negative consequences of depression during pregnancy observed in offspring during childhood include language impairment, attention-deficit disorder and impulsiveness, behavioural problems, sleep problems, and other psychopathology (O'Connor et al., 2007; Van den Bergh, Mulder, Mennes & Glover, 2005).

2.3.2 Obstetric complications.

Untreated perinatal depression has been linked to various obstetric difficulties that cause poor birth outcomes and could be life threatening to both mother and child. These complications include: preterm births; low birth weight; gestational hypertension and ultimately pre-eclampsia; miscarriage and spontaneous abortion; spontaneous early labour; babies small for gestational age (SGA); and neonatal complications, such as growth retardation, low Apgar

scores, and low cortisol levels in infants at birth (Alder, Fink, Bitzer, Hösli & Holzgreve, 2007; Arck et al., 2001; Chung, Lau, Yip, Chiu & Lee, 2001; Dayan et al., 2002; Kurki, Hiilesmaa, Raitasalo, Mattila & Ylikorkala, 2000; Orr, Sherman & Blackmore Prince, 2002).

2.3.3 Problematic social and health behaviour.

Research has found that when maternal depression goes untreated it can lead to an inability to avoid unhealthy behaviour that holds direct negative consequences for both mother and foetus, and ultimately leads to poor life quality. Such behaviour includes failing to maintain a nutritious diet, poor obstetric care, smoking, alcohol abuse and use of other substances, and a heightened risk for suicide (Hallberg & Sjoblom, 2005; Nonacs & Cohen, 2003; Zuckerman, Amaro, Bauchner & Cabral, 1989).

Women suffering from maternal depression have been found to be at an increased risk of postpartum depression and on-going depressive episodes throughout their lives (Cooper & Murray, 1995). Such untreated depression is further associated with low self-esteem, marital problems, and impaired occupational and social functioning (Da Costa, Dritsa, Rippen, Lowensteyn & Khalifé, 2006; O'Hara, Zekoski, Philipps & Wright, 1990; Weinberg et al., 2001).

2.4 Barriers to Service Utilization for Perinatal Depression

The perinatal period has been identified as a high-risk period for mental health concerns (O'Mahen & Flynn, 2008). This increased risk for depression during and after pregnancy becomes even more complicated when combined with barriers to mental health service use, increasing the vulnerability of these women (Song, Sangs & Wong, 2004). These barriers exist despite the fact that treatment is often available (Dennis & Steward, 2004; O'Mahen & Flynn, 2008). A number of recent studies have investigated reasons for why at-risk or

depressed pregnant women do not use available mental health services (Abrams et al., 2011; Dennis & Chung-Lee, 2006; Goodman, 2009; Kopelman et al., 2008; O'Mahen & Flynn, 2008). Barriers that have been identified include: logistical barriers; maternal role barriers; culturally motivated attitudes toward mental health care; lack of symptom information and institution-related barriers; unacceptability of pharmacological treatment; depressive symptoms and ambivalence toward pregnancy; and life hardship and perception of mental illness.

2.4.1 Logistical barriers.

Logistical barriers are closely linked to socioeconomic status. Research shows that those factors associated with falling into the minority group or low-income group, act as barriers to treatment (Goodman, 2009). These factors include financial barriers, such as cost of treatment services, insurance, and problems with child care; transportation, including both cost and distance concerns; struggling to get off from work; insufficient time; and language differences (Alvidrez & Azocar, 1999; Ballestrem, Straub & Kachele, 2005; Kopelman et al., 2008; Scholle, Haskett, Hanusa, Pincus & Kupfer, 2003; Templeton, Velleman, Persaud & Milner, 2003). Furthermore O'Mahen and Flynn (2008) found that women experiencing perinatal depressive symptoms are significantly more concerned about logistical barriers than either attitudinal or knowledge barriers. Minimizing these logistical barriers will make treatment more universally available across all populations, as access disparities will be minimized or eliminated (Price, 2010).

2.4.2 Maternal role barriers.

Experiencing perinatal depressive symptoms may be linked to a certain degree of stigmatization, as pregnancy is traditionally considered to be a joyful event. Goodman (2009) found that as many as 42.5 % of pregnant women who experience depressive symptoms may

feel guilty that they are not rather feeling happy and excited during this time. Additionally, fear of being labelled as an inadequate parent was expressed by a participant in the study of Kopelman et al. (2008) wherein she said, “You get that look like, ‘You shouldn’t be having children if you need this kind of help’” (p. 431). Also themes that arose in the study done by Abrams et al. (2011) suggest that participants perceive postpartum depression as a type of mental illness that involves mothers’ primary care giving abilities. As a result, these women were apprehensive about losing their parental rights and having their baby taken away from them (Jesse, et al., 2008; Kopelman et al., 2008; Mauthner, 1999).

Research further reports that women from ethnic minority groups experience significantly more embarrassment and fear of stigma than their white counterparts. This finding therefore suggests that stigma acts as a greater barrier to mental health service use among these groups (Abrams et al., 2011; Alvidrez & Azocar, 1999). These feelings of guilt and shame caused women to minimize their symptoms or to completely deny feeling depressed at all in order to uphold an image of themselves as competent mothers. Consequently, these depressed women also prefer to receive mental health services at their obstetric care centre, in order to avoid being labelled as a psychiatric patient and to be able to confide in a practitioner with whom they are already comfortable (Goodman, 2009).

From another perspective, many new mothers feel that the depressive symptoms they experience may be a normal part of motherhood due to the new set of responsibilities that come with being a parent (Kim & Buist, 2005). For this reason many feel that it is expected of their maternal role to be able to cope with these symptoms on their own (Templeton et al., 2003). These women often have to endure a constant and isolated battle with themselves – with their own and society’s expectations surrounding motherhood on the one side, and their true feelings and everyday struggles on the other side. One participant in the study of Mauthner (1999) articulated this point as follows:

It was like, on the one hand, there was me sort of 'I can't cope with this, I can't deal with it, how am I going to manage for a whole day, what time's he (her husband) going to come home' ... and, on the other hand, there was me saying to myself 'For heaven's sake, it's only two children, some people have four ... you've got everything that you need to deal with them, it isn't a big problem, you can handle them, you've handled much worse than this in your life ... two bloody kids, really, it's not a big deal. (p. 154)

These women suffer an on-going battle in their minds on their own, often due to a lack of support, but also due to feelings of shame for failing to be an adequate mother. These mothers are also more likely to rather seek comfort in informal treatment, in the form of support from friends and families, rather than seeking help from formal mental health services (O'Mahen & Flynn, 2008). However, this can be problematic as friends and family members are often uneducated with regards to perinatal depression.

Lastly, Parvin, Jones, and Hull (2004) found that depressed Bangladeshi women denied their symptoms due to fear of giving their families bad reputations or that symptom disclosure would cause distress within their families. Templeton et al. (2003) reported that women from Black and ethnic minority communities are expected to keep their depressive symptoms to themselves and cope on their own because you "don't hang your dirty laundry outside" (p. 215). Additionally, the image of strong womanhood that is connected to African American middle-class women, acts as another cultural norm around motherhood that deters women from recognising or voicing their depressive symptoms (Amankwaa, 2003). It should therefore be taken into account that mental illness is not always observed as a medical condition across all cultures, but is seen as a weakness in some and therefore may act as a barrier to attaining mental health care (Dennis & Chung-Lee, 2006).

2.4.3 Culturally motivated attitudes toward mental health care.

In the study done by Abrams et al. (2011), among various others, it is suggested that culturally motivated attitudes hinder formal mental health service use in the following three important ways. Firstly, seeking informal advice from friends and family, in itself, is suggested to act as a barrier to seeking formal support from mental health practitioners. This is because the majority of such informants were found to either respond by offering support or by reassuring the mother that all new mothers go through “stress” when they have a new baby. In this way, their responses may lead to a postponement of seeking professional care, as the mother tends to normalise her symptoms as normal post-pregnancy hormones or stress (Abrams et al., 2011). Furthermore, family and friends who hold negative perceptions of professional care based on prior bad experiences may deter mothers from seeking formal mental health care (Dennis & Chung Lee, 2006; Templeton et al., 2003; Teng, Blackmore & Steward, 2007).

Secondly, among certain cultures mothers are actively discouraged to seek help. Research suggests that Black mothers perceive themselves as strong, self-reliant women to such an extent that this perception hinders seeking formal mental health care. These women simply feel that it is their duty to cope and to be a good mother no matter what (Abrams et al., 2011; Amakwaa, 2003; Templeton et al., 2003).

In the study performed by Edge et al. (2004) the mothers suggested that this self-concept of autonomy emanated from a history of discrimination and disadvantage during which depression was not an appropriate response to hostile circumstances. One participant explained it as follows:

I think it all relates to slavery ... We had to be strong for our kids ... we had to protect them, had to be strong for them ... and it's just been instilled into the daughters ... that

you need to be strong, to hold your family together. You can't depend on no man ...

You [*emphasis in the original*] need to be strong. (p. 434)

Abrams et al. (2011) and Amakwaa (2003) further found that the cultural norms among African Americans dictate that paying for psychological services is frowned upon, as it “is not seen as a smart purchase in our community”(Amakwaa, 2003, p. 545). This perception may be particularly influential among low-income groups who are confronted by numerous financial stressors, as participants in the study by Edge et al. (2004) suggested that they would not even have been depressed in the first place had they been financially independent.

Among other cultures, such as Latinas (Abrams et al., 2011), Korean women (Kim & Buist, 2005), and Jordanian women (Nahas & Amasheh, 1999), a strong family ethic exists, which acts as a significant barrier to seeking professional perinatal care. Women in these cultures are prohibited from discussing their mental illness with outsiders, unless their husbands approve. This cultural norm has been found to be the cause of women often being too afraid or ashamed to discuss private matters with mental health professionals, or doing so in secret.

Thirdly, research suggests that women belonging to an ethnic minority group often display a mistrust toward mental health professionals, which acts as a barrier to seeking perinatal care (Abrams et al., 2011; Anderson et al., 2006; Cook, Selig, Wedge & Gohn-Baube, 1999; Edge et al., 2004; Flynn, Henshaw, O'Mahen & Forman, 2010; McIntosh, 1993; Templeton et al., 2003). Women in this group often feel disempowered due to their gender and low socio-economic status, which stands in stark comparison to their perception of mental health care as a powerful public service that holds authority over their lives. These mothers fear to be judged as unfit parents by the system and potentially having their babies taken away from them (Anderson et al., 2006; McIntosh, 1993; Templeton et al., 2003).

Additionally, Black Caribbean mothers feared that contact with mental health services would ultimately have a lasting negative outcome. They feel that enquiring about a common mental illness, such as perinatal depression, would end in re-diagnoses of the mother with a more serious mental illness, such as schizophrenia:

I'm very much aware that black people are more likely to be labelled as having psychiatric problems ... They're not recognised with postnatal depression, but yet they recognise other [more serious] forms of psychiatric problems quite readily ... Therefore I don't want people labelling me. (Edge et al., 2004, p. 434)

Furthermore, the mothers' mistrust in mental health care professionals was sustained by the view that the mental health care professionals were uncaring, impersonal, and only interested in patients' money (Abrams et al., 2011). However, when providers did seem caring, mothers felt that this was only due to the fact that the mothers were perceived as a liability, as someone who is going to slit her wrist at any moment. Or stated differently, mothers felt that mental health professionals, during therapy specifically, were merely trying to minimize risks rather than truly care about their patients' mental health and well being (Flynn et al., 2010).

Lastly, although research found religious or spiritual practices to act as a type of self-help act from which distressed mothers often gain strength, consolation, and cure, it has also been found to act as a barrier to seeking professional mental health care (Abrams et al., 2011; Dennis & Chung-Lee, 2006). Mothers find comfort and confidence in religious practices such as prayer or listening to Christian music, in religious beliefs such as "the Lord never gives us more than we can handle (Abrams et al., 2006, p. 545), and the belief that God Himself will cure these mothers if He would want them healthy. Furthermore, Edge et al. (2004) found that the Black Caribbean mothers in their study relied on black-led churches and faith communities for emotional, spiritual, and practical support. Due to these

perceptions mothers suffering from perinatal depression were encouraged to accept their distress without seeking professional mental health care. In relation to help-seeking behaviour, religion acted as a double-edged sword.

Additionally, women that participated in the study of Abrams et al. (2011) described three other types of self-help strategies that these mothers used to manage their symptoms. The researchers divided these strategies into three groups, namely emotional, cognitive, and behavioural practices. Firstly, emotional practices included crying and talking to family, friends, or mothers going through similar distress. Secondly, cognitive practices consisted of talking to oneself and trying to maintain positive thinking, focusing on future goals, and on one's children. Thirdly, behavioural practices involved maintaining good physical health, keeping a journal and trying to stay busy but also trying to get enough rest in. All three of these strategies simultaneously acted as barriers to attain professional mental health care.

2.4.4 Lack of symptom-related information and institution-related barriers.

Apart from the fact that many women perceive their depressed symptoms as normal and are therefore unaware that they are suffering from a mental illness (Kim & Buist, 2005) many claim that they knew something was wrong with them but could not identify what it was due to unfamiliarity with the illness (Edge et al., 2004). One woman claimed that she thought she was “going crazy” (Templeton, et al., 2003, p. 213), whilst another, when labelled with the illness, was confused about what this diagnosis meant: “I don't know what postnatal depression is supposed to be, how you're supposed to feel, look or whatever, I don't know. I have no idea” (Edge et al., 2004, p. 434). Additionally, participants in the study of Flynn et al. (2011) expressed a need for information on how to measure the severity of their depressive symptoms in order to identify whether they were merely undergoing normal pregnancy experiences or whether they needed to seek mental health care for depression.

In other studies, women who did know what perinatal depression was, were confused about where to obtain appropriate mental health services (Holopainen, 2002), as they perceived it to be inappropriate to receive mental care from doctors and nurses, who they thought should rather focus on physical care (Parvin et al., 2004). Naturally, these women did not disclose their symptoms to their general practitioners. Furthermore, in the study of Amankwaa (2003) the researcher found that African-American women preferred mental care from religious sources, such as a religious healer, rather than from western mental health services.

As opposed to uninformed mothers, many women felt that it was rather the health professionals that lacked appropriate knowledge concerning perinatal depression. Related general problems that depressed mothers had with health professionals, across the literature, include: dismissal of symptoms as normal or hormonal; not picking up on their patients' distress or being disinterested; lack of knowledge about adequate referrals and resources in their community that would be better equipped to help their patients; prescription of medication rather than counselling; and language difficulties that caused the health professional never to understand the depth of the problem (Amankwaa, 2003; Kopelman et al., 2008; Mauthner, 1997; Parvin et al., 2004; Templeton et al., 2003). Additionally, participants in the study of Abrams et al. (2011) perceived mental health care as uncaring since a wait-and-see approach and medication-first approach acted as substitutes for taking time to really listen to the mothers' concerns.

Stated differently, these mothers perceived mental health professionals as scientists in white coats with clipboards "just looking like they're doing an experiment" (Abrams et al., 2011, p. 543). In contrast, mothers described their ideal help to be in the form of a trustworthy woman, who takes time to listen to their stories in a non-critical and sympathetic

manner, and who provides information in nonmedical or de-stigmatising language. Evidently, mothers felt that the available mental health care was not the appropriate help they needed.

These attitudes that women express toward health care providers are of extreme importance as research shows that patient-provider agreement in itself can act as a barrier to appointment keeping. Wells, McDiarmid, and Bayatpour (1990) reported that the greater the extent of agreement on the nature and scope of the problem between the pregnant woman and health care provider is, the greater the patient satisfaction is, which in turn cause greater compliance to appointments. These findings were attained regardless of the patient's level of depression, amount of social support, or amount of life stressors. Additionally, women that gain satisfaction from their patient-health-professional relationship have been found to experience more brief duration of depressive symptoms than those women who were unsatisfied with this relationship (Edge et al., 2004).

Women also expressed dissatisfaction with the healthcare system itself, such as having to wait too long for services, care being interrupted, not being treated by the same doctor each time (Jesse et al., 2008); treatment steps being too many and time consuming (Flynn et al., 2011); overcrowded clinics, clinics being too far away, lack of evening or weekend services (Cook, Selig, Wedge & Gohn-Baube, 1999); and inappropriate referrals, concerning patient need, patient-provider fit and location of clinic (Kim et al., 2010). These factors are important as research has found that women who were dissatisfied with mental health services were four times more likely to receive insufficient perinatal care (Cook et al., 1999).

Additionally, in the study of Flynn et al. (2011) when women were asked about their treatment location preferences, the majority preferred to receive mental health treatment in the obstetric clinic or at their homes. Reasons provided for preferring to receive mental health treatment in the obstetric clinic include: the convenience of receiving obstetric and mental

health care on the same day and same location, and familiarity of clinic and staff members and convenience. On the other hand, reasons provided for preferring to receive mental health treatment at home include: comfort, and usefulness in the light of postpartum infant care issues, such as the baby's sleep concerns and child care.

These problems linked to mental care caused many women to terminate their treatment, only further adding to the treatment-barrier-problem and inflict negative treatment beliefs within these women. These beliefs, such as that seeking mental health care would ultimately be of little benefit, have been identified as a barrier to treatment in itself (Bayer & Peay, 1997).

2.4.5. Reluctance towards pharmacological treatment.

Recent literature has shown that there are no risk-free options regarding pharmacological treatment of perinatal depression (Pearlstein, 2008). The foetus is prone to risks, as it is exposed to antidepressants through the placenta (Hendrick et al., 2003); and the infant is prone to possible risks as it is exposed to antidepressants during breastfeeding (Pearlstein, 2008). However, the consequences linked to untreated perinatal depression are significantly more harmful to mother and foetus/infant than consequences linked to treatment (Ryan, et al., 2005). Additionally, Cohen et al. (2006) have found that significantly more women (68%) who discontinued their medication experienced a relapse of depression, compared to those who adhered to the antidepressants (26%) during pregnancy. However, research on this topic is still contradicting and this causes confusion, guilt, anxiety, fear, and distrust in the mother-doctor relationship (Boath, Bradley, & Henshaw, 2004).

Across the broad literature findings show that women prefer psychotherapy or counselling (i.e., active treatment) to medication, and even claim that antidepressants are an unacceptable treatment option for depression during and after pregnancy (Abrams et al., 2011;

Alvidrez & Azocar, 1999; Goodman, 2009; Mauthner, 1999; O'Mahen & Flynn, 2008; Sleath et al., 2005; Whitton, Warner & Appleby, 1996). This point of view is especially true for mothers who are breastfeeding (Chabrol, Teissedre, Armitage, Daniel & Walberg, 2004) or who are Black (Dwight-Johnson, Unutzer, Sherbourne, Tang & Wells, 2001). Goodman (2009) found that 66% of the women who participated in his study found antidepressants unacceptable during pregnancy and 64% during lactation. Similarly, in the study of Sleath et al. (2005) only 23.3% of the women found antidepressant use appropriate during pregnancy.

Apart from the risks that antidepressant medication can pose to the foetus or infant, other reasons provided for these negative attitudes toward medication, include stigma or fear of being seen as a 'pill-popper' (Boath et al., 2004) and fear of addiction (Whitton et al., 1996). These concerns might partly be due to the fact that many doctors are viewed as simply "pushing meds" without providing information about possible side-effects and risks involved with taking the medicine. Kopelman et al. (2008) captured one such experience in their study — "They [medical providers] say it [medication] is safe – take this three times or four times [a day], whenever you need it – but then you read that it's really dangerous...so I lose my trust" (p. 431).

However, research shows that there is a link between acceptability of medication treatment during pregnancy and breastfeeding and both symptom severity (Sleath et al., 2005) and familiarity with antidepressant use (Goodman, 2009). This implies that psycho-education regarding antidepressant treatment and its use consequences would produce more favourable attitudes towards it.

2.4.6 Depressive symptoms itself and ambivalence toward pregnancy.

Research has found that the physical symptoms of depression can themselves act as a barrier to treatment. Such symptoms include passivity, social withdrawal, loss of energy, extreme

tiredness, and ambivalence which all make it hard to even speak and report problems to health providers (Cook et al., 1999; McKee, Cunningham, Jankowski & Zayas, 2002; Templeton et al., 2003; Thome, 2003). A large body of literature reported that these symptoms of depression were more frequently found among those women that indicated a lack of either partner or in-law support in their lives (Chan, Chung & Lee, 2002; Cooper et al., 1999; Danaci, Dinc, Deveci, Sen & İçelli, 2002; Holopainen, 2002; Leung, 2002; Oats et al., 2004). Additionally, Flynn et al. (2011) found the depressive symptoms among mothers to be linked to a need for more active referrals from clinic staff, as one participant maintained: “You don’t even have the energy to try and find it, you just want someone to bring in to your door” (p. 5).

Furthermore, Cook et al. (1999) found feelings of depression towards one’s pregnancy to be the most frequently reported barrier to receiving inadequate mental health care. Such an attitude of secrecy towards one’s pregnancy has been found to place these women at a five-fold risk to receiving inadequate mental health care, than those women who tell their friends and family about their pregnancy (Cook et al., 1999). Pregnancies that are unwanted or unplanned usually result in feelings of ambivalence toward the unborn infant, which in turn, may interfere with the woman’s willingness or ability to attend mental health appointments (Cook et al., 1999).

2.4.7 Life hardship and perception of mental illness

Confounding life circumstances is another factor identified in research that acts as a barrier to reporting depressive symptoms. Social and environmental hardships in life include difficulties with money, employment and housing, lack of support, feelings of loneliness, and constant demands of child-care (among many). These life hardships have been related to a viewpoint that treatment would not be effective, as it does not address those external factors

that caused the depression in the first place (Abrams et al., 2011; Anderson et al., 2006; Cook et al., 1999; Holopainen, 2002; McIntosh, 1993; Oats et al., 2004). Women who support this notion felt that provision of more basic needs, and thus a change in their life circumstances, would be the answer to successful treatment of their depression – rather than counselling or medication. One participant expressed this opinion as: “If they really want to make a difference here, throw \$10,000 at me.” (Anderson et al., 2006, p. 935); and another said, “If somebody could give us a house and a job that’s all we need. That’s why I’m depressed.” (McIntosh, 1993, p. 180).

This desire for basic physical needs to be addressed before mental health needs, depicts Maslow’s hierarchy of needs theory (1954): Food and shelter, a steady and reliable income, and a safe living environment takes priority over mental health care. As expected, this lack of primary survival needs contribute more significantly to perinatal depression among marginalized women than their more well-off counterparts, as these women are described to have more unstable family and living situations (Abrams et al., 2011). In literature, this is also referred to as intrapersonal risk factors to receiving inadequate mental health care (Cook et al., 1999). What complicates this barrier even further, is the fact that these social problems did not usually exist one at a time, but rather the problem was multi-causal – “It was due to all the problems I had at the time rolled into one.” (McIntosh, 1993, p. 181).

Another reason why women struggling with adverse life circumstances perceive depression treatment to be ineffective is that they felt their depression was only a normal response to a hard life – “Walk in my shoes for one week. You’ll be depressed, too” (Anderson et al., 2006, p. 930). They perceived the depression that they suffer from, as separate from the one that causes impaired functioning and requires mental health care. These women did not perceive themselves as being ill, because in their eyes their problem was

classified as a social problem, rather than a medical one. A participant implied this view as follows:

If you can't change it, there is no reason to dwell on it, that's how I think. I don't need a therapist. I don't think so because I function fine. I go to work; I do what I have to do, so it's fine. I take care of the kids, it's fine (Anderson et al., 2006, p. 935)

For this reason, these mothers saw no role for a mental health professional in their lives. Or in the case where a health professional was needed, it was only to fulfil a social control function, such as in cases of child abuse (McIntosh, 1993).

2.5 Theoretical Framework

According to Eccles, Grimshaw, Walker, Johnson, and Pitts (2005) the role of theory in research is to provide a “coherent and non-contradictory set of statements, concepts or ideas, organizes, predicts and explains phenomena, events, and behaviour.” In addition to this idea Sales, Smith, Curran, and Kochevar (2006) felt that theory should not only create a framework within which a research study should be structured, but should also lay the foundation for intervention planning. In other words, theory should be tightly linked to strategies adopted and tools selected in the face of intervention planning. This is especially true “when the targeted action takes place in an organization with multiple actors, multiple layers, and complex factors affecting decision-making processes, which characterizes almost any health care organization” (Sales et al., 2006, S44).

Theory thus plays an important part in explaining appointment-keeping behaviours across the broad literature and also in the present study. Theories previously used in studies that investigate barriers to mental health treatment utilization, include the Health Belief Model (Becker et al., 1979) and Cognitive Behavioural Theory (Flynn et al., 2010). However, such investigation is limited as these theories mainly focus on individual psychological and

behavioural sources from which attendance barriers can emanate. For this reason the present study will explain counselling appointment-keeping behaviour according to an ecological perspective, as it assumes a multi-level approach which allows for influences from various interacting dimensions (Chisholm et al., 2007).

2.5.1 The Ecological Systems Theory and barriers to service utilization.

Kurt Lewin is a modern pioneer in Social Psychology. During the time that he published his first book, *Principles of Topological Psychology* (1936), he contradicted popular views that emphasized the importance of an individual's past when studying individual behaviour (Morf, Panter & Sansone, 2003). Lewin (1935) identified an individual's context as an important influence on individual behaviour, and he represented his theory in the following psychological equation: $B=f(P,E)$. Through this equation Lewin (1935) reported an individual's behaviour to be a function of that individual in his or her environment (Balkenius, 1995). Lewin (1935) therefore paved the way for further investigation into the person-in-context approach.

This person-in-context outlook recognizes that all behaviour occurs in the person's surroundings (Scileppi, Teed & Torres, 1999). Bronfenbrenner's (1986) Ecological Systems Theory suggests that an individual's behaviour is shaped by four levels of environmental influences, namely: (1) the intrapersonal level (including individual beliefs and cognitions); (2) the interpersonal level (including all personal interactions and relationships); (3) the community level (including social institutions such as healthcare, transportation systems and other community structures); and (4) the societal level (including cultural influences and societal classes). Bronfenbrenner (1979) further emphasized the fact that these four environments are all arranged according to nested hierarchical systems, of which higher systems contain all the lower systems. Additionally, each of these different environmental

contexts exists in interdependent relationships with one another, so that changes in the one will ripple through to the others.

Within the context of this research, the Bronfenbrenner's (1975) Ecological Systems Theory can be used to explain how potential participants are influenced by their interrelated environments in terms of attending scheduled counselling appointments. This model therefore has the potential to illustrate how structural factors (in addition to individual and behavioural factors) may act as barriers to appointment-keeping behaviour among the potential participants.

2.6 Conclusion

It cannot be denied that the rates of perinatal depression are too high when, in the same breath, service utilization is low – even when such services are available and of no cost. Further qualitative research is needed to investigate in-depth experiences of women suffering from perinatal depression, together with their mental health service use behaviours and attitudes. This is especially true when referring to research done in South Africa. The present study will aim to identify and understand the motivations for depressive pregnant women to decline available and free mental health services provided at Mowbray Maternal Hospital by the PMHP.

Chapter 3: Method

3.1 Context

The Perinatal Mental Health Project (PMHP) project was launched in September 2002 at Mowbray Maternal Hospital (MMH), with its main goal to provide mental health services at the same location where women receive obstetric services. At their first visit, pregnant women receiving primary level care are assessed for depression and anxiety. The screening tools used are the Edinburgh Depression Scale (Cox, 1996), and an 11-item Risk Factor Assessment questionnaire devised by the PMHP. Patients are referred for counselling based on the scores from these two measures. However, many of these at-risk women fail to attend their original or rescheduled counselling appointments.

3.2 Participant Profiles

An overview of participant profiles will be provided in this section. Each participant's name was replaced with a pseudonym to ensure confidentiality. Profiles consist of demographic details, background and living situation information, and a reflection on my (the researcher's) behalf on each interview conducted.

3.2.1 Thandi.

Thandi is a 29-year-old Black woman. She lives and works at a bed and breakfast cottage in Franschoek. However, she stayed with her ex-partner in Cape Town when she delivered her baby and for the rest of her maternity leave. Thandi gave birth at 36 weeks, according to her due to too much stress. Additionally, she had two other children from two previous partners. She was the first participant to show-up for a scheduled face-to-face interview. She was also the first participant that I interviewed for the present study, but not the first scheduled

participant. When I told her that she had so far been the only one who had turned-up for an interview (as the other participants simply did not show) she replied: “That is very rude.”

The interview flowed easily and without much effort as she elaborated on every question without having to be continuously prompted. The interview felt more like a story telling of her life. I easily became caught-up in it and constantly had to remind myself that I was doing an interview and needed to ask certain questions and elaborate on certain answers in order to acquire the needed information for my study. Furthermore, Thandi seemed very sad and regretful about certain decisions that she made in her life. This evoked a great deal of sympathy for her within me and I wished that I could help her rather than just to listen to her.

3.2.2 Nomsu.

Nomsu is a 22-year-old Black woman. She lives in Salt River with her husband and daughter. She was the first participant with whom I conducted a telephonic interview. She works as a hairdresser and never seemed to have a quiet moment for an interview. So, when she agreed to do the interview I jumped at the opportunity because I was scared that I would not get another chance to conduct an interview with her.

This interview turned out to be the most difficult one of all due to the loud children’s voices in Nomsu’s background. She struggled to hear me and concentrate on my questions and consequently I was forced to repeat questions two or three times. It felt to me that the interview did not flow naturally. It was very frustrating for both of us.

3.2.3 Ayesha.

Ayesha is a 21-year-old Coloured Muslim woman. She lives with her mother in Woodstock. She often visits her father, who lives in Mitchell’s Plain. She was the only participant that was still pregnant at the time that our interview took place. Ayesha was also unemployed at

the time that our interview took place but was employed prior to finding out that she was pregnant.

The first thing that Ayesha told me, in a very irritable tone, was that I pronounced her name wrong. Her tone of voice remained cheeky throughout the whole interview. This was a very difficult participant in the sense that she didn't easily elaborate or open up on matters, and she often sounded irritated with the questions posed to her. For instance, when I asked her to elaborate on her relationship with her mother she seemed to take offense and just curtly answered, "It's fine." It seemed as if by enquiring about her family relations, I was implying that they had a troubled relationship. Additionally, when I asked her at the end of our interview how she experienced the interview, she replied: "I feel it should rather have been done face-to-face." I felt irritated with her reply as she made me wait for two hours at the hospital (which is, according to her, very near to her house) on the day that our interview was scheduled for. She also didn't answer her phone when I tried to reach her to ask if she was still coming, and she didn't reply to my message asking if we could reschedule another face-to-face interview. Only a few weeks later, she agreed to do a telephonic interview.

3.2.4 Fatima.

Fatima is a 32-year-old Coloured woman. She lives with her parents in Mitchell's Plain and was unemployed at the time that our interview took place. Prior to her pregnancy, she was employed full-time. Fatima needed an emergency caesarean due to the fact that her baby's heart went into distress during birth. This was very traumatic for her. Her baby was also under-weight (1.8 kg) and consequently she had to do kangaroo mothering – a process that she described as tedious. It was very hard to get hold of her as she did not show-up for two of our scheduled face-to-face interviews at MMH and she rescheduled one. She also did not own a cell phone.

Fatima was easy to talk to and completely opened up to me – even about her prior drug-related problem that caused considerable damage in her and her family's lives. (She used drugs up until two to three months into her pregnancy.) Our interview was very relaxed and filled with laughter. At first, I struggled to get hold of her and her mother, who was the owner of the cell phone number that was provided in her patient file, continuously reminded me to be patient with her as she said Fatima had her own time and lived in her own world. Her mother was also the first person to inform me of her prior drug-related problem. Through the process of trying to reach Fatima, her mom and I became acquainted and she always made sure that Fatima phoned me back. This support was very helpful to me as her mother encouraged her participation in the study.

When I finally got hold of Fatima and she agreed to do the interview, her baby woke up halfway through the interview and we had to put it on hold. I tried to phone her back several times that day but she didn't answer the phone. The next day (Friday) I sent her a message saying that she can let me know when she is able to complete our interview. I didn't hear from her again. The following Wednesday I phoned her back and we were able to finish the interview. This break was in actual fact beneficial as it gave me time to reflect on her answers and on the probes I failed to ask her. However, I felt that the break should have been shorter. After our interview Fatima told me that if I ever needed a participant for another future study, she would be more than willing to participate. It seemed as if she enjoyed the interview as much as I did.

3.2.5 Lindiwe.

Lindiwe is a 22-year-old Black woman. She arrived early for our face-to-face interview and seemed young and friendly. She lives with her mother and brother. During the time that she became pregnant, she was enrolled as a student at the University of Cape Town (UCT) and

had a part-time job. She terminated her studies after giving birth. She described her birth giving experience as very traumatic as she was in labour for three days.

During our interview she was very easy to talk to and elaborated on each question without being prompted to do so. She had a story telling voice and style so that you just wanted to listen to her for hours. At the time of and before our interview my thesis writing process had been standing still for quite some time, as I started a new permanent job and therefore had less time and infrastructure to conduct interviews – I now had to do telephonic interviews using my cell phone and struggled to hear what the participants were saying. The struggle to find appropriate participants for my study also persisted. However, after my interview with Lindiwe I felt excited about my thesis and motivated to complete it. She also showed good insight into the barrier-problem and gave helpful ideas on how to improve the system.

3.2.6 Amy.

Amy is a 25-year-old coloured woman. She lives with her husband and son in the same house as her husband's parents, brother and sister in Retreat – however, they have a separate entrance to their part of the house. Amy was permanently employed during the time that our interview took place. I conducted a telephonic interview with her during her lunch break, as she was unable to take time off from work to meet me face-to-face.

Amy seemed very self-assured and gave straight and determined answers. At the same time she was also very friendly and told me that I could phone her back if I had any additional questions to ask her.

Overall, only one participant (Ayesha) was still pregnant during the time that our interview took place. Furthermore, half of the participants (Thandi, Nomsu and Amy) were

permanently employed at the time that the interviews took place. Although, prior to their pregnancies all the participants had jobs, of which five were of a permanent nature and one was part-time. All of the participants that were unemployed were dependent on their nuclear families for financial support, as these participants were also unmarried. Only two of the participants, namely Nomsu and Amy, were married at the time that the interviews were conducted. Although both of them were permanently employed, only Amy's husband had a permanent job. Nomsu's husband was a seasonal worker and at the time of the interview he was unemployed. Lastly, four mothers experienced difficulties during pregnancies. See Table 1 below for an overview of the demographic details and pregnancy status of participants.

Table 1
Participant Portfolios

Name	Age	Race	Employment	Relationship status	Living arrangements	Pregnancy status
Thandi	29	Black	Employed	Single	Single, female headed household with 3 children	Delivered
Nomsu	22	Black	Employed	Married	Lives with husband	Delivered
Ayesha	21	Coloured Muslim	Unemployed	Single	Lives with mother, sister, brother in-law, niece, and brother	Pregnant (7 months)
Fatima	32	Coloured	Unemployed	Single	Lives with parents	Delivered
Lindiwe	22	Black	Unemployed	Single	Lives with mother and brother	Delivered
Amy	25	Coloured	Employed	Married	Lives with husband and in-laws	Delivered

3.3. Sampling Strategy

Possible participants were recruited through purposeful sampling or, in other words, choosing information-rich cases that would purposefully fit this study (Patton, 1990). Inclusion criteria for participants were therefore (1) qualifying for counselling referral, based on the screening at PMHP, but failing to attend the scheduled mental care appointments; and (2) being able to answer interview questions in either English or Afrikaans.

Accordingly, sampling was done by using PMHP patient files to select possible participants. An interview time and place was negotiated with those women who agreed to participate. This step is of extreme importance as these women have already missed several scheduled mental care appointments with the PMHP counsellor. For this reason, interviews were offered to be conducted after hours to avoid competing with the women's working hours. Sampling continued until no more participants were willing to partake in this study – keeping in mind the timeframe of two years and scope of the study (i.e. within the scope of a Master's dissertation). All participants were informed that the results of the study would be shared with the staff of the PMHP, whilst maintaining confidentiality, with the aim of improving treatment accessibility and services.

3.4 Procedure

A qualitative approach was used in order to elicit a rich description from participants with regards to motivations for not attending scheduled counselling appointments. Keeping in mind the timeframe of two years granted for this study, twenty-three possible patients were selected by the hospital staff to partake in this study. Potential participants were contacted telephonically and asked to participate in the present study. Possible participants were therefore recruited with the knowledge that the researcher was interested in their motivations for failing to attend scheduled counselling appointments. Overall, patients were very reluctant

to participate in the study even though the meeting place and time for the interview were their decision and transportation money was offered to cover any costs that they might face due to the study. Patients often agreed to participate and meet me at a specified time and location but then failed to show up. Out of the twenty-three patients phoned, four patients were impossible to reach due to faulty telephone numbers in their patients files; and thirteen patients refused to participate due to reasons such as “my husband does not want me to participate,” “I am feeling much better now,” “I don’t need counselling,” and “I am not pregnant anymore and therefore want nothing to do with the study.” Ultimately, only six patients were willing to participate in the study.

Initially, interviews were planned to take place face-to-face. However, due to the obstacle of compliance to scheduled interview appointments on their behalf, possible participants were given the option of either a face-to-face or telephonic interview. Finally, only two participants were willing to conduct face-to-face interviews. All interviews were conducted in English. Pseudonyms were used to ensure the anonymity of the participants. At the start of the interviews, participants were reminded again what the purpose of the present study was.

The interviews were guided in a semi-structured manner by the investigator. A set of predetermined questions was used to guide but not limit the interview. Semi-structured interviews are most useful for novice researchers in that it contains some structure yet has enough flexibility to allow for creativity and probing. This form of data collection also aids with the identification of common themes across individual interviews (Patton, 1990). The open-ended questions allowed each participant to elaborate on answers that held the most significance for her. I was responsible for both maintaining the conversation within the

specified framework and follow-up relevant areas via prompts. The interview format and questions were developed according to the research goals of the study at hand. (Appendix A.)

3.5 Analysis

All interviews were tape-recorded. I, the investigator, transcribed interview recordings verbatim into MS Word files. Transcription in itself can already account for the first step of analysis, as it is an act of interpretation of both verbal and nonverbal expressions of the participants (Lapadat & Lindsay, 1999). All of the transcripts were then read several times in order to gain a deep understanding of the data content, which proved greater familiarity with the data.

Thematic analysis was used to organise data in rich detail (Braun & Clarke, 2006) in the following manner: Analysis was entered with a basic awareness and sensitivity to barriers to mental health care found in existing literature (Tuckett, 2005). These broad sensitizing concepts formed a tentative starting point for initial coding of the raw data. The coding process included organization of data in meaningful groups (Tuckett, 2005). Themes were then manually created by assembling overarching codes into potential themes and gathering all data pertinent to each potential theme. During this process a “thematic map” (Braun & Clarke, 2006, p. 19) of the data was created that enabled me to explore the relationships between themes in order to identify the main themes and sub-themes within the main themes. All themes were then revised in order to check if the coded data within each theme formed coherent meaning. The original raw data were also revisited to check if any additional data that had been skipped during initial coding process, should be added to the themes. A detailed analysis of each theme was then produced and a relevant participant quotation was used to name each theme.

Thematic analysis allowed me to immerse myself in the data in order to produce a “thick description” of it (Braun & Clarke, 2006, p. 37). Present study results were reported in Chapter 4 according to the main and sub-themes.

3.6 Reflexivity

Reflexivity is described as the researcher’s conscious awareness of herself in relation to the research process (Elligson, 1988; Shacklock & Smyth, 1998; Terre Blanche, Kelly & Durrheim, 2006). Reflexivity therefore becomes a process of self-analysis (Hellowell, 2006; May, 1988). A qualitative researcher is simultaneously also the research instrument for both data collection and analysis (Terre Blanche & Kelly, 1999). It is therefore important for the researcher to remain consciously aware of her own biases, beliefs, experiences and expectations that could affect the research process and outcomes. As qualitative research evaluations are contingent on the subjectivity of the researcher, it is essential to develop reflexivity and to record personal reflections. In this manner, qualitative methods satisfy the demands of scientific method required for any research study (Ellington, 1988; May, 1988).

In order to objectively stand outside one’s own work, and to be reflexive about it, and about one’s own relation to it, Hellowell (2006) argues that the researcher should be able to locate herself on an insider- outsider researcher continuum. The researcher as an insider is described as an individual who holds previous intimate knowledge of the community under investigation. However, this does not necessarily mean that the researcher should be a current member of the community being researched, only that she is familiar with the setting and the people that she is researching (Merton, 1972). Additionally, the word community, in this instance, does not only refer to a specific group of people that share the same values and beliefs, or an organisation. The word community is a much wider concept and can be related to gender, age, class, etc.

On the other hand, the researcher as an outsider refers to a situation where the researcher is not previously familiar with the community under investigation. Traditionally, this was the most accepted kind of qualitative research as Burgess (1984) reports that being a stranger in a specific social setting gives the researcher the ability to be objective in relation to the research at hand.

In the face of these opposing stands that a researcher could take with regards to her research participants, Hellowell (2006) argues that the researcher should rather opt to be both inside and outside the views and experiences of the participants, or in other words, express both empathy and alienation toward research participants. Alienation in this sense refers to detachment from the researched. This would enable the researcher to take advantage of the benefits related to both stances.

In order to ensure the validity of my own research methodologies and to “avoid the illusion that I did not have illusions” (Dlukulu, 2010, p. 157), I applied a reflexive approach. The aim of my research project was first explained to the potential participants when they were contacted to estimate whether they would be willing to participate in my study. The aim was then explained a second time to the actual participants before the commencement of our interviews. Participants were also informed that they had first-hand experience with the barriers faced when seeking mental health care and had therefore significant contributions to make to overcoming the research problem. Additionally, in order to clarify any preconceived notions that participants held of me, I clearly identified my role as researcher. Due to the fact that participants had the choice of conducting the interview at MMH, I distinctly identified my role as separate to that of a counsellor or any other health professional. This was important as possible institution-related barriers might be disclosed, and if participants thought that I was in any way attached to MMH they might not feel confident to disclose

such barriers. In this manner a relationship of mutual confidence and trust was achieved to facilitate the information sharing stage that was about to follow.

After an extensive review of the related literature on barriers to mental health care utilization, I may unconsciously have sought out evidence of these barriers during the interview and analysis stage. In order to prevent this, I firstly focused on asking “what” open-ended questions instead of “why” question. “What” questions, according to Stiles (1993), are useful in gathering data about what the participant had first-hand experience of; compared to “why” questions that could generate justifications and general theories. Secondly, I discussed my preconceptions with my supervisor so that the study does not unjustly reflect my interpretations. My supervisor specifically challenged potentially speculative explanations where he felt I went beyond the data to give my own interpretation of it. In these cases he asked me to go back to the transcribed interviews and report the participants’ own words in order to make sure that the participants’ views were reported instead of my interpretation of their disclosures.

With regards to Hellowell’s (2006) insider-outsider researcher continuum, I identified elements of both insiderness and outsidersness that impacted on the study. In terms of the gender and age dimensions, elements of insiderness existed as I was a female interviewing female participants and I was a 24-year-old researcher interviewing mostly participants in their twenties. On the other hand, being a white middle-class single woman who has never been pregnant before or experienced depressive symptoms, added to elements of outsidersness.

In order to best establish an accommodating context for the participants, I adopted a fairly informal style of relating to the participants and tried to remain approachable and understanding throughout the interview – an approach similar to that adopted by Frosh, Phoenix, and Pattman (2002). Throughout most of the interviews, participants spoke

comfortably and seemed genuine. However, one participant (Ayesha) seemed suspicious and did not easily open-up or elaborated on answers without having to be continuously probed. As such, I was continuously aware of the importance of being receptive to any discomfort and/or defensiveness experienced by the participants, and consequently the importance of continued reflexivity in the interviews. I also kept a reflective journal throughout the interview process in order to maintain awareness of these issues during thematic analysis.

3.7 Ethical Procedures

Ethical clearance for the study was obtained from: (1) the provincial Department of Health (Appendix B); (2) Subcommittee A of the University of Stellenbosch (Appendix C); (3) the Perinatal Mental Health Project (Appendix D); and (4) the research committee of Mowbray Maternity Hospital (Appendix E). Before any interview took place, each participant was reassured that I was not employed by the PMHP or Mowbray Maternity Hospital.

Participants were further guaranteed that their answers would in no way jeopardise any future care they or their families would receive at health care facilities. Additionally, the goal of the study was explained to each participant and confidentiality of her responses was guaranteed. Pseudonyms were used in the Results and Discussion chapter to assure further anonymity of participant responses. Participants were then asked to give either written or verbal consent and permission for the interview to be audio-recorded, depending on whether interviews were conducted face-to-face or telephonically. Additionally, the two participants that attended their scheduled face-to-face interviews received monetary compensation of R50 as contribution toward their travelling expenses and as gratitude for their participation in the study.

3.8 Significance of the Study

The present study offered an original perspective on mental health care appointment-keeping behaviour within the South African context. The ecological theoretical framework within

which this study was grounded, considered counselling attendance as a product of the participants' environment, together with the interplay between the systems operating within this environment. By interviewing patients who had previously missed scheduled counselling appointments, it was also possible to identify how the different systems within the participants' environments contributed to the participants' attendance-keeping behaviour.

Chapter 4: Results and Discussion

Six participants were interviewed for the purpose of this study. From the data elicited, barriers to mental health service utilization were identified using Bronfenbrenner's (1979) Ecological Model, as such a theoretical framework allow for references to be made to a participant's behaviour as influenced by her environment.

4.1 The Ecological Systems Theory

Barriers to mental health care utilization that exist among depressive pregnant women can best be understood within Ecological Systems Theory (Bronfenbrenner, 1979, 1994) since the theory addresses the participant's adherence to mental health care treatment within a context that stretches from an individual to a global level. Furthermore, this multi-levelled framework allows the researcher to regard the study participant's environment as an intricate conceptual map of influences on appointment-keeping behaviour of these women (Reppucci, Mulvey & Kastner, 1983).

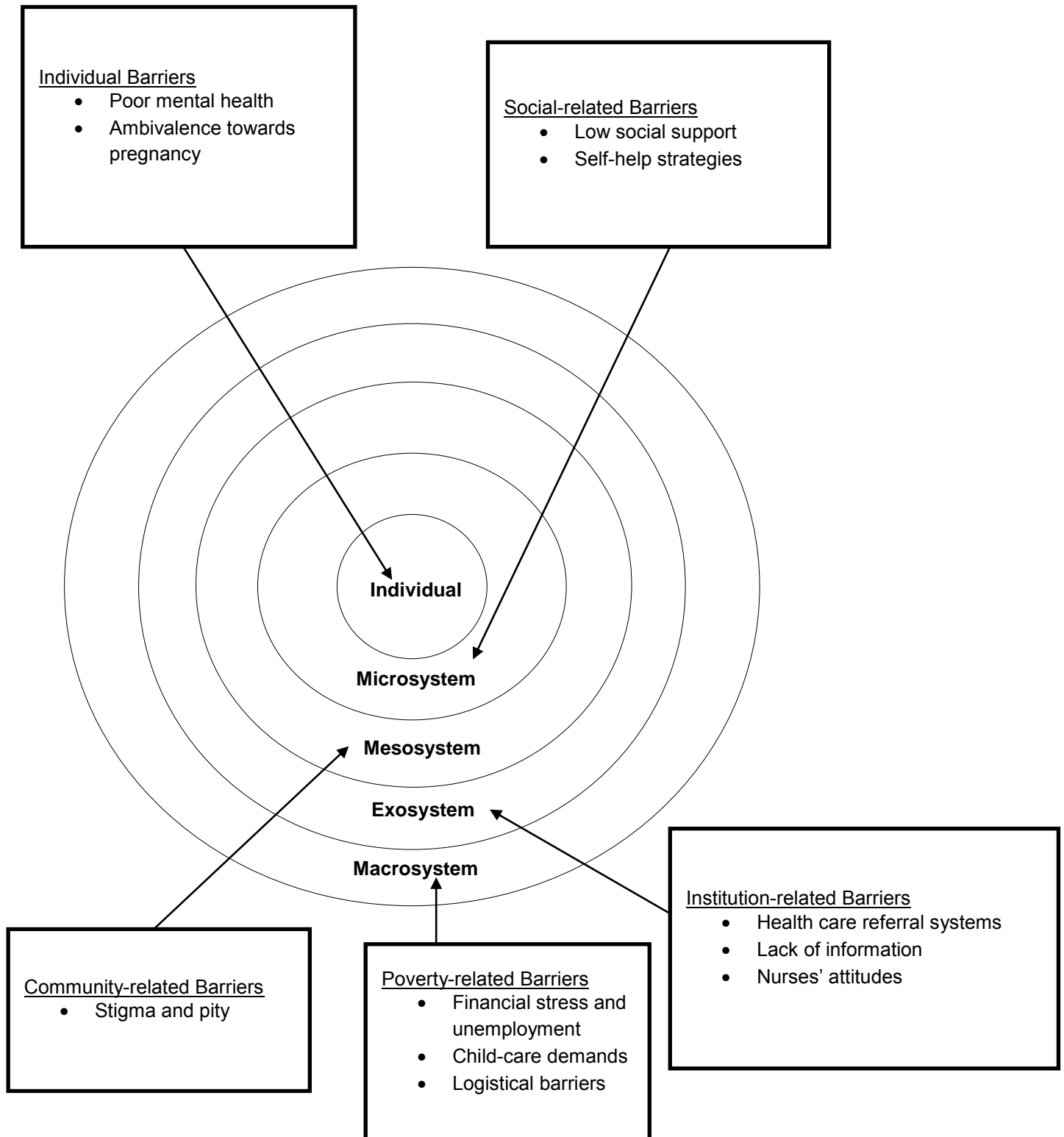
This conceptual map considered the barriers situated within the participant's environment as arranged according to nested hierarchical systems, of which higher systems contain all the lower systems. These systems have been compared to "a set of Russian dolls" (Bronfenbrenner, 1979, p. 3). Additionally, each of these different environmental contexts exists in interdependent relationships with one another, so that changes in the one will ripple through to the others. The participant is then embedded at the centre of these interrelated environments and acts as her own system. This individual system further consists of various cognitive, emotional and behavioural sub-systems (Potgieter, 1988). The various systems operating within the participant's ecological environment include the individual herself as a system, the microsystem, mesosystem, exosystem and macrosystem. The results that emerged

from participant responses will be reported and discussed in accordance with the Ecological Systems Theory (Bronfenbrenner, 1977, 1994) throughout the rest of the chapter.

4.2 The Ecological Systems Theory and Barriers to Service Utilization

The following five themes emerged from the interviews through thematic analysis: (1) individual-related barriers; (2) social-related barriers; (3) community-related barriers; (4) institution-related barriers; and (5) poverty-related barriers. Within certain themes further sub-themes were also identified as is evident from Figure 1 below. All the themes and sub-themes will be discussed throughout the rest of the chapter.

Figure 1. Adapted Ecological Systems Theory



4.2.1 The individual as a system.

Potgieter (1988) reported that the participant could be viewed as a self-standing system, consisting of various sub-systems. The present study considers these sub-systems as cognitive and emotional barriers in the participant's environment. For the purpose of this study, the individual system includes individual-related barriers.

4.2.1.1 Individual-related barriers.

Individual-related barriers refer to behavioural and psychological factors that exist within the participant and act as barriers to mental health care use. The following issues will be discussed within the framework of individual-related barriers: (1) poor mental health and (2) ambivalent feelings toward the pregnancy.

4.2.1.1.1 "I wasn't in a good state of mind."

Poor mental health was in most cases reported as excessive crying by participants. Feelings of intense sadness and depression were also disclosed. This poor state of mind was associated with the effect that depressive symptoms had on the participants' ability to make use of the available mental health services.

Chronic crying was a recurrent theme that emerged from the interviews. Nomsu even described her state as "cryful", meaning that she perceived herself to be too emotional. Fatima's counselling appointment was scheduled for the same day as her obstetric check-up, meaning that she was at the hospital when her appointment was due. When asked why she was unable to attend her counselling appointment she explained it as follows:

I remember the second one that I didn't go to was because that day I wasn't in a good state...I wasn't in a good state of mind. And I just felt that I was going to be too emotional in session.

The fact that participants described their conditions as unstable, unpredictable and “up and down” (Thandi), might explain why they would make a counselling appointment on one day but not attend it on the next day. In this manner poor mental health acted as a barrier to counselling appointment attendance.

When the depressive symptoms were reported as relating to the lack of a partner in the lives of the participants, they described these symptoms even more strongly and overwhelming. Due to feeling all alone in her pregnancy, even though her parents and the rest of her close family supported her emotionally and financially, Ayesha indicated that “most of the time I am sad and depressed and worried.”

Similarly, Lindiwe who broke-up with her partner almost immediately after giving birth became so depressed that she was unable to discuss her situation, even with friends and family, without breaking down. She furthermore neglected her baby, as just looking at her daughter made her cry. She also lost a considerable amount of weight and reported that the people around her could see that she was not well. She described her state as follows:

It was everything, I was losing weight, not only because I was breast-feeding, I was losing weight like crazy. People could see on my expression that I’m not happy. People would ask me about it and I would just cry. I’d get home and think about it I’d cry. And I didn’t care about my child; I didn’t have a routine at the time and wouldn’t think of bathing her. I’d be lazy. I’d just look at her and I’d cry. So, I feel that I broke down I really do, I’d never seen myself that way in my life. I’ve never been such person to be like that in my life and before I met him I was very independent person, I was like this free, cute little girl who does her own thing.

Again, in this situation, being so emotional that she couldn’t even say her ex-boyfriend’s name without starting to cry, having to discuss her situation and state of mind with a stranger

might have seemed like an impossible task. Lindiwe explained this difficulty of opening-up to others, as follows:

I was really a mess. I used to cry every time somebody would ask me about the situation. From what I see of myself now talking to you about it, I can see I'm very better because I would cry about it if my friends asked about it, I would cry alone just thinking about it. Now, I feel much calmer speaking about it, though at times I would feel like crying. But it is not as much as it used to be. I would just burst into tears and nobody would know what is wrong with me.

As reported in this section, poor mental health, and especially depressive symptoms during and after pregnancy, was reported to be an individual-related barrier to available mental health service utilization. This barrier lies within the participants' individual system of their ecological environment. Poor mental health is an important barrier to investigate in the face of low mental health care service utilization. Reasons provided for this include the fact that antenatal depression has been identified as the leading cause of complications related to childbirth, and postpartum depression has been identified as the leading cause of maternal morbidity (O'Hara & Swain, 1996) – especially when it is untreated (Bonari et al., 2004). Additionally, pregnancy and childbirth represents a period of great vulnerability to mental illness (Ryan et al., 2005), especially when referring to perinatal depression (Stocky & Lynch, 2000).

In keeping with previous literature (Cook et al., 1999; Price, 2010; Templeton et al., 2003; Thome, 2003) the present study detected depressive symptoms as a barrier to perinatal mental health care utilization. Poor mental health was identified among present study participants, especially in the form of chronic crying. This finding was similar to that of McIntosh (1993) whose study participants reported tearfulness to be the most common

symptom of their depressed mood. Present study participants also indicated feelings of sadness and depression to be strongly linked to a lack of partner support. This finding stands in agreement with findings of a similar South African study performed by Cooper et al. (1999) who found that the presence of feelings of depression were more likely brought about by a lack of emotional and practical support from a partner, than a lack of support from relatives and friends. In keeping with Section 2.2 of the Chapter 1 of the present study, both studies therefore agree that the absence of partner support is a major risk factor for the onset of perinatal depression.

Findings presented by McKee et al. (2002) were both contradictory and similar to present study findings in terms of poor mental health of participants. Firstly, in contrast to present study findings, McKee et al. (2002) found that the number of supports available to their pregnant study participants had no effect on the impact of depression on their functional status. On the other hand, the study found that poor mental health of the pregnant study participants affected health utilization in important ways such as adherence to treatment recommendations and appointment keeping. The latter finding supports present study findings as participants reported inability to attend scheduled counselling appointments due to a poor state of mind.

Furthermore, the qualitative study results of Chan et al. (2002) report that postnatal depression was more frequently found among those women that indicated a lack of either partner or in-law support in their lives. This finding was in line with a present study participant, Amy, as she expressed feelings of sadness and excessive crying due to her husband's inability to disclose the news of her pregnancy to his parents due to fear of rejection and shame. She further indicated that after giving birth, the main cause of conflict between her and her husband was due to different outlooks on child nurturing held by her and her mother in-law. Ayesha also indicated that her in-laws were displeased by the fact that she

was pregnant. The in-law conflict together with a lack of partner support caused a great deal of distress to Ayesha during her pregnancy, as she reported a general depressed and sad mood. Consequently, poor mental health, and especially depressive symptoms during and after pregnancy, was reported to be an individual-related barrier to appointment-keeping behaviour of the study participants.

4.2.1.1.2 “Finding out that I was pregnant was a little bit of a disruption.”

Feelings that arose when finding out that they were pregnant and further attitudes toward their pregnancy and motherhood impacted on mental health service utilization among the present study participants. Ambivalent feelings toward their new role as mothers were associated with whether participants used mental health care services to deal with related stress.

The majority of the participants indicated that they were in shock when first discovering that they were pregnant. Only Lindiwe made the conscious decision with her partner to become pregnant. Reasons provided for why pregnancies were unplanned and sometimes unwanted at the time in the participants' lives, firstly involved the relationship between the participant and the partner. Pregnancies were undesirable when this relationship was complicated (Ayesha: “we were on war terms at the time”) or broken (Fatima). Other reasons provided for why pregnancies were not ideal include having a drug-related problem (Fatima) and being rejected by the partner's family (Amy).

Fatima reported that the pregnancy caused disruption to her life and left her feeling disorganized, as she explained:

Finding out that I was pregnant was a little bit of a disruption... I'll say a bit “deurmekaar.” So like unorganized. That's basically how it is now and it is so because, I had a baby at the ripe age of 32 years old. So, I do feel as if I am a bit unorganized.

This feeling of disruption persisted as even after giving birth she is still “just trying to find my feet.”

This particular participant missed our face-to-face interview appointments three times, after which the interview process was adapted to a telephonic interview. Her mother further informed me that she was extremely disorganized and did not have a sense of time firstly due to her prior drug-related problem, and secondly the unexpected pregnancy thereafter. In this manner, being overwhelmed by the pregnancy to such an extent that the participants' lives were turned upside-down, could in itself have acted as a barrier to mental health service use.

Amy reported that the fact that her boyfriend (currently her husband) refused to tell his parents about the pregnancy, for more than seven months into the pregnancy, caused the majority of her stress and ambivalent feelings towards her pregnancy. Her partner was the one to insist that she should make use of counselling services, due to the fact that she was crying continuously. However, she felt that she didn't “need the counselling because the only thing that is stressing me out is us not telling your parents.” Although, simultaneously she also regrets not speaking to a counsellor during her pregnancy as her partner, refused to tell his parents that she was pregnant and failed to understand why it upset her to such an extent. He failed to comprehend that he was the main reason why she needed counselling in the first place, as Amy reported ‘it wasn't that I wasn't coping with the pregnancy, it was just basically worry that ‘Is he going to tell his parents?’” These feelings of ambivalence towards her pregnancy were translated into feelings of ambivalence towards mental health care. On the one hand she felt that she needed to talk to a health professional as her partner failed to understand that he was the main source of her stress during her pregnancy. However, on the other hand she felt that counselling would not be useful because the stress was related to an external factor (i.e. her husband) that could not be changed by therapy.

Lindiwe, who after her partner suggested it, decided to become pregnant, was “ecstatic” when she first found out that she was pregnant. However, these feelings of excitement and joy turned into feelings of extreme sadness after she and her partner broke up. She felt disappointed mainly because “the actual reason why I fell pregnant wasn’t for myself, it was for him”, and therefore felt that she “made the wrong decision, for all the wrong reasons.” While, he was able to extract himself from the situation after breaking up with her, she was left with a daughter who required constant care.

Although this point was not specifically reported by all the participants, it is very likely that the majority of the participants that broke-up with their partners before, during or after their pregnancy could relate strongly to this point. This is especially true seeing that low partner support was such a recurrent theme generated from the interviews (discussed in Section 4.3.2.1).

Upon reflection, Lindiwe reported that she now realized that she “made [an] irrational decision” when deciding to become pregnant. This was also due to the fact that she felt she “did everything in the wrong order” as she reported to agree with her mother who:

wanted the best for me and she’s always wanting me to finish school first and then think about having babies, having a family, having a stable job. So, she thinks I started with the wrong decision first. I should have thought about it before I made the decision or just talked to her.

The last quotation refers to the fact that Lindiwe wished she had first finished her studies and gotten married before becoming pregnant. At this moment in her life she reported that she still needs “someone to nurture me. And now I can’t be looking to be nurtured when I have a small child to nurture myself.” Feelings of disappointment and regret toward a planned pregnancy might act as a barrier to seeking mental health care, as treatment could not undo the pregnancy.

Lindiwe further reported being in a state of complete denial about her pregnancy as she doesn't "think it sunk in that [she] was pregnant" until she gave birth. For this reason she admitted that she carried on like a "normal" student and didn't restrict herself and her life style in any way. Due to these feelings of denial, she reported never allowing herself to deal with the emotions that came along with finding out that she was pregnant. Additionally, she also never allowed herself to think about how her life would permanently change after giving birth. Consequently, she also never gave herself the opportunity to even consider making use of counselling services. She voiced it as follows:

I didn't feel pregnant at all. I would go out with my friends. I would sleep over at my friends' houses. There's nothing I didn't do. So, I don't think it actually sunk in until I gave birth, that I'm a mother. And I think that's a part of why I couldn't get over what's happened in my life. It's because I didn't give myself time when I was pregnant to understand that I am going to be a mother... I can't do the things I used to do and I was pregnant, I was single and I'm going to have a constant reminder in my life that there's somebody that I must look after.

As reported in this section, how the participants felt about being pregnant, at the time that they first found out that they were pregnant and thereafter, was reported as an individual-related barrier to available mental health service utilization. This barrier is located within the individual system of the participant's ecological environment and will be discussed accordingly.

Present study participants indicated that they were in shock when first discovering that they were pregnant. Reasons provided for pregnancies being unplanned and in some cases unwanted at the time in the participants' lives, included: relationship complications with their partners; having a drug-related problem; and being rejected by the partner's family. This finding was in line with that reported by Cook et al. (1999) and Templeton et al. (2003). Both

studies reported pregnancies that were unwanted or unplanned generally resulted in feelings of ambivalence toward the unborn infant. Cook et al. (1999) further reported that such feelings of depression towards their pregnancies were the most frequently reported barrier to receiving adequate mental health care by the study participants. Present study participants did not clearly identify the fact that their pregnancies were unplanned or unwanted as a barrier to utilizing available mental health care services. However, because the sample of women did not attend their scheduled counselling appointments and the majority of the sample indicated that their pregnancies were unplanned, the possibility of the link exists.

4.2.2 Microsystem.

The Ecological Systems Theory describes the microsystem as the immediate setting in which the participant lives. This setting then also includes any personal interactions and relationships with partners, relatives, in-laws, friends, colleagues, neighbours and other structures with which the participant has direct contact (Bronfenbrenner, 1979). For the purpose of this present study, the microsystem includes the social-related barriers.

4.2.2.1 Social-related barriers.

Social-related barriers refer to those factors that are related to the relationships that participants have with other individuals in their lives and that impact negatively on participants' appointment-keeping behaviour. The following issues will be discussed within the framework of social-related barriers: (1) low social support and (2) self-help strategies.

4.2.2.1.1 "I'm all alone in my pregnancy."

Social life hardship includes social isolation and feelings of loneliness. These circumstances were associated with failure to utilize mental health care services mainly due to the fact that participants felt that treatment would not be effective, as it does not address those external

factors that caused the stress in the first place. Feelings of intense isolation in their pregnancy were associated with failure to utilize mental health care facilities. The participants in the study voiced various elements and different ideas of social life hardship. This brought to light a significant difference that exists between receiving support from the family when compared to receiving support from the father of the baby. (From this point onwards the father of the baby will be referred to as the partner.) Different relationships between the participants and their partners also caused variations in the quality of emotional support that they received from the partners. These two points will now be further discussed.

Overall, participants expressed extreme feelings of loneliness in terms of their pregnancy and childcare after birth. These feelings were especially linked to the absence of the partner during and after the pregnancy. The majority of the participants were supported practically and financially by their nuclear families – especially by their mothers. Only Thandi received no support from her family and she seemed to experience even more intense feelings of loneliness and regret. These feelings were expressed in the following two quotes: “I’ll support myself. I will go back to work and I will support myself. That is what I normally do. I do that coz I don’t have a mother”; and

I could have maybe if my mom or my father were there, you know, not that I’m blaming them, but if they were there, coz my mom had difficulty to raise us, she had to give me to stay with someone else, and I’ve never got that chance you know of a supportive mother who can tell me this is wrong this is right. I was doing my own thing. Sometimes I had to stay home alone. Maybe that’s why I ended up being pregnant with the first child.

On the other hand, Lindiwe didn’t receive any support from her partner but had strong familial support. She explained that if she had nobody to support her (similar to Thandi’s

situation) she would have committed suicide, as the situation would then have been completely hopeless. She expressed the importance of familial support as follows:

I've got hope more. And I think that's why I've been able to get over this whole situation a bit. It's a lot easier now because she's there [*her mother*]. She's supporting me and she's helping me. That is something that you need in your life when you are going through such a situation. If there is nobody around you I just think I would have committed suicide. That's just to the point where I would have gone if there was nobody around to talk to, or nobody around healing me or there is nobody helping me with the situation that I am going through.

Additionally, Lindiwe also thought that she would have been able to support herself throughout the whole pregnancy. However, during her pregnancy and especially after she broke up with the partner, she realized that she in fact needed her family's support, as she explained:

I was very bold, I was stubborn as well. I used to tell myself that I wouldn't need anything from anybody because I got my boyfriend. And I don't know why they are telling me all of these things because I don't think I'm gonna ever ask them for anything. When in actual fact, I actually needed all of them to be there for me.

This above-mentioned quote shows that although the participants are struggling with feelings of loneliness without the partners in their lives, a complete lack of familial support would have made the pregnancy and childcare even more challenging.

However, it seemed that familial support, no matter how strong, never completely satisfied the mother's needs for belongingness and love, as Lindiwe described it:

I have my mother and I have my friends but it's not the same. You kind of feel that you need that person that was meant to be with you from the beginning to the end. If he is not there it is kind of depressing and also stressful.

In cases where the father of the baby wanted nothing to do with neither the mother nor child, participants struggled to come to terms with the fact that the partners refused to even compromise with them so that at least his child would be a part of his life. Lindiwe was so distressed by this that she referred to her experience as “disturbing”, especially because Lindiwe believed she and her partner had jointly decided to get pregnant. Overall, these women experienced pain because they feel that they were intended to share the joys and responsibilities linked to being a new parent with a partner that would find himself in the same boat as they are. However, they are now left to fill this role alone, as Ayesha reported: “And because of the father I don’t get no support. He’s just doing his own thing and I’m all alone in my pregnancy” and “I have to see to everything my daughter needs.”

However, in cases where the father was still present, other types of stresses were experienced. Many participants referred to their relationship with their partners as destructive. This was either due to the fact that he was not emotionally supportive (Thandi: “sometimes saying harsh things to me”); or due to the fact that the partner wanted a relationship with his child which made it impossible for the participants to break completely free from their past relationship with him. The mothers who allowed partners to be a part of their baby’s lives were always present when the partners spent time with the babies. Therefore the relationship was maintained between the participant and the partner and this caused painful emotion in the participants. Fatima explained this situation as follows:

The agreement is or the agreement was that we were going to keep the relationship very professionally in a sense that I’m going to be a part of obviously his life for the benefit of the child. And both of us agreed that we were obviously going to move on with our lives. But to a certain degree I don’t think or don’t feel that that is currently what both of us are living up to at the moment. And it’s simply because when he spends time with the child I am there and, not that this is an excuse coz it shouldn’t actually be an excuse,

but my baby is a breast baby so I am breast feeding. And also because I feel comfortable being there. Obviously with my presence also there just means that the two of us also still have a relationship. And sometimes it just leaves me a bit tied up because of the things that we speak and the moments that we have and stuff like that... It's also beneficial for me to be there because he also to a certain degree teaches me one or two things in terms of you know how I should go about certain things so I feel that I can learn a lot from him but as I say to a certain degree it's also a bit destructive sort of for me because it brings me in on from an emotional perspective. Ja, which is not ideal.

On the other hand, requests from partners who wanted a relationship with the baby but refused to even talk or see the mother caused a great deal of conflict in the participants' lives.

Lindiwe explained this situation as follows:

Like a simple situation last week, he sent me a message saying he misses his child. But he misses his child he just doesn't want to see me. And he doesn't want to interact with me, so he would appreciate it if I took the child to his house or he was going to send his mother to come fetch the child. And I told him my child is only three months. I told him I couldn't do that because I can't just give my child to anybody, even though if he is the father of the child, and not know where they are taking her, what they are going to do with her. He doesn't know her routine, he doesn't know what she's like, and he doesn't know that she's teething at the moment. So I couldn't just say yes to something like that. And that's where I saw that I'm really not over this whole thing. It disturbs me actually that he isn't spending time with his child and that he's not able to compromise and come to an actual decision that we can actually be friends and that he would then have an actual relationship with his daughter. It disturbs me the most that he is acknowledging his first child more than he is acknowledging my child. In the actual fact he was the person who asked me to get pregnant.

Lastly, Amy who is now married to the partner discussed conflicts with her in-laws and specifically her mother in-law who held a different opinion regarding childrearing and tried to enforce her beliefs on Amy. This in-law related conflict, in turn, put strain on the relationship between Amy and her husband and therefore affected the quality of the emotional support she received from him. Amy explained her relationship and conflicts with her mother in-law as follows:

I won't say we're very close but um we will get along and there is certain things that we don't see eye-to-eye with when it comes to the baby...Like my son was, I won't say constipated but he didn't have stool for the past two days, she wanted me to rush him to the doctor last night. And I wasn't happy about that and I told her that I feel he is okay and that we just need to wait so last night we didn't see eye-to-eye about that. But um it's little things. It's basically not that we don't see eye-to-eye it's only when it involves a child, you know what I mean. So, it's not really that we don't get along, we do get along, but at times like she would want to feed the child and I'm not happy with it you know what I mean, stuff like that...And if I'm not happy with stuff with his mommy I will tell him [*her husband*].

Possible reasons provided by the present study participants for the fact that familial and friends support, alone, was not sufficient were, firstly, that participants did not want to burden their families or friends with their own problems. This was because participants felt they had their own lives and problems to deal with. Participants therefore did not share highly personal details with their friends and family, nor opened up completely about those things that caused stress in their lives. As Fatima replied when asked whether her friends offered a form of emotional support to her, "I'm not tapping into them." Similarly, Amy replied to the same question as:

I also got two other girl friends that I see maybe once a month. But I don't really speak to them about personal things, so I won't say that my friends are really there to support me in that way. But we do speak about my son and the marriage but I won't speak to them about stuff that I'm unhappy with like if I'm unhappy about his mom maybe feeding my son, I won't speak about stuff like that to them.

Lastly, when Ayesha was asked whether she received emotional support from her sister, she replied: "it's just that I don't bother her much because she has her own life." However, this "space" that participants create between themselves and others prohibits family and friends to truly understand what the participants are experiencing. This therefore makes it impossible for friends and family to help and support the participants.

Furthermore, five out of the six participants were not married when they first found out that they were pregnant. For this reason, they felt that their families were ashamed or disappointed in them for falling pregnant out of wedlock. Participants therefore did not have the liberty to speak openly to them about problems and related stress regarding the pregnancy. When asked how their families reacted when they first told them that they were pregnant, most of the participants used words like "really disappointed", "wrong decision", "couldn't understand what went wrong", "disappointed in themselves", and "sad, crying, unhappy." Overall, responses of family members concerning the pregnancy were negative. Some parents saw the pregnancy as the termination of their daughter's tertiary education and independence. Others saw it as a threat to the family's status within the community and church. Some parents even saw it as a sign of failure of their own parenting skills. Fatima disclosed that between herself and her parents "it's a broken relationship and not something that can be fixed in a day, figuratively...the journey is still very long." One can see that these negative responses to their pregnancies acted not only as additional stress to the participants' lives, but also to more isolation and therefore less social support.

On the other hand, some participants merely preferred other means of social support, apart from familial, friends or partner support. They preferred to speak to an individual unknown to them as “you can feel more open to speak about stuff” (Ayesha) and because “there was nobody to talk to who had constructive criticism or had a constructive solution to what was happening in my life” (Lindiwe). The last quote especially points to the fact that even though participants have friends and family to talk to, they prefer the comfort of talking to a stranger and especially someone qualified to deal with the problems that the participants present to them.

This above mentioned point shows that the participants expressed a need for therapy as a counsellor is a stranger who would be able to provide a “constructive solution” to their distress. However, due to the fact that counselling was freely available to the participants, other factors existed that stood in the way of them making use of this service. This emphasizes the need to overcome these barriers that stand in their way to utilize these available services.

Lastly, Lindiwe described her feelings of loneliness as “I gave birth all alone, with the nurse.” This paints such a powerful picture of how emotionally painful it must have been for these women to go through such a traumatic experience, which is traditionally thought of as a precious and exciting experience, all by themselves. One can almost feel the great disappointment of giving birth and then not having any loved one close by to share the experience with.

Low levels of social support, especially from participants’ partners, were reported in this section to be a social-related barrier to available mental health service utilization. Barriers associated with social support can be located within the microsystem of the participant’s environment. The reason for this was that social networks within the present study participants’ immediate environments were found to impact on their counselling

appointment-keeping behaviour in two ways. Firstly, a lack of specifically partner support was strongly related to depressive symptoms that (as previously discussed) acted as a barrier to service use in itself. Secondly, participants shared the viewpoint that treatment would be ineffective as it cannot address or change external factors such as lack of support. This attitude towards counselling acted as barrier to seeking mental health care.

In agreement with a large literature body (Cooper et al., 1999; Holopainen, 2002; Oats et al., 2004) the present study results indicated a strong link between a lack of partner support and depressive symptoms experienced by the participants. The link came to light as the participants expressed extreme feelings of loneliness and sadness, although they were supported practically and financially by their nuclear families – especially by their mothers.

This study's results are both similar and different to the results reported by Cooper et al. (1999). The latter study detected no difference between depressed and non-depressed participants in terms of availability of support from relatives or friends. This difference was only detected in cases where a lack of partner support was reported. On the other hand, in the present study depressive symptoms were detected in both cases. However, symptoms were more severe in cases where partner support was unavailable to the participants.

Additionally, a viewpoint was shared by present study participants that in the case of neither familial nor partner support, their pregnancies and childcare would have been even more difficult. Lindiwe even went so far as to say that she would have committed suicide if no form of support system were available to her. However, it was also found that familial support, no matter how strong, never completely satisfied the mothers' needs for belongingness and love.

A salient reason proposed by the study participants regarding why partner support might have such a significant influence on their mental health and treatment adherence behaviours, was: longing for companionship with someone that would find himself in the

same situation as the participant. This finding was in line with that of Okun and Keith (1998) as findings reported that only partner support, when compared to support from relatives and friends, was related to depressive symptoms in young adults. In keeping with this finding, Walen and Lachman (2000) found that social exchanges with one's partner were a significant predictor of well-being and health. The same was found to be true with regards to family and friend support, albeit to a lesser extent.

Related to this finding, present study participants reported that they could not completely open-up to their friends and relatives. One reason provided for this was that participants did not want to burden them with their problems. This was similar to findings reported by Mauthner (1999) as participants indicated that they felt they would be "burdensome" if they disclosed their feelings. Another reason reported by present study participants was that when opening-up to relatives and friends it would place participants in a vulnerable position with people they interacted with on a daily basis. This finding was similar to findings reported by McIntosh (1993) as participants reported being too ashamed and embarrassed to open-up to relatives and friends about something that they regarded as a sign of failure and personal inadequacy. With relation to the last mentioned point, some study participants indicated a need to open-up to an individual unknown to them, who would hold an objective perspective to their situation.

Furthermore, in the present study participants gave accounts of conflicts with their in-laws. These conflicts consequently impacted negatively on the relationship with their partners and therefore quality of partner support. These findings stand in agreement with results of Chan et al. (2002), who detected a linkage between lack of partner and in-law support and features of depression among their study participants. Additionally, in agreement with Danaci et al. (2002) and Leung (2002), Amy reported that conflict with her mother in-law revolved around the fact that they had different child-rearing ideas. These differences can lead to

feelings of helplessness and depression in the young mothers, which in turn can impact negatively on mental health service use

Stress related to feeling all alone in their pregnancies often caused physical problems with the pregnancy. These pregnancy-related problems held deleterious consequences for both mother and infant. This is a similar finding to that reported by a large literature body (Alder et al., 2007; Arck et al., 2001; Chung et al., 2001; Dayan et al., 2002; Kurki, et al., 2000; Orr et al., 2002).

4.2.2.1.2 *“I think that talking to a stranger is better than somebody you know.”*

Self-help strategies refer to any measures, apart from professional care, taken by participants with the goal of minimizing their emotional distress. In the study at hand, participants opted to speak to a friend or relative, as a means of relieving stress or distress. This self-help strategy in itself was associated with failing to seek formal mental health support.

Ayesha indicated that although she had friends and family to speak to about the stress in her life, she preferred to rather speak to someone she did not know. She voiced this as follows: “I have family and everything but I prefer not to speak to them... Cause sometimes I just feel like I need to speak to someone else... then you can feel more open to speak about stuff.” All the other participants in the study, when asked to whom they spoke to as a means to gaining emotional support, referred to either a relative or friend.

Thandi, Fatima, Lindiwe and Amy reported that they initially thought talking to a friend or family member would help ease their distress. However, in actual fact, the relief was only momentarily as the problem persisted in the long run and therefore caused continuous distress during their pregnancies.

In relation to the afore mentioned idea, Thandi indicated that talking to a colleague “helped at that moment but it didn’t really help because I ended up giving birth on 36 weeks

so I think that played a role as well – stressing too much.” Similarly, Amy spoke to her mother about the marital distress due to her husband’s refusal to tell his parents that she was pregnant. Seeking informal care in this case also did not seem to have solved the problem, as Amy reported: “I had the support but I just felt that maybe at the time maybe I should have just seen someone.” Additionally, Fatima had her partner, a close friend and her mother to speak to and she still felt that it did not completely help her, as she reported: “I was very caught up with the fact that I was pregnant so it took me a while to sort of find acceptance.”

Lindiwe indicated that she had a close friend whose advice she could trust and who never judged her when she opened-up to her about her problems. However, in the same breath she raised the following concerns about opening-up to the people in one’s life:

I think that talking to a stranger is better than somebody you know. You never know when you’re talking to somebody that you know if that person has good intentions for you. She wants you to break down or she doesn’t want you to persevere forward and she keeps on telling you the wrong advice. So, I feel that talking to somebody outside of your situation, who can look into your situation and give constructive criticism or constructive advice, is better than somebody you know.

This above-mentioned quotation emphasizes how seeking informal advice from friends and family can deter participants from seeking formal mental health care. This was due to the fact that informal others may not be adequately informed on how to deal with problems the participants present to them.

Lastly, the EDS and risk factor assessment questionnaire scores of Nomsu indicated that she was high-risk depressive. However, when she was offered formal mental health care in the form of counselling she indicated that she would rather speak to her sister and husband about her stress. In this manner, having the option and preferring to rather speak to someone familiar and close to the participant deterred her from seeking formal mental health care.

As reported in this section, self-help strategies include reaching out to relatives, partners, friends and others. These strategies were reported to act as a barrier to mental health service utilization. This barrier can be located within the microsystem of the participant's environment for the use of this study. Participants in the present study opened-up to friends, family and colleagues as an alternative to professional mental health treatment. Similar behaviour was detected among study participants of Abrams et al. (2009); Flynn et al. (2010); Kim et al. (2010); McIntosh (1993); and O'Mahen and Heather (2008).

In keeping with findings of Flynn et al. (2010), Lindiwe indicated that it was easier to open-up to her friends as such confidants never responded with judgement. Similar to findings reported by Kim et al. (2010), Thandi indicated that because she was unable to attend her scheduled counselling appointment due to employment-related problems, she reached out to a colleague for help. Although participants from both the present study and similar studies (Flynn et al., 2010; Kim et al., 2010) initially thought talking to a friend or relative would help ease their distress, in actual fact the relief was often momentary. Their problems persisted in the long run and still caused physical and emotional distress during their pregnancies.

Reasons proposed by the literature for this phenomenon include the fact that informal confidants were found to either respond by offering support or by reassuring the mother that all new mothers go through similar stress when they have a new baby. In this way, their responses may lead to a postponement of seeking professional care, as the mother tended to normalise her symptoms as normal post-pregnancy hormones or stress (Abrams et al., 2011). Present study results similarly emphasize how seeking informal advice from friends and family can deter participants from using formal mental health care. This barrier exists because confidants assured participants that their distress were normal responses to their new role as mothers and in this way deterred the participants from seeking professional help.

4.2.3. Mesosystem.

The mesosystem is the second system in the multi-levelled nested Ecological Systems Theory. The mesosystem is described as connections and influences that exist between the participant's microsystems. Strong linkages between the various microsystems may lead to positive development of the specific participant (Bronfenbrenner, 1979). For the purpose of this present study, the mesosystem includes community-related barriers.

4.2.3.1 Community-related barriers.

Community-related barriers refer to those factors that lie within the community that the participants are embedded in and that hinder appointment-keeping behaviour. The following issue will be discussed within the framework of community-related barriers: Stigma and pity.

4.2.3.1.1 "I didn't want people feeling sorry for me. I wanted to be strong."

Social stigma as a barrier to mental health care service utilization could be located within both the meso- and macrosystem. However, due to the nature of the stigma experienced by the study participants, i.e. stigma affecting their interpersonal relationships, this topic will only be discussed with regards to the system containing these relationships i.e. the mesosystem.

Lindiwe and Amy explained that a major reason for their distress experienced during their pregnancies was due to experiencing pity and stigma from people around them. Lindiwe was, prior to becoming pregnant, enrolled at a tertiary institution, was financially independent as she was working part-time, and was in a stable relationship. She commented on the manner in which the people around her reacted to her situation after she became pregnant:

That is the kind of thing that I see happening around me where some people feel sorry for me - “Ag shame”- and that’s what I hated the most. That’s why I felt depressed the most because I didn’t want people feeling sorry for me. I wanted to be strong.

This above-mentioned quotation indicates that sympathy from others with regards to her situation made the participant feel inadequate, as she wanted to prove to them that she could be strong and adapt to the new developments in her life. Instead she broke down into a depression. Although she was aware of the available counselling services at the hospital, and held a positive attitude towards counselling, she did not make use of these services. A possible reason for this might be because she was afraid of even more pity from those around her, expressed as: “People think counselling is a bad thing, that you’ve broken down that you that you are depressed when you go for counselling.”

Additionally, Amy experienced extreme distress during her pregnancy, because her partner refused to tell his parents that she was pregnant for more than seven months into her pregnancy. Possible reasons that she provided for this included: “he was scared of disappointing them”, “maybe they were going to reject him”, and “his father is like a very well-known person in the church. I think that can also be it, that he was scared that they would be ashamed, that we weren’t married.” However, she also added that her partner never told her the actual reason why he was unable to disclose the news of her pregnancy to his parents. One can therefore assume that all of these theories about the shame and rejection that her pregnancy might cause his family were simultaneously also the roots of her distress. This fear of bringing shame to her partner’s family might have been an influencing factor in her decision to reject mental health care.

Social stigma was thus seen as a major reason for the participants’ pregnancy-related distress and is discussed as a community-related barrier. Lindiwe specifically reported that her mental breakdown was directly related to perceived feelings of pity for her situation from

significant others in her life. These feelings of sympathy made her feel inadequate as a mother, similar to findings reported by Mauthner (1999) and Templeton et al. (2003). In this manner, social stigma acted as a barrier to seeking professional help. Additionally, present study findings together with findings reported by Abrams et al. (2011) and Kopelman et al. (2008) suggested that participants felt that seeking mental health treatment during and after pregnancy was regarded by others as having a breakdown and therefore being an incompetent mother. Stigma therefore plays a facilitating role in firstly initiating a breakdown on the mother's behalf, and then causing further distress due to the breakdown. Consequently, stigma had been reported to act as barrier to mental health care utilization.

In keeping with Parvin et al. (2004) and Templeton et al. (2003), another form of stigma reported in the present study was fear of disclosing the pregnancy status to in-laws. This was due to the concern of giving the family a bad reputation. In Amy's case, this was specifically due to the fact that the pregnancy was out of wedlock and the in-laws attained high status in their church. For this reason, she was forced by her partner to keep her pregnancy a secret from her in-laws for more than seven months. Consequently, this form of stigma can, firstly, cause major distress to the pregnant woman, which can act as barrier to treatment use in itself. Secondly, stigma can also act as a barrier to seeking professional help due to fear of giving the family a bad name.

Lastly, Abrams et al. (2011) and Alvidrez and Azocar (1999) found that women from ethnic minority groups experience significantly higher levels of stigma than their white counterparts. The present study did not allow for such a distinction to be made due to the fact that the sample consisted only historically Black women. However, feelings of embarrassment were detected from the participants. This was mainly due to the fact that participants, after finding out that they were pregnant, were reduced to being dependent on their families for housing, money, food, transportation and practical help with childcare. This

feeling of embarrassment might translate into fear of being judged and sympathized with by those around them, as they felt that they were independent self-standing individuals prior to the pregnancy. Stigma might also arise from the fact that pregnancies were often out of wedlock and partners had left the women to deal with the pregnancy on their own. Fear of stigma from these various sources, might lead to further fear of stigma in the mental health care environment. In this manner, fear of stigma might act as a barrier to seeking professional help.

4.2.4 Exosystem.

The Ecological Systems Theory describes the exosystem as containing linkages between the micro- and mesosystem, so that this system does not include the participant but rather influences her environment and experiences directly (Bronfenbrenner, 1979). Visser (2006) goes further to describe the exosystem as the organizational level of the patient's environment. For the purpose of this present study, the exosystem includes institution-related barriers.

4.2.4.1 Institution-related barriers.

Institution-related barriers refer to those factors within the mental health care facility that impact negatively on patients' appointment-keeping behaviour. The following issues will be discussed within the framework of institution-related barriers: (1) referral protocol barriers, (2) nurses' attitudes as experienced by participants, and (3) lack of information provided by the nurses.

4.2.4.1.1 Referral protocol barriers.

During a patient's first visit at Mowbray Maternity Hospital, she is assessed for depression and anxiety. The screening tools used are the Edinburgh Depression Scale and an 11-item

Risk Factor Assessment questionnaire devised by the Perinatal Mental Health Project. These pregnant women are then supposed to be referred for counselling based on the scores from these two measures. However, when the nurses failed to refer high-risk patients for counselling, it was associated with the inability of the patient to make use of the available counselling services at the hospital.

In the present study, Nomsu, Ayesha and Lindiwe were not referred for counselling services, even though their EDS scores and Risk factor Assessment scores indicated that they were at high risk for depression and anxiety. Lindiwe described her experience as follows:

The nurse gave me that form and she told me that I should fill it out confidentially, not with my boyfriend around. And I filled it out and I signed it. And she just told me that she was going to put it in my folder and that's all. Nobody told me why I was doing it; nobody told me that I would be called for something or nothing like that.

The above-mentioned quotation emphasizes the importance of explaining the scoring protocol followed to patients and the importance of follow-up thereafter. These steps are important in the face of diminishing the problem of non-adherence to scheduled counselling meetings.

Nomsu and Lindiwe reported that although they were phoned by a counsellor at the hospital, the counsellor merely asked them questions around their birth giving experiences and the problems or stress that they were currently facing in their lives. Nomsu indicated that the counsellor communicated to her that "if there's something wrong that I could go to her", although she never scheduled a formal counselling appointment for the participant.

On the other hand, Ayesha indicated that the counsellor phoned her "but she never phoned me back. And I was waiting on her call" as she "could do with speaking to someone." Similarly, Lindiwe also indicated that "there wasn't anybody that informed me to go for counselling and that we can make an appointment for you on such and such day." This was

especially problematic as Lindiwe emphasized the fact that she desperately needed treatment. These disclosures clearly indicate how a nurse that fails to explain the depression and anxiety scoring procedure and who fails to thereafter schedule counselling appointments for the appropriate patients, act as a barrier to patients utilizing the mental health services of the hospital.

After being assessed for depression and anxiety upon their first hospital visit, patients are sometimes only informed that their tests scores indicate a need for counselling after a few months have passed. During this time their crises that have caused the depression and anxiety in the first place, could have been resolved and they no longer have a need for counselling in their lives anymore. This phenomenon was therefore associated with non-compliance to scheduled counselling appointments.

Amy, Ayesha and Fatima indicated that if they had been referred for counselling immediately after being assessed for depression and anxiety, they would have made use of the treatment as they were experiencing crises during that time in their lives. Fatima reported that the referral process was too lengthy as “I think I needed to go see a counsellor two months ago.” Amy on the other hand felt that her crises had been resolved before the referral took place as she explained:

Seeing that we worked things out and everything was out in the air and *they [her in-laws]* knew about the pregnancy, I felt ‘Okay, why should I go when I’m happy?’ They know and I’m relieved so I didn’t need it [*therapy*] anymore.

None of these three participants wished to see a counsellor during the time that interviews were conducted for the present study, as they felt that their crises had been resolved. Even though Ayesha was never referred for counselling, when asked whether she would consider using counselling at the time that the interview took place she responded with the following: “I don’t know. I’m almost done with my pregnancy. I don’t know if I’m still going to need to

go to a counsellor.” However, Ayesha, Fatima and Amy experienced difficulties during their pregnancies. These difficulties may have been brought on by the stress related to the crises they were experiencing during their pregnancies. These examples therefore emphasize the importance of immediate intervention after depression and anxiety assessment has taken place.

Furthermore, Amy suggested that initiating a connection between the counsellor and the referred patients at their first visit to the hospital could accelerate the referral process. In this manner, the patient would know whom they would talk to when going for counselling. Patients would also gain a better understanding of what would happen during counselling and why counselling was important for them specifically. Amy voiced this idea in the following light:

The filling out the forms, that’s a good idea. But then maybe just speeding up the process, maybe coming when the person is actually visiting, having a visit, and get the counsellor to come personally and maybe just afterwards speak to the person. You know because that is basically how you lose them and not letting them come for their actual visit. You know what I’m trying to say. So, you maybe go to them when they are seeing the doctors or having their visit and maybe after their visit get to speak to them and maybe ask them how they feel about doing it now, so that they can basically see who they are going to speak to, ... So that they can maybe build a relationship before the actual meeting or visit or counselling session.

Participants reported that when the appropriate hospital referral protocol is not applied, it has been said to act as an institution-related barrier to mental health care service utilization. A common phenomenon reported by present study participants was failure on the nurses’ part to firstly explain what measurement scores meant, and secondly what counselling procedures

would entail in the face of referrals. Additionally, cases were reported where participants signified high depressive and anxiety scores but were not referred for counselling. These findings stand in contrast to the fact that participants voiced a great need for counselling at the time that they completed the depression and anxiety measurements, but were unaware of how to make use of the counselling services available at the hospital.

These findings are in keeping with Holopainen (2002) whose study results indicated that depressive pregnant women are often unsure of where to obtain appropriate mental health services. This is especially relevant to MMH where obstetric care and mental health care are offered at the same location. The present study together with Parvin et al. (2004) found that women were often reluctant to disclose their symptoms to the nurses and doctors as participants perceived it inappropriate to receive mental care from general practitioners who they felt should rather focus on physical care. Confusion therefore arose around where to attain mental health care in an institution that offers both obstetric and mental health care. Greater confusion existed in cases where the nurses failed to perform appropriate referral protocol and was a reported barrier to mental health care utilization by study participants.

Additionally, the present study together with Flynn et al. (2010) found that the process of entering mental health treatment is too extended. Present study participants were sometimes only informed that their tests scores indicated a need for counselling, after a few months have passed since their first visit to the hospital. During this time they either lost motivation to seek care or their crises, that caused the distress in the first place, had already been resolved. These participants therefore no longer had a need for counselling. This phenomenon was therefore associated with non-compliances to scheduled counselling appointments. Additionally, a need was voiced by both studies' participants for the referral process to be accelerated. This could be achieved by scheduling counselling appointments

immediately after being assessed for anxiety and depression in order to reduce non-compliance to scheduled appointments.

4.2.4.1.2 *“we all just want that comfort of knowing.”*

High anxiety levels experienced by patients in the face of counselling are partly related to not knowing what to expect of the process. This unfamiliarity with counselling is linked to a lack of information about the process provided by health care professionals in the hospital. In this manner, anxiety with regards to the counselling process was associated with non-compliance to scheduled counselling appointments.

Fatima and Amy voiced fear in the face of having to go for counselling. The reasons provided for this anxiety and nervousness was brought on by the fact that the nurse did not explain, firstly, why they needed to fill in the questionnaires that assessed their depression and anxiety levels. Secondly, anxiety was related to nurses' failure to disclose why patients were referred for counselling. Lastly, nurses also failed to explain what could be expected from the counselling procedure. To these participants counselling in itself was an “unfamiliar” territory. Fatima went even further to say that even if all of the above mentioned information was provided, the idea of having to go for counselling is still a fear evoking idea:

I mean anyone that wants to see a counsellor has got a problem, or not a problem per se, but they have an issue or something. So, just the fact that you have an issue or something relative that you need to see a counsellor, it's already a scary concept, is already a scary thought.

Fatima's counselling appointment was scheduled on the same day as her antenatal check-up, meaning that she was at the hospital at the time of her appointment. However, she still failed to attend her counselling appointment due to reported anxiety. Her anxiety was caused by the following unanswered questions she struggled with: “if I'm going to go for the counselling

session what's really going to happen? Will there be another one? Will they refer me to another hospital?" However, her fears could have been diminished if information had been provided that could have answered these questions on the counselling procedure. Ultimately, this participant felt that anxiety was the main reason that the hospital is experiencing an attendance problem to counselling appointments. She voiced this as follows: "at the end of the day what keeps them away is just the anxieties and also a level of fear because people don't know what to expect and people don't know what's going to happen thereafter."

Amy similarly reported that one reason why she failed to attend her counselling appointment was due to feeling nervous about it. She however offers an alternative solution to this problem as she suggests that the counsellor should introduce herself to the appropriate patient on her first visit to the hospital. She expressed this idea as follows:

So that they can maybe build a relationship before the actual...counselling session...and they know or get to be comfortable with the person that they will speak to. Because normally when you go for a visit the first time you are a bit uncomfortable and you know you're shy and stuff like that.

The above mentioned quotation suggests that meeting the main person who would be involved throughout the entire process of counselling and having the opportunity to ask specific questions about the process, is suggested to have a diminishing effect on the anxiety levels of referred patients. This extra step in the referral process could additionally have a diminishing effect on the problem of non-compliance to counselling appointments experienced by the hospital.

Participants experienced increased levels of anxiety due to a lack of information provided on counselling as treatment for depressive symptoms. Failure on health

professionals' part to provided appropriate information to participants was reported as an institution-related barrier to appointment keeping.

Anxiety due to a lack of information was detected among present study participants in the face of counselling. This was reportedly caused by a lack of information offered by the nurses with regards to the counselling process offered by the hospital. Fatima reported that she was at the hospital at the time that her counselling appointment was scheduled for, but failed to attend the appointment due to fear and unanswered questions regarding the process. In this way, anxiety due to a lack of information was associated with non-compliance to scheduled counselling appointments.

In related literature however, a lack of information that act as barrier to treatment seeking usually revolved around both perinatal depression symptomology and where to obtain appropriate treatment (Edge et al., 2004; Holopainen, 2002; Kim & Buist, 2005; Templeton et al., 2003). However, in the present study, participants were aware of and reported their depressive symptoms. They were also informed that they could obtain mental health treatment from MMH as all of the participants received obstetric care at the same hospital.

In the face of anxiety due to a lack of information related to obtaining mental health treatment, present study participants voiced a need to form a connection between themselves and the counsellor at their first visit to the hospital already. This finding was similar to findings of Flynn et al. (2010) who reported that participants expressed a need for an immediate connection with the on-site social worker at their first clinic visit. In this manner, the participant would become familiar with the counsellor and would have a better understanding of what would happen during counselling and why counselling was important for each participant specifically. This extra step in the referral process could lower patient anxiety levels in the face of the counselling process and may increase attendance thereof.

4.2.4.1.3 *“all they do is the physical part, and that’s it.”*

Some participants reported feeling displeased about the way that nurses treated them during their obstetric appointments. These negative participant perceptions of nurses’ attitudes towards patients were associated with whether they attended counselling appointments.

Ayesha and Lindiwe raised concerns about the way in which patients were treated at the hospital. Most of the participants felt that the medical or physical part of services offered by the hospital were excellent. However, these two participants particularly emphasized that when looking at the entire treatment package in a holistic manner, it lacked an emotional side.

Ayesha felt that the nurses are only interested in the mother’s body and the baby’s health, as she reported: “they only need to see you for scans and stuff like that.” She felt that nurses attended to set tasks and nothing more. Ayesha voiced her concern as follows:

Like some of the nurses can be rude and stuff... Just like, just in a moody way. Like if they’re busy with you they won’t do it in a nice, happy, jolly way. They’ll just be quiet and be like awkward and say okay there done... They won’t sit and speak to you and tell you ‘okay your baby is fine’. Like speak! Like we will speak now. They’re just busy; will tell you how your baby is, ‘okay your baby’s fine’, get up from the bed and there you go. See you at your next appointment.

The above-mentioned quotation emphasizes the strong need of the patient for nurses to also acknowledge her emotional pain or discomfort, instead of simply being concerned with her physical health.

Lindiwe raised a similar point when she said:

But I feel to a certain extent all that they do care about is the patient and the baby and not how the patient is feeling. So, I’d come every morning of the days of my appointments and the days that were scheduled and I’d get my treatment and they’d do everything that they needed to do and they do it very well, asking me if I’d taken my

pills, how am I feeling. But I don't think they were interested to know how I am actually feeling inside and not just about me and the baby's health. So, I feel that they are lacking in that.

Lindiwe also shared the need with Ayesha to be acknowledged as a human being with feelings and emotions and not simply as a body of a patient. However, Lindiwe took it a step further as she commented on the fact that because nurses hold a position of authority in the hospital system, patients do not feel have the confidence to speak to them freely about their situations. Lindiwe expressed her concern as follows: "like some nurses I think because she is an authority I don't know how to speak to her." This might be the same problem experienced by patients when being referred to a counsellor, which may deter patients from showing up for scheduled counselling appointments.

Lindiwe alternatively raised a need for an environment within the hospital structure where patients can interact with other patients who are going through similar experiences, such as "group sessions." She motivated a need for such a space with: "when people share stories it's a way of healing as well, to heal yourself." In this way, Lindiwe feels that patients can relate to one another, learn from others' experiences and become aware of the fact than they are not alone in their situation as many others are undergoing the same experience. Lindiwe expressed this need as follows:

They do need to have more sessions where, or maybe in group sessions with expecting mothers where they can all share their stories about how they are doing at the moment, where others are lacking, how they fell pregnant. So that we can hear others' experiences so that we can understand what we are all going through. We are all expecting children and we are not sure if it's our first child, how we are gonna feel, what is supposed to happen. Classes telling you what is going to happen after you've

give birth, what you should do. So, I think they need more of those because I was totally lost...Because sometimes when you hear about somebody else's pain you kind of feel that yours isn't that much.

In accordance with a broad literature body, the present study findings also emphasized the influence of the relationship between the patient and the health care professionals on appointment-keeping behaviour. A poor provider-patient fit was found to act as barrier to mental health service utilization (Abrams et al., 2009; Ahmed et al., 2008; Cook et al., 1999; Dennis & Chung-Lee, 2006; Kim et al., 2011; McIntosh, 1993; Parvin et al., 2004; Thome, 2003; Wells et al., 1990). This institution-related barrier is located within the exosystem of the participants.

Present study participants felt that although MMH offered excellent obstetric care to patients, the treatment package as a whole lacked an emotional side. This was especially true when referring to the nurses at the hospital. Dissatisfaction with mental health care is an important barrier to investigate in the face of appointment-keeping, as Cook et al. (1999) reported a poor patient-provider fit to cause a four times higher likelihood of receiving inadequate prenatal care. Furthermore, in keeping with Abrams et al. (2009), Ahmed et al. (2008), and McIntosh (1993), present study participants felt that the hospital nurses treated them in an impersonal manner. This viewpoint was due to the fact that nurses seemed to only focus on completing their tasks relating to physical care of the pregnant mothers. Nurses reportedly did not create a dialogue space for discussions of participants' emotional states. In addition to the care that they already received, participants voiced a need for nurses to also acknowledge their emotional distress, instead of only being concerned with their physical health and that of their unborn infants. Participants' beliefs that nurses are uncaring could have been translated to the notion that all health professionals are uncaring, and in this way acted as a barrier to counselling appointment keeping.

Additionally, due to the fact that nurses held a position of authority in the hospital, participants disclosed that they did not have the confidence to speak to them freely about their situations. This might be the same problem experienced by participants when being referred to a counsellor. Perceiving counsellors as being inaccessible might have caused participants to stay away from scheduled counselling appointments. Beliefs that mental health care professionals are not freely approachable can be overcome by addressing participants' concerns and emotional needs, or otherwise stated, treating participants as human beings with feelings and emotions instead of only a physical body under assessment.

In the face of the afore-mentioned barrier, findings of Abrams et al. (2009) and Ahmed et al. (2008) together with the present study, suggest a need for an environment within the hospital structure where patients can interact with other patients who are going through similar experiences. One example of such a structure reported by the present study participants was a need for group sessions. In this manner patients could relate to one another, learn from others' experiences and become aware of the fact that they are not alone in their situation as many others are undergoing the same experiences. Showing an interest in patients' emotional experiences could help overcome the perceptions that the health care setting is uncaring and could make mental health services more accessible to patients.

4.2.5 Macrosystem.

The macrosystem, according to the Ecological Systems Theory (Bronfenbrenner, 1979), differs greatly from the other levels, as it does not consist of any contexts that influence the participant's life directly. Rather, it refers to the cultural ideologies, norms, attitudes and values that set the stage for behaviour within a specific cultural group. This system is referred to as the "blue print" of the participant's society (Bronfenbrenner, 1994). While these laws

may be formal rules and regulations, most are implicit. For the purpose of this present study, the macrosystem includes poverty-related barriers.

4.2.5.1 Poverty-related barriers.

Poverty-related barriers refer to those factors that are closely related to socioeconomic status of the study participant and that impact negatively on their appointment-keeping behaviour. The following issues will be discussed within the framework of poverty-related barriers: (1) environmental life hardship (2) constant child-care demands, and (3) transportation barriers.

4.2.5.1.1 Financial life hardship.

Financial life hardship can be described as participants being over-whelmed by financial stress and unemployment (either of herself or her husband). These circumstances were associated with the participant's inability to adhere to scheduled counselling appointments.

Fatima and Lindiwe elaborated on the fact that they were financially independent and therefore stable prior to becoming pregnant. Lindiwe described her situation as follows:

I was really very stable in the sense [that I had] my own bed, I was financially independent and I had a good relationship with work and the people at my work...I drove my own car and you know I had you know all of those nice little things.

Lindiwe, who was also a tertiary student at the time that she became pregnant, described her situation as follows: "even when I was at university I got a part-time job, I worked at the same time. So, I made my own money, I was a very independent girl." From these disclosures one can see that both participants were proud of the fact that they could stand on their own two feet and did not rely on anyone for money.

However, after becoming pregnant and breaking-up with their partners, both participants' situations shifted to being unemployed, moving back to their parents' homes and being financially dependent on their parents. Lindiwe said that "the only stress in my life at

the moment is the fact that I'm not working" and for this reason she would "go on the internet to look for a job" on a daily basis.

Participants therefore reported experiencing a great deal of stress that revolved around trying to recover the independence that they had prior to becoming pregnant. This was especially true for the older participant, Fatima. The inability to take care of themselves financially led to reported feelings of worthlessness and depression that further complicated appointment-keeping behaviour.

In relation to this sense of failure linked to where participants were at the time of their lives, compared to where they had hoped to be, Thandi elaborated on her disappointment when comparing her life to her peers':

When I look at other children they have cars, houses, better jobs. And me, you know, I have children, that is all I have and I'm working hard for them. It makes me feel like I'm a loser in life.

Strong feelings of regret when reflecting back on her life, created a sense of hopelessness for the future – "there are days you feel like you just don't want to be anymore...there are days you are looking for what to go on."

This disjuncture that existed between where participants were at the time of their lives, compared to where they had hoped to be, brought about feelings of failure within the participants. Feelings of failure were intensified when comparing themselves to their more independent and financially stable peers. Strong feelings of regret were evoked when reflecting back on their lives and created a sense of hopelessness for the future. In this manner, these confounding financial life hardships acted as barriers to mental health service utilization.

Lastly, both Thandi and Nomsu identified leave-related problems as barriers to mental health care utilization and Amy was unable to meet face-to-face for the present study interview, as she was unable to get off from her work. Thandi worked in the housekeeping industry and travelled by train from Franschhoek to MMH. She was only able to attend appointments at the hospital on her off days, as it would take her an entire day to travel to the hospital and back. She further indicated that if unexpected guests turned-up she was unable to take planned leave, as they would then rather demand her assistance at the guest cottage. This was also the case on the day that she had a scheduled counselling appointment, as she explains: “that day there was guests since I told you I was working in housekeeping so they couldn’t let me go, you know.”

Nomsu similarly explained that on the days that she had an obstetric appointment at the hospital she would “wake up early in the morning so that I maybe 10’o clock 9’o clock I can go to work.” This quotation shows that the participant attempts to schedule her appointments in such a way that she would miss as little as possible of a day’s work. This might be due to payment restrictions or fear of being fired from work. She further reports that the fact that her husband was unemployed at the time that the interview took place, restricted the freedom with which she felt she could make appointments at the hospital: “Coz sometimes if I think of coming to the hospital, like I’ll be thinking I have to go to work because my husband isn’t working at the moment.”

In keeping with findings from Flynn et al. (2010) and McIntosh (1993), the present study also found leave-related issues to complicate appointment-keeping behaviour. Participants reported that they were only able to attend scheduled counselling appointments either on their off days (that were not set in stone due to the nature of their work e.g. in the hospitality sector) or early in the mornings in order to avoid missing work. Reasons provided for this included fear of payment restrictions or being fired from work. This was especially

true in the cases where participants were the sole breadwinners of their families. In this manner, employment instability and leave-related problems acted as barriers to mental health service utilization in the present study.

Like so confounding financial life hardship acted as a barrier to mental health service utilization in two important ways. Firstly, participants were left feeling that treatment would not be effective, as it does not address their financial problems that caused the stress in the first place. Secondly, employment issues left participants in a situation where they did not have enough freedom and time to attend counselling appointments.

In the broad literature (Abrams et al., 2011; Anderson et al., 2006; Cook et al., 1999; McIntosh, 1993) life hardships caused by financial distress have been related to a viewpoint that treatment would not be effective as it does not address those external factors that caused the distress in the first place. This point relates strongly to Maslow's hierarchy of needs theory (1954) that depicts the desire for basic physical needs to be addressed before mental health needs. Otherwise stated, needs associated with food and shelter, a steady and reliable income, and a safe living environment take priority over mental health care needs. The present study reports findings that are in line with the previous mentioned points and places these poverty-related barriers within the macrosystem of the participants.

4.2.5.1.2 "it's just baby from the time I open my eyes to the moment I close my eyes."

Logistical barriers are closely related to the socioeconomic position of the participants and include constant child-care demands and lack of practical support. These factors were associated with the participants' inability to adhere to scheduled counselling appointments.

Mothers in the present study reported on constant childcare demands. When asked to describe a normal day in their lives, the majority of the participants described how they would, from the moment that they wake-up to the moment that they go to bed at night, attend

to the needs of their babies. Fatima, however, was the only participant to clearly identify constant child-care demands as a barrier to mental health service:

It's get up, attend to the baby. If the baby sleeps I usually take my time to do his washing. And you know do something related to the baby. And then he wakes up again and then it's playtime, and then it's feeding time and then it's bath time. So it's just baby from the time I open my eyes to the moment I close my eyes...Ja, baby world.

Ayesha was the only participant in the present study sample that was still pregnant during the interview and even she indicated that "the first thing that I think about is the baby and I think is the baby okay."

It further came to light that those participants who were still practically supported by the partners, had to train the partners to help out with duties that revolve around taking care of the baby, such as bathing, feeding, changing nappies, etc. Due to the fact that these partners initially thought childcare was mostly a role that the mother filled, many conflicts revolved around child-care duties. Amy, when asked to describe the relationship between herself and her husband, explained: "we don't see eye to eye on certain things like cleaning and sometimes helping...there's times that he comes home and then he wants to play games and that sometimes upset me." Thandi also explained that due to the amount of time and energy that a baby requires from its parents she had to train the father of her baby to help her with child-care demands: "I had to train him you know. You have to look after the baby, you have to help me feed the baby, you have to help me change the nappy, and stuff like that." This was owing to the fact that she could not cope with all the child-care demands by herself.

Similar to findings reported by Alvidrez and Azocar (1999), Flynn et al. (2010), and O'Mahen and Flynn (2008), the present study therefore found constant child-care demands to be associated with failure to attend scheduled counselling appointments and will be discussed in accordance with the macrosystem. As expected of a new mother, participants described

their days being arranged completely according to childcare demands. Very often, these mothers had no partner support and relied on their own mothers and other relatives for practical help with childcare demands. As their normal routines had been completely re-arranged according to the new demands that a baby brings, mothers often had time for little else, including attending counselling appointments. In this manner constant child-care demands together with a lack of partner support acted as a barrier to utilizing mental health care services.

4.2.5.1.3 “I don’t know if I will have transport.”

The last mentioned logistical barrier is that of transportation restrictions. Most participants in the study at hand did not own their own vehicles. Restriction to transportation was therefore associated with failing to attend scheduled counselling appointments, on the participants’ behalf.

Only Lindiwe was able to drive herself to the hospital upon her first visit. The rest of the participants either relied on their relatives and partners for transportation, or on public transportation and walking. When relying on others for transportation, participants had to fit in with the drivers’ schedules. For that reason Ayesha indicated that if asked to attend counselling the following day, the only thing that would stop her was “I don’t know if I will have transport” as her mother brought her for her first appointment at the hospital.

Thandi, who travelled by train to the hospital, indicated that this means of transportation was difficult. She was also worried that “since I had problems before with premature baby I was scared that anything could happen.” This quotation indicates that public transportation might not be entirely safe for single pregnant women to use. For this reason and the previous mentioned example, transportation restrictions had a debilitating effect on

appointment-keeping behaviour of the participants in the present study. This barrier is discussed in accordance with the macrosystem below.

Transportation restrictions reported by present study participants acted as a barrier to appointment keeping. This finding was in keeping with findings reported by a large body of literature (Abrams et al., 2009; Alvidrez & Azocar, 1999; Cook et al., 1999; O'Mahen & Flynn, 2008; Rosen et al., 2004). Reasons provided for this included firstly that when participants were reliant on others for transportation, their scheduled counselling appointments could easily interfere with the drivers' own schedules. Also, in accordance with Flynn et al. (2010), participants often relied on public transportation, such as trains and minibus taxi's, or walking as a means of transportation. Some of the participants perceived these transportation means as difficult and unsafe to use when travelling as a single pregnant woman.

As only one participant, Lindiwe, was able to drive herself to the hospital for appointments, the present study sample experienced transportation restrictions as a barrier to counselling appointment keeping. However, it is interesting to note that the same problem was not experienced when participants had obstetric appointments as participants attended all of these appointments. Transportation might therefore only be one of the reasons why participants missed their counselling appointments, as barriers are often multi-causal (McIntosh, 1993)

4.3 Limitations of Study

Limitations posed by this study could be attributed to the data collection stage. Firstly, interviews were initially set out to be conducted face-to-face. However, due to logistical, mental health related, and other barriers, the majority of potential participants were unable to

meet in person. The data collection framework was then adjusted in order to accommodate all participants who agreed to be a part of this study.

However, telephonic interviews seemed to produce dialogues of lower quality than those produced from face-to-face interviews. Reasons for this include inability of the researcher to read and react to participants' body language and facial expressions; inability to ensure privacy of the conversation; and difficulty with hearing and therefore having to repeat questions and answers up to four times, causing frustration on both the interviewer's and interviewee's part. Creswell (1998) reported similar limitations. All of the above mentioned obstacles related to telephonic interviews brought about restrictions to the natural flow of the conversations and ultimately the quality of participants' responses.

On the other hand, Sturges and Hanrahan (2004) reported that telephonic interviews might increase potential participants' willingness to take part in the study, in cases where the topics of interest are sensitive because they evoke feelings of embarrassment. Present study results show that due to stigma and pity, some study participants felt embarrassed about their situations. For this reason, including telephonic interviews as potential mode of data collection increased the number of participants who were willing to participate. For this reason telephonic interviews can also be perceived as a strength of the study at hand.

4.4 Recommendations for Future Research

The present study explored patients' perspectives on barriers to counselling attendance. Future research could, in addition to interviews with hospital patients, include health care professionals (nurses, midwives and psychologists) and focus groups, as this will allow for triangulation of the perspectives of all significant players.

Having identified the problems and concerns with regards to attending counselling appointments, future research direction may be aimed at reducing the identified barriers to mental health care service use. For example, an investigation into how group sessions for depressive pregnant patients could potentially minimise institution-related barriers and lack of social support should be considered. By doing so, this form of therapy might be included in the treatment package offered by PMHP, if found that it acts as facilitator to attendance behaviour.

4.5 Study Impact

The results of the qualitative analysis provided necessary data regarding the perceived barriers that participants deem important when considering whether or not to enter the counselling process. This study addressed the psychological, behavioural, social, institution-related and poverty-related barriers to appointment keeping experienced by high-risk depressive patients of MMH.

4.6 Conclusion

Through face-to-face and telephonic interviews with patients from MMH a range of barriers to mental health care service utilization were identified. The main themes identified were associated with individual-related barriers, social-related barriers, community-related barriers, institutional-related barriers and poverty-related barriers. Semi-structured interviews with participants allowed for flexibility to explore recurrent themes that emerged during these interviews. The discussion of these main themes and their related subthemes were considered within the framework of Bronfenbrenner's (1979) Ecological Systems Theory and is visually illustrated in Appendix E. Although these barriers were different, the various systems in the participants' environments were interconnected. The need for interventions was highlighted

by research, in keeping with the fact that change in any of the systems would consequently lead to change in the participants' attendance behaviour.

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Appendix A

1. The reason I contacted you is that you made an appointment to see a counsellor at Mowbray Maternity Hospital. The nursing staff referred you to counselling because you filled in a questionnaire about how you were feeling, and they thought you might need some help. I am interested to know any reasons you may have had for not going to that appointment.
2. Can you please describe your everyday life to me? This description may include tasks, obligations, formal or casual employment.
3. Can you please tell me about what your travel arrangements were when you went to Mowbray Maternity Hospital when you completed the questionnaire about how you were feeling?
 - a) What prevented you from coming to the counselling session using that method of transport?
4. What changes can be made that would help you to get to the counselling appointment?
5. Was there anything different in your life at the time that you had the counselling appointment compared to when you completed the questionnaire?
6. When you made the appointment it seems as if you thought you could attend the appointment. What, if anything, changed? Can you tell me as much about this as possible?
 - a) Did your mood improve or get worse? If it did, how did it change?
7. Even though you said that you wanted the appointment, did you feel that you needed it?

8. Have you received help elsewhere? If so, where or from who?

9. What levels of support do you have available to you?
 - a) Financial support
 - i. Were you employed when you were pregnant? What maternity benefits, if any, did you receive?
 - ii. Does the father of your child support you financially?
 - iii. Do your parents support you financially?
 - iv. Do you have any other forms of financial support?
 - b) Practical support
 - i. Does the father of the child assist with childcare (e.g. feeding, changing nappies, putting the child to bed, etc.)?
 - ii. Do you have any other help with respect to childcare?
 - iii. Does anyone help you with housework?
 - c) Emotional support
 - i. Do you have someone you can talk to about your emotions?
 - ii. Do you prefer to talk to medical personnel about your emotions?
 - iii. Do you prefer to talk to a religious or spiritual leader about your emotions?
 - d) Do you feel that your family members are supporting you?
 - e) Do you feel that your friends are supporting you?

10. Is there anything related to the service at Mowbray Maternity Hospital that prevented you from attending your appointment. If so, what were they?
 - a) Who did you think you were coming to speak to at the appointment?

- i. Did you understand the difference between HIV counselling and the PMHP counselling?
- b) Were you helped and given a questionnaire in a language other than your first language?
If so, did you feel that there were any misunderstandings between you and the hospital staff?
- c) Did the nurse or midwife who referred you to the counsellor explain why you were being referred? What explanation were you given?

11. Were you able to attend all your antenatal check-ups? If not, what prevented you from attending? If so, what was different about going to a counselling appointment?

12. Do you know anyone who has made use of mental health services (in your family, community, friend circle)? What do you think your family and friends thoughts are of people who need help with mental health issues? What are your thoughts?

Appendix B

Ethical Approval: Western Cape Department of Health

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FINMICE

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DEPARTMENT of HEALTH

Provincial Government of the Western Cape

STRATEGY & HEALTH SUPPORT

healthres@pgwc.gov.za
tel: +27 21 483 9907; fax: +27 21 483 9895
1st Floor, Norton Rose House, 8 Rebeck Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: RF 96/2011
ENQUIRIES: Dr V Appiah - Bolden

Ryneveld street,
Martha Hof number 9,
Stellenbosch,
7600

For attention: Jessica Laubscher,

Re: Barriers to perinatal mental health care

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact the following people to assist you with any further enquiries.

Mowbray Maternity Hospital Prof Sue Fawcus (021) 659 5578

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (healthres@pgwc.gov.za).
3. The reference number above should be quoted in all future correspondence.

We look forward to hearing from you.

Yours sincerely

DR T NALEDI
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 22.08.2011

Appendix C

Ethical Approval: Stellenbosch University Sub-Committee A



UNIVERSITEIT-STELLENBOSCH-UNIVERSITY
jou kennisvenoot • your knowledge partner

12 August 2011

Tel: 021 - 808-9183
Enquiries: Sidney Engelbrecht
Email: sidney@sun.ac.za

Reference No. 575/2011

Ms J Laubscher
Department of Psychology
University of Stellenbosch
STELLENBOSCH
7602

Ms J Laubscher

LETTER OF CONDITIONAL ETHICS CLEARANCE

With regard to your application, I would like to inform you that the project, *Barriers to Perinatal Mental Health Care*, has been approved on condition that:

1. The researcher will remain within the procedures and protocols indicated in the proposal, particularly in terms of any undertakings made in terms of the confidentiality of the information gathered.
2. The research will again be submitted for ethical clearance if there is any substantial departure from the existing proposal.
3. The researcher will remain within the parameters of any applicable national legislation, institutional guidelines and scientific standards relevant to the specific field of research.
4. Any notes and/or amendments are submitted to the office of Mr. Sidney Engelbrecht (sidney@sun.ac.za / 021 808 9183) at the Division for Research Development, Stellenbosch University.
5. The researcher will consider and implement the foregoing suggestions to lower the ethical risk associated with the research.
6. The researcher will submit the letters of permission from Mowbray Maternal Hospital and the Provincial Department of Health to Mr. Sidney Engelbrecht (sidney@sun.ac.za / 021 808 4622) of the Division for Research Development, Stellenbosch University.

Best regards



MR SF ENGELBRECHT

Secretary: Research Ethics Committee: Human Research (Non-Health)



Afdeling Navorsingsontwikkeling • Division for Research Development
Privaat/Private Bag XI • Matieland 7602 • Suid-Afrika/South Africa
Tel: +27 21 808 9184 • Faks/Fax: +27 21 808 4537
www.sun.ac.za/research

Appendix D

Ethical Approval: Perinatal Mental Health Project



Perinatal Mental Health Project
Centre for Public Mental Health
Department of Psychiatry & Mental Health, University of Cape Town
46 Soutwest Road, Building B, Rondebosch 7700, Cape Town, South Africa
Tel: +27 (0) 21 689 6590
Fax: +27 (0) 66 542 2613
Website: www.pmhproject.co.za
Email: simonethonikman@networld.co.za

Research Ethics Committee
University of Stellenbosch

26 July 2011

To Whom It May Concern:

**Ethics approval for Jessica Laubscher's M.A research
"Barriers to Perinatal Mental Health Care"**

The Perinatal Mental Health Project hereby endorses Jessica Laubscher's research project – Barriers to perinatal mental health care – based at the Perinatal Mental Health Project's (PMHP) site at Mowbray Maternity Hospital.

The PMHP was launched in September 2002 at Mowbray Maternal Hospital with its main goal to provide mental services at the same location where women receive obstetric services. We are aware that a number of women who are offered mental health services after screening, and who have accepted it, do not attend their scheduled sessions or any other follow-up sessions that are arranged.

As a means to overcome this problem, Jessica's research goal is to investigate, through interviews with the women who defaulted all their appointments, what the barriers are that prevent these women from not using the available mental health services.

I understand that Mr Zuhayr Kafaar of your Department of Psychology, will provide the appropriate supervision and training to complete this project in a successful manner. Furthermore, I believe that she will be trained in the appropriate skills to undertake this project in a compassionate and confidential manner.

Sincerely

Dr Simone Honikman MBChB (UCT) MPhil (MCH)(UCT)
Project Director

Appendix E

Ethical Approval: Mowbray Maternity Hospital



DEPARTMENT
of HEALTH

Provincial Government of the Western Cape

OBSTETRICS / GYNAECOLOGY

stlawcus@pgwc.gov.za
tel: +27 21 659 5578; fax +27 21 685 2991
Mowbray Maternity Hospital
12 Hamsey Road
Mowbray
7700
16 August 2011

To
Ms J. Laubscher
Department of Psychology
Stellenbosch University

Dear Ms, Laubscher

Re: Barriers to perinatal Health Care. – Research project MA (PSYCHOLOGY)

Permission is granted for you to conduct the above study at Mowbray Maternity Hospital,
Provided the University of Stellenbosch REC criteria are adhered to.

Thank you.

Professor S.R. Fawcus (MBBS FRCOG)
Head Obstetric MMH
Associate/Professor
Department: Obstetrics/ Gynaecology
University of Cape Town