

**Depressed women's emotional experiences of the mother-child relationship:
Perspectives from a low-income South African community**

Marleen Lourens

Thesis presented in fulfilment of the requirements for the degree of Master of Arts
(Psychology) at Stellenbosch University



Supervisor: Prof. Lou-Marié Kruger

April 2014

The financial assistance of the National Research Foundation (NRF) towards this research is hereby acknowledged. Opinions expressed and conclusions arrived at, are those of the author and are not necessarily to be attributed to the NRF.

Declaration

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Date: 30 October 2013

Abstract

The present research study formed part of a larger longitudinal project concerned with low-income South African women's subjective experiences of depression (Lourens & Kruger, 2013). The present study specifically focussed on how depressed women experienced their relationships with their children. The study aimed to provide a descriptive overview of how one group of depressed South African mothers experience their relationships with their children, as well as to compare the findings with existing literature. Therefore, the scope of this study does not include in-depth analyses of findings.

While numerous researchers have examined and identified the important negative effects of depression in mothers on children during the past decade, a very limited number of studies have been focussed on the opposite direction of the depressed mother-child relationship. Very few studies have explored how relationships with their children may influence the development and subjective experience of depression and emotional distress in mothers, as well as, on the other hand, may protect against depression and emotional distress (Dix & Meunier, 2009; Greig & Howe, 2001; Leung & Slep, 2006; Rishel, 2012; Turney, 2012). The present study attempted to address this gap in the literature.

The feminist social constructionist perspective was utilised as theoretical framework (De Vos, Strydom, Fouché, & Delpont, 2011). Consistent with social constructionism, the study was conducted within the qualitative research paradigm (De Vos et al., 2011). Convenience sampling was used to recruit participants most suitable for the aims of the study (*APA Dictionary of Psychology*, 2007).

Data were collected by means of in-depth semi-structured interviews. A semi-structured interview schedule was utilised as data collection instrument. Each interview was recorded by video camera, as well as by voice recorder, in order to ensure back-up recordings. The interviews were then transcribed. Social constructionist grounded theory was used to analyse the data (Charmaz, 1995).

The results indicated that the depressed women and children in this study seem to be different from the stereotype of the depressed mothers and children in the literature. Depressed mothers are typically portrayed in the literature as not able to form a close and secure bond with their children, while the children of depressed mothers are almost always portrayed in the literature as showing behavioural and emotional problems, as well as being "parentified" (Coyne & Thompson, 2011; Dix & Meunier, 2009; Turney, 2012). Although the depressed women in the present study did report child factors which contributed to their

depression, they - to the contrary - also emphasised that their children are an important protective factor against their experience of depression. The participants also highlighted that they have the ability to be protective, supportive and caring towards their children, despite their depressive symptoms. The majority of depressed women also described a “very good” mother-child relationship. As such, the participants in the present study showed us a brighter picture of the depressed mother-child relationship.

Opsomming

Hierdie navorsingstudie het deel gevorm van 'n groter longitudinale projek wat op lae-inkomste Suid-Afrikaanse vroue se subjektiewe ervarings van depressie gerig was (Lourens & Kruger, 2013). Die huidige studie was spesifiek gerig op hoe depressiewe vroue hul verhoudings met hul kinders ervaar. Hierdie studie het ten doel gehad om 'n beskrywende oorsig te voorsien van hoe een groep depressiewe Suid-Afrikaanse vroue hul verhoudings met hul kinders ervaar, asook om die bevindinge te vergelyk met bestaande literatuur. Om hierdie rede sluit die omvang van hierdie studie nie 'n diepgaande analise van bevindinge in nie.

Terwyl talle navorsers die belangrike nuwe-effekte van moeders se depressie in terme van hul kinders gedurende die laaste dekade ondersoek het, is 'n baie beperkte aantal studies op die teenoorgestelde rigting van die depressiewe moeder-kind verhouding gerig. Slegs 'n paar studies het hoe verhoudings met hul kinders die ontwikkeling en subjektiewe ervaring van depressie in moeders kan beïnvloed, ondersoek, of daarteenoor, hoe dit die moeder kan beskerm teen depressie (Dix & Meunier, 2009; Greig & Howe, 2001; Leung & Slep, 2006; Rishel, 2012; Turney, 2012). Die huidige studie het gepoog om hierdie gaping in die literatuur aan te spreek.

Die sosiaal konstruksionistiese feministiese perspektief is as teoretiese raamwerk gebruik (De Vos, Strydom, Fouché, & Delport, 2011). In ooreenstemming met sosiale konstruksionisme, is hierdie studie binne die kwalitatiewe navorsingsparadigma uitgevoer (De Vos et al., 2011). Gerieflikheid steekproeftrekking is gebruik om die mees gepaste deelnemers vir die doelstellings van hierdie studie te werf (*APA Dictionary of Psychology*, 2007).

Data is deur middel van in-diepte semi-gestruktureerde onderhoude ingesamel. 'n Semi-gestruktureerde onderhoudskedule is as data-insamelingsinstrument gebruik. Elke onderhoud is op videokamera, sowel as op band opgeneem, ten einde meer as een opname van elke onderhoud te verseker. Die onderhoude is getranskribeer. Data-analise het plaasgevind deur van sosiale konstruksionistiese gegronde teorie gebruik te maak (Charmaz, 1995).

Die resultate het aangedui dat die depressiewe vroue en hul kinders in hierdie studie verskil van die stereotipe van depressiewe moeders en hul kinders in die literatuur. Depressiewe moeders word in die literatuur tipies voorgestel asof hulle nie in staat is om 'n naby en veilige binding met hul kinders te vorm nie, terwyl die kinders van depressiewe

moeders amper altyd in literatuur met gedrags- en emosionele probleme voorgestel word (Coyne & Thompson, 2011; Dix & Meunier, 2009; Turney, 2012). In teendeel – alhoewel die depressiewe vroue in die huidige studie wel gerapporteer het dat hul kinders bydra tot hul depressie – het hulle ook klem geplaas op die feit dat hul kinders ‘n belangrike beskermende faktor is teen hul ervaring van depressie. Die depressiewe vroue het ook beklemtoon dat hulle die vermoë het om beskermend en ondersteunend teenoor hul kinders te wees, ten spyte van hul depressiewe simptome. Die meerderheid deelnemers het ook ‘n “baie goeie” verhouding met hul kinders beskryf. As sodanig, het die depressiewe vroue in die huidige studie vir ons ‘n helderder prentjie van die depressiewe moeder-kind verhouding getoon.

Acknowledgements

To my loving family and friends (especially Mom, Dad, Elené, Jean, Ouma and Oupa, Megan, Guzelle) – thanks for your diligent support throughout this year and for keeping believing in me.

To Christi – thanks for your continuous love and encouragement – especially during the moments when everything felt too much.

To Prof. Lou-Marié Kruger for sharing your expertise with me, as well as all your guidance during this year. I feel privileged to have had you as my supervisor.

To the National Research Foundation and the Ithemba Foundation for their financial contribution to this study – without you the study would not have been possible.

To all on the staff at the local community clinic – thank you so much for helping me with the recruitment of the participants.

To Aunt Sienna at the local community centre – thanks for your warm and friendly welcome and for providing a venue for the interviews.

Sincere thanks to all the women who participated in the research study – I sometimes wanted to cry with you and at other times I laughed with you. Thank you for accepting me and welcoming me into your world.

“Now to Him who is able to do immeasurably more than all we ask or imagine, according to His power that is at work within us, to Him be glory...” – Ephesians 3:20

Table of Contents

Declaration	ii
Abstract	iii
Opsomming	v
Acknowledgements	vii
Table of Contents	viii
List of Tables	xiii
Chapter 1: Introduction	1
1.1 Literature Review	4
1.1.1 The impact of depression in mothers on children	4
1.1.1.1 Parenting style	4
1.1.1.2 Attachment style	5
1.1.1.3 Modelling	5
1.1.1.4 Biological pathways	6
1.1.2 Depressed mothers' subjective experience of their children and the mother-child relationship	6
1.2 Research Rationale	7
1.3 Research Questions	7
1.4 Research Context	8
1.5 Research Aims and Objectives	8
1.6 Outline of Subsequent Chapters	9
Chapter 2: Theoretical Framework	10
2.1 Social Constructionist Perspective	10
2.2 Feminist Perspective	11
2.3 Social Constructionist Feminism	12

Chapter 3: Literature Review	14
3.1 Traditional Conceptualisations of Depression in Women	14
3.2 Social Constructionist Feminist Perspective on Depression in Women	15
3.3 Overview of Literature on Depression in Women in South Africa	15
3.3.1 Phenomenological manifestations	16
3.3.2 Epidemiological studies	17
3.3.3 Studies concerned with the causes of depression	18
3.3.4 Correlational pathways	19
Chapter 4: Methodology	21
4.1 Design	21
4.2 Participants	22
4.3 Data Collection, Instruments and Procedures	25
4.4 Data Management	25
4.5 Data Analysis	25
4.6 Ethical Considerations	27
4.7 Validity	27
Chapter 5: Results and Discussion	30
5.1 The Impact of Children on their Depressed Mothers	32
5.1.1 Child qualities and behaviour that contribute to depression in women	32
5.1.1.1 Child behavioural problems	33
5.1.1.1.1 Child's substance abuse	33
5.1.1.1.2 Child's criminal behaviour	36
5.1.1.1.3 Teenage pregnancy	36
5.1.1.1.4 Child's disobedience	37

5.1.1.2 Child personality	38
5.1.1.3 Child with a disability	39
5.1.1.4 Loss of a child	44
5.1.1.5 Child as a reminder of previous abusive relationship	44
5.1.2 Child qualities and behaviour that protect against depression in women	46
5.1.2.1 Attuned child	46
5.1.2.2 Understanding child	47
5.1.2.3 Child as source of pleasure and hope	47
5.1.2.4 Protective child	50
5.1.2.5 Comforting child	50
5.1.2.6 Partnering child	51
5.1.2.7 Loving child	52
5.1.2.8 Dependent child	53
5.1.2.9 Child as God-given gift	54
5.1.3 “Very good” mother-child relationship	54
5.1.3.1 Child as communicator	55
5.1.3.2 Child as help	56
5.1.3.3 Physical closeness	57
5.1.3.4 Strong bond between the mother and her child	57
5.2 The Impact of Depressed Mothers on their Children	58
5.2.1 Feelings that depressed women have vis-à-vis their children	59
5.2.1.1 Feeling isolated	60
5.2.1.2 Feeling stuck or trapped	61
5.2.1.3 Feeling overwhelmed	63
5.2.1.4 Feeling stressed	63
5.2.1.5 Feeling irritated	65
5.2.1.6 Feeling disappointed in themselves	66

5.2.1.7 Feeling resentment towards child	67
5.2.1.8 Feeling detached from child	67
5.2.1.9 Feeling guilty	68
5.2.1.10 Feeling protective towards child	70
5.2.1.11 Feeling attuned, understanding and loving towards child	71
5.2.2 Behaviours that depressed women display vis-à-vis their children	73
5.2.2.1 Unresponsiveness, abandonment, neglect and withdrawal	73
5.2.2.2 Physical aggression or violence	74
5.2.2.3 Verbal aggression	78
5.2.2.4 Self-sacrificing behaviours	79
5.2.2.5 Motivational behaviours	79
5.2.2.6 Supportive behaviours	80
5.2.2.7 Coping behaviours	81
5.2.3 Women's perceptions of the impact of their depression on their children	82
5.2.3.1 Depressed women's perception of the impact of their depression on the mother-child relationship	83
5.2.3.1.1 Misunderstandings and disconnection	83
5.2.3.1.2 Child withdrawal	84
5.2.3.1.3 Child anxiety	84
5.2.3.1.4 Modelling	86
5.2.3.1.5 Closeness	87
5.2.3.1.6 No impact on mother-child relationship	88
5.2.3.2 Depressed women's perception of the impact of their depression on parenting	89
5.2.3.2.1 No impact on mothering role	89

5.2.3.2.2 Inadequate mothering	90
5.2.3.2.3 Uninvolved mothering	91
5.2.3.2.4 Substitute mothering	91
5.2.3.2.5 Compromised discipline	92
5.2.3.3 Depressed women's perception of the impact of their depression on the child him/herself	94
5.2.3.3.1 Impact on emotions and behaviour	94
5.2.3.3.2 Impact on development	97
5.2.3.3.3 Impact on personality	98
Chapter 6: Conclusion	101
6.1 Limitations	109
6.2 Future Studies	109
References	110
Bylae A: Semi-gestruktureerde Onderhoudskedule	131
Appendix A: Semi-structured Interview Schedule	134
Bylae B: Ingeligte Toestemmingsvorm	137
Appendix B: Informed Consent Form	140
Appendix C: Transcribed Interview	144
Transcription Conventions	191

List of Tables

Table 1: Demographic Details of Research Participants	24
Table 2: Two Main Categories and Their Associated Subcategories	31

1. Introduction

The *Diagnostic and Statistical Manual for Mental Disorders* (DSM-5) (American Psychiatric Association, 2013) defines major depressive disorder (MDD) as a depressive disorder in which a person experiences at least five of the following symptoms over a two-week period: a depressed mood, a loss of interest in pleasurable activities, changes in appetite and weight, changes in sleeping and activity patterns, a lack of energy, feelings of guilt, difficulty in making choices and to think, as well as recurrent thoughts of death and suicide. International and South African epidemiological studies have shown consistently that women are almost twice as likely as men to develop depression (Accortt, Freeman, & Allen, 2008; Burke, 2003; Kessler, 2003; Ngcobo & Pillay, 2008). The World Health Organization (2006) identified depression as the largest cause of disease-related disability among women worldwide (Lafrance & Stoppard, 2006; Tomlinson, Swartz, Cooper, & Molteno, 2004). In a South African epidemiological study conducted in a peri-urban setting by Tomlinson, Grimsrud, Stein, Williams, and Myer (2009), the prevalence of depression among female respondents was significantly higher than that among male participants, with South African women being 1.75 times more likely to develop depression during their lifetime than South African men. Differences between the sexes regarding the manifestation and rates of depression are also evident in sub-Saharan Africa (Tomlinson, Swartz, Kruger, & Gureje, 2007).

Mental health problems, including depression, are responsible for a large part of the disease burden in low-income communities worldwide (Havenaar, Geerlings, Vivian, Collinson, & Robertson, 2008). Numerous South African and international studies have shown consistently that depression is more prevalent among persons with low or no income when compared to high-income individuals (Belle, 1982; Elliot & Masters, 2009; Lazear, Pires, Isaacs, Chaulk, & Huang, 2008; Levy & O'Hara, 2010; Kub et al., 2009; Nadeem, Lange, & Miranda, 2009). Low-income communities largely consist of households in which the members who are able to work, are unemployed or earn such a low income that it is very difficult for them to provide in the basic needs of their family members, or to sustain a family as a whole (Preston-Whyte, 1991). Having said this, it is clear that women from low-income communities are extremely vulnerable to the development of depression, making this an important area in which to generate current local knowledge that may contribute to a more nuanced understanding of depression in mothers in the South African context (Burdette, Hill, & Hale, 2011; Elliot & Masters, 2009).

Depression is particularly prevalent in women during their childbearing and child-rearing years (ages 16 to 53), resulting in a large number of children worldwide who have mothers suffering from depression (Belle, 1982; Burke, 2003; Dix & Meunier, 2009; Lazear et al., 2008; Rishel, 2012). Around the world, women mostly are the main caregivers of children. This means that much research has been conducted on the possible detrimental impact of depression of mothers on children (Burke, 2003). Research showed that depression in women does not only have a major impact on women themselves, but also has a significant impact on women's interpersonal relationships with their children, their husband or partners, other family members, as well as the relationship with the wider community (Burke, 2003; Greig & Howe, 2001; Rishel, 2012; Turney, 2012). Research claims that children of depressed women are at increased risk of social, cognitive and psychological deficits and child abuse. They are also at risk for developing depression or other psychiatric illnesses such as conduct disorder (Burke, 2003). An increase in marital conflict within families of women suffering from depression may also leave children with an elevated risk of a negative outcome (Burke, 2003).

The epidemiological literature thus clearly suggests that women, especially low-income women in developing countries, are at risk for developing the mental illness called depression. However, feminist researchers, such as Ussher (2010) and Stoppard (2000) have been critical of this literature and has problematized depression as a psychological construct. They state that the biomedical definition of depression, as contained in the DSM-5, may be problematic in the sense that it denies a variety of perspectives regarding the understanding of depression, as well as women's subjective experiences of depression and the impact of their social contexts. As such, attention is diverted from what feminist researchers regard as the causal source of depression, namely, the social and political conditions in the society (Dukas, 2009). According to them, women's subjective understanding and experience of their psychological distress, within their social and political contexts, are explicitly denied (Stoppard, 2000; Ussher, 2010). Therefore, feminist researchers emphasise the importance of understanding how women themselves experience their psychological distress (Ussher, 2010), if effective and appropriate psychological services are to be developed. They specifically highlight the fact that very few studies regarding depression actually take into account women's own descriptions of their experience of distress, as well as their own social contexts (Cosgrove, 2000; Dukas, 2009; Inhorn & Whittle, 2001; Lafrance & Stoppard, 2006; Ussher, 2010). As a result, existing psychological services to mothers with depression may not always take into account the subjective concerns and experiences of depressed women,

which may lead to the ineffectiveness of such services and the women not coming back for further psychological help (Lourens & Kruger, 2013).

In a comprehensive review of the South African literature (the only one that exists), Dukas (2009) found that, despite the prevalence of depression among women in South Africa, there is a paucity of research regarding depression from the perspective of women themselves. Subsequently, our research team at the Psychology Department of the University of Stellenbosch embarked on a longitudinal qualitative research project specifically aimed at the exploration of the different subjective emotional experiences of women with depression in a low-income, semi-rural community in South Africa (Lourens & Kruger, 2013; Taylor, 2011). In our preliminary studies we found that the participants, who were low-income adult women, identified the following factors as impact on the development and experience of psychological distress: physical abuse as a child, relationship problems with a husband or partner, loss of a child or significant others, as well as problematic relationships with their own children (Lourens & Kruger, 2013). The narratives of the participants in the 2011 study suggested that they themselves considered problematic relationships with significant others as an integral part of their distress or depression: it seemed to be both a stressor and a buffer. This finding seemed to merit further investigation as it seemed to have implications for psychotherapeutic interventions.

The present study aimed to provide a descriptive overview of how one group of depressed South African women, who also happened to be mothers, experienced their relationships with their children. More specifically, I explored how the relationship with their children, in the experiences of the mothers themselves, may have contributed to, as well as may have protected against women's experience of emotional distress and, conversely, how they themselves perceived their emotional distress to impact on their relationships with their children, their parenting and on their children themselves. As such, the study investigated one of the factors that depressed women in the first stage of the study regarded as pivotal, not only in the development of depression, but also in their subjective experience of depression. As the current study is an overview, it will not be possible to discuss all the emerging categories in depth. It is hoped that this study will play a role in the proposal and development of more appropriate therapeutic interventions for mothers with depression and their children in low-income South African communities.

Although the construct of depression as defined in the DSM-5 will be utilised for the purposes of the present study, we also need to be very critical of this definition of depression. The operational definition of depression as contained in the DSM-5 can be described as

categorical, since this definition allows clinicians to identify individuals as depressed or not depressed. On the other hand, depression may also have a more dimensional aspect, according to which depression can vary in terms of severity - from mild neurotic depressive symptoms to severe psychotic symptoms (Cole, McGuffin, & Farmer, 2008).

1.1 Literature Review

The vast majority of literature regarding mothers with depression and the relationship between the depressed mother and her child, emphasises the detrimental effect of depression on children (including child developmental problems, child problem behaviour, child emotional problems, learning difficulties, insecure attachment and impaired social skills), as well as how the child's problem behaviour and emotional experiences may contribute to the mother's depression (Flykt, Kanninen, Sinkkonen, & Punamäki, 2010; Lazear et al., 2008; Najman et al., 2001; Treutler & Epkins, 2003).

In this section I specifically review the prominent notions in existing literature regarding the negative impact of women's depression on their children. In addition, I report on literature regarding depressed women's experience of their children, since the current study is specifically interested in how the way in which depressed women experience their relationships with their children, may contribute to or may protect against the development and experience of depression.

1.1.1 The impact of depression in mothers on children.

It is a well-established fact that depression in mothers poses a risk to healthy child development. Currently, research is more focused on the specific ways in which the depressive symptoms of women may impact on the healthy development of their children (Flykt et al., 2010). Four main theories regarding the impact of depression in women on their children can be discerned in the literature. These theories respectively focus on parenting style, attachment style, modelling and biological pathways.

1.1.1.1 Parenting style.

The notion that depressed women may have decreased ability in effectively parenting their children, compared to women with no symptoms of depression, is supported by extensive literature (Dix & Meunier, 2009; Rishel, 2012; Turney, 2012). In their review of the affective, motivational and cognitive processes that might be responsible for the negative effect of depressive symptoms on parenting, Dix and Meunier (2009) found that depressive

symptoms compromise parenting skills, because these symptoms reduce attention to the child and child-oriented goals; increase negative appraisals of the child; increase high negative emotion towards the child; and increase positive evaluations of coercive parenting.

Depressive symptoms in mothers are also associated with ineffective discipline, including disciplining methods that are inconsistent, manipulative, physical and harsh (Burke, 2003; Dix & Meunier, 2009; Jacob & Johnson, 1997; Leung & Slep, 2006; Lovejoy, Graczyk, O'Hare, & Neuman, 2000).

Feng, Shaw, Skuban, and Lane (2007) highlighted that impaired parenting in depressed women may take place through two different pathways. First, the depressed mother may be likely to express more negative affect and less positive affect toward her child (Feng et al., 2007). Second, depressed mood may lower mothers' responsiveness and sensitivity to their children's needs (Feng et al., 2007).

1.1.1.2 Attachment style.

The most prominent literature regarding the pathway through which depression in women may have a detrimental effect on child development, is the negative interactional style associated with depression (Edhborg, Lundh, Seimyr, & Widström, 2001). Mother-child interaction has been identified as a key factor in the development of behavioural and emotional problems, including depression, in the children of depressed women (Kim-Cohen, Moffit, Taylor, Pawlby, & Caspi, 2005; Rishel, 2012). A negative maternal interactional style may include that the depressed mother experiences difficulties in understanding her child's needs, as well as in responding to the basic needs of her child in good time (Donovan, Leavitt, & Walsh, 1998; Leadbeater, Bishop, & Raver, 1996).

1.1.1.3 Modelling.

Women with depression have been described in the literature as expressing more withdrawal, flat affect and negative feelings (Dix, Gershoff, Meunier, & Miller, 2004; Herrera, Reissland, & Shepherd, 2004). Research has showed that children of depressed women are likely to mimic their mother's interactive style, which may include showing lower responsiveness, as well as less positive and more negative emotions when compared to children without a depressed parent (Flykt et al., 2010). In addition to their more negative interactive behaviour, the behavioural signals of children of depressed women are also more difficult to interpret, which may lead to the development of a vicious cycle of mutual rejection between the depressed mother and her child, which may aggravate both the

mother's experience of depression and child problem behaviour (Hoffman & Drotar, 1991; Murray, Stanley, Hooper, King, & Fiori-Cowley, 1996).

1.1.1.4 Biological pathways.

Several possible biological pathways for the intergenerational transmission of emotional problems between depressed women and their children have been suggested. It has, for instance been postulated that children of depressed women may be genetically predisposed to stress responses. This may leave them more vulnerable to negative environmental influences associated with a depressed parent (Field, Diego, & Hernandez-Reif, 2006; Flykt et al., 2010). Also, the unborn baby of a depressed mother may be exposed to harmful physiological effects, including an increase in heart rate, a delay in growth, low birth weight and prematurity (Field et al., 2006).

1.1.2 Depressed women's subjective experience of their children and the mother-child relationship.

The existing literature regarding depressed women's emotional experiences of their children is surprisingly sparse. In a study by Coyne and Thompson (2011), which focused on depression in the mother as a predictor of the internalisation of problems in pre-schoolers, it was found that mothers with high depressive symptoms are very likely to feel out of control with their parenting role, including feeling out of control with their children's behaviour and their children's emotional states. They found that this lead the depressive mother to adopt passive emotion coping strategies, failing to model appropriate emotion regulatory strategies for her children, and to be unable to effectively help her children to regulate their negative emotional states (Coyne & Thompson, 2011). In numerous cases, it also resulted in the child internalising his or her emotional problems (the child may, for example, experience depression himself or herself) or in externalising his or her emotional problems in the form of problematic behaviour (Coyne & Thompson, 2011; Dix & Meunier, 2009). This in itself would mean that women, who are already depressed, have to deal with child problem behaviour and child internalised emotional problems. This, in turn, aggravated the negative emotions of the depressed mother, thus contributing to a vicious cycle (Dix & Meunier, 2009).

Although children's behaviour problems and internalised emotional problems appear to contribute and influence mothers' experience of depression, relatively few studies have investigated how depressed women themselves experience their children's behavioural and

emotional problems (Dix & Meunier, 2009). Elgar, Curtis, McGrath, Waschbusch, and Stewart (2003) indicated that depression increases the risk of behaviour and adjustment problems in children of depressed women (including disturbances in the child's social functioning, aggression and hyperactivity), but the problematic behaviour and emotions of children may simultaneously increase mothers' depressive symptoms. The reciprocal relationship between the experience of depression in women and the behavioural and emotional problems of their children has been reported consistently in clinical studies, but has not yet been adequately investigated in community samples (Dix & Meunier, 2009).

In conclusion, it is clear that the negative impact of women's depression on their children has been studied extensively. However, relatively little attention has been paid to the impact of children on the emotional distress and depression of their mothers. More specifically, the ways in which the mother-child relationship may serve as a buffer against mothers' subjective experience of depression (Siefert, Finlayson, Williams, Delva, & Ismail, 2007) has not been studied adequately.

1.2 Research Rationale

Although numerous researchers have written about how depressed women have a negative impact on their children, few studies have focussed on how the mother-child relationship impact on women's depression and emotional distress (Dix & Meunier, 2009; Flykt et al., 2010; Greig & Howe, 2001; Leung & Slep, 2006; Lovejoy et al., 2000; McMahan, Barnett, Kowalenko, & Tennant, 2006; Rishel, 2012; Turney, 2012). Also, no studies could be found in which depressed women themselves reflected on how they experience their emotional distress to impact (or not) on their children. The present study is an attempt to address these gaps in the literature. It is hoped that this will play a role in the proposal and development of more appropriate and effective therapeutic interventions for depressed women and their children.

1.3 Research Questions

Considering the abovementioned gaps in the literature, the following research questions were explored:

- How does one group of depressed women from a semi-rural South African community subjectively experience their relationships with their children?

- How do the depressed women themselves experience the relationships with their children to contribute to and protect against the development and experience of their emotional distress?
- How do the depressed women themselves perceive their emotional distress to impact on their relationships with their children, their parenting and on the children themselves?

1.4 Research Context

A semi-rural low-income coloured¹ community in the Western Cape has been identified as an appropriate social context that meets the aims of the proposed study. Coloured and black women from low-income communities are highlighted in the literature as extremely vulnerable to depression (Burdette et al., 2011; Elliot & Masters, 2009).

1.5 Research Aim and Objectives

The present study forms part of a larger longitudinal project concerned with low-income women and depression. The larger project aims at developing a better understanding of low-income South African women's subjective experiences of depression, with the idea that such an understanding is pivotal in the development of more effective and appropriate psychological services to the specific target group (Lourens & Kruger, 2013). This specific study, concerned with depressed women's relationships with their children, had the following aims:

- To investigate how one group of depressed South African women experience their relationships with their children.
- To explore how the depressed women experience the relationships with their children to impact on the development and experience of their emotional distress.
- To explore how the depressed women themselves perceive their emotional distress to impact on their relationships with their children, their parenting and on the children themselves.

¹ Coloured: Term used in the South African Population Registration Act of 1950 (now repealed) to describe persons of mixed racial origin (Rumble, Swartz, Parry, & Zwarenstein, 1996). Although continued political controversy exists about the use of the term, racial categories are socially constructed and, as such, they still carry a lot of social meaning in post-Apartheid South Africa. Jewkes, Abrahams, and Mvo (1998) argue that it is impossible to conduct meaningful psychological research within the post-Apartheid South African context, without referring to the racial categories previously used, since they still influence existing power relations. Having said this, the term 'coloured' will be utilised in the present study to refer to South Africans of mixed and diverse racial origins.

For the purpose of this study the term “depressed women” will be used to indicate women who have been diagnosed with suffering from a major depressive disorder as defined by the American Psychiatric Association (1994; 2013).

1.6 Outline of Subsequent Chapters

In Chapter 2 the theoretical points of departure of the present study are discussed, with specific reference to the feminist social constructionist perspective. As is the case with most qualitative designs, especially those using grounded theory, Chapter 3 only provides a preliminary literature review. Appropriate existing literature is incorporated into the results and discussion chapter (Chapter 5), which enables the researcher to compare the findings with the literature. The methodology used in this study is discussed in detail in Chapter 4, after which the results of the study and the discussion thereof in terms of existing literature follows in Chapter 5. Chapter 6 includes the concluding remarks, recommendations, as well as the limitations of the study.

2. Theoretical Framework

The **feminist social constructionist perspective** was utilised as theoretical framework, according to which all observations and data are organised and analysed (De Vos, Strydom, Fouché, & Delpont, 2011). It was thought that this theoretical perspective will facilitate a deeper understanding of the subjective perspectives of the depressed women themselves (Cosgrove, 2000; Ussher, 2010).

2.1 Social Constructionist Perspective

Essentially, social constructionism is based on the philosophical assumption that human beings make sense of their experiences through language (Ngcobo & Pillay, 2008; White, 2004). Language is seen as constructive - the medium through which the social world develops (Macleod, 2002). For example, the social constructionist viewpoint specifically emphasises that gender is socially constructed and focuses on the identification of the subtle and various complex ways in which gender is “produced” (Cosgrove, 2000, p. 249).

The social constructionist perspective also emphasises that knowledge cannot be generated independently of values (Charmaz, 1995). The social and political context of an individual, especially the values which are honoured in a specific context, can have a major influence on the individual’s stance with regard to a specific topic (Charmaz, 1995). If the role of social and political contexts are ignored in the development of psychological research, the resulting knowledge will invariably be over-simplistic, biased and prejudiced (Stoppard, 2000).

White (2004) suggested that human beings construct “frameworks of meaning” (p. 11) in order to make sense of a specific situation or the world. Beliefs, knowledge, world views, narratives and theory are all regarded as ways of making sense of different kinds of human experience (White, 2004). White (2004) highlights that, whatever the situation, humans have their own linguistic symbols and subjective interpretations as means for constructing meaning or forming an understanding, which shape their interaction or action.

According to White (2004), human beings interact with their environment and with other human beings by attaching meaning to a situation or an object, otherwise any interaction or action would be pointless or meaningless. Meaning making is therefore necessary for purposeful human interaction or action (White, 2004).

The study of human beings in different cultural, historical and geographical contexts has demonstrated that the construction of meaning can take place through limitless

differential ways (White, 2004). Research, using a social constructionist approach, is focussed on the identification of the numerous different ways in which human beings construct their social reality in order to identify the further implications for human interaction, practice and experience (Willig, 2001).

2.2 Feminist Perspective

According to Shefer (2008), the term feminist research refers to all research focussing on women's subordination in patriarchal societies. The common component of all feminist research is to challenge the unequal power structure that exists between men and women (Shefer, 2008). Within the feminist perspective, depression in women is conceptualised as the result of the interaction between women's social, political and economic marginalisation (Lafrance & Stoppard, 2006). This perspective also emphasises that knowledge about the experience of depression is mainly constructed by men and, as a result, the subjective experiences of women are explicitly denied (Dukas, 2009; Willig, 2001). This may not only further exacerbate inequalities between men and women in society, but may also hamper the development of more effective therapeutic techniques, which are especially focussed on the needs and concerns experienced by women with depression.

Gergen (2008) suggested that "at its core, feminist research is designed to seek social justice, to enhance women's voice and influence in society, and to explore alternative ways of understanding the world through women's experiences" (p. 280). For many feminist researchers, the lived experiences of women, for example as mothers, wives or employees, become the basis for investigating the nature of women's subjective experiences (Gergen, 2008).

It is also important to highlight the fact that various forms of feminism exist, including liberal feminism, radical feminism, cultural feminism, socialist feminism, women of colour feminism, lesbian feminism, transnational and postcolonial feminism, third-wave feminism, as well as postmodern feminism (Charvet, 1982; Enns, 2010).

According to Enns (2010), liberal feminism, radical feminism, cultural feminism and socialist feminism mainly informed earlier feminist practices. These forms of feminism tried to attribute gender inequality to single causes (Enns, 2010). **Liberal feminism** identified gender socialisation as the single cause of gender inequality in the society, while **radical feminism** underscored the patriarchal structure of the society as the main cause of the inequality between genders (Enns, 2010). **Cultural feminism** looked to the devaluation of women's opinion as the main cause of their oppression (Enns, 2010). On the other hand,

social feminists proposed a holistic and integrated analysis of gender inequality (Enns, 2010). As such, social feminism highlights the important interconnections that may exist between rigid gender socialisation (accentuated by liberal feminism), women's exploitation and the patriarchal structure of the society (standpoint of radical feminism) and racism (emphasised by women of colour feminism) (Enns, 2010).

Women of colour feminism accentuates and describes how race, sexual orientation, class, gender, and other social identities directly influence the daily lived experiences of women (Enns, 2010). Women of colour feminism claims to be a more complex approach than models which only focus on common or universal struggles experienced by women (Enns, 2010). **Lesbian feminists** are activists who challenge heterosexism and motivate women to define equal gender relationships outside of the patriarchal structure of the society (Enns, 2010). **Transnational and postcolonial feminism** is essentially based on the view that the oppression of women transcends far beyond national boundaries and is formed by numerous factors, including culturally embedded gender roles, class and economic conditions, cultural values, religion and health practices (Enns, 2010). **Third-wave feminists** mostly include women from younger generations who are committed to a wide variety of human rights movements and are willing to take action (feminism of action) to protect these rights, including access to adequate health care and the right to vote (Enns, 2010).

Postmodern feminists highlight the importance of a questioning mindset regarding "common" knowledge, especially knowledge which claims that reality and identity can be understood as stable or universal (Enns, 2010). Postmodern feminists claim that concepts such as "identity" and "reality" are socially constructed in the context of power relationships and historical events, and reproduced by means of language (Bohan, 2002; Enns, 2010). Lastly, social constructionist feminism, which forms the theoretical framework of the present study, is discussed below.

2.3 Social Constructionist Feminism

Social constructionist feminists utilise both the abovementioned social constructionist and postmodern feminist perspectives to form their understanding of depression in women. As such, the social constructionist perspective provides the epistemological basis for their understanding, as well as informs their critique of positivistic perspectives to depression research (Stoppard, 2000). By means of their postmodern feminist standpoint, social constructionist feminists strive towards the validation of women's experiences of depression, while simultaneously asking questions about how their depressive experiences are understood

and explained (Stoppard, 2000). In this way, social constructionist feminists want to investigate women's own accounts of their lived experiences of depression, in order to offer less-stigmatising and more affirming ways to understand women's experiences of depression (Stoppard, 2000).

According to social constructionist feminists, the way the word depression is used by women on a daily basis and the meaning they attach to it have not been sufficiently investigated (Stoppard, 2000). Social constructionist feminists, like Stoppard (2000), explain that the way in which the woman may report her experiences to a health care professional becomes a construction of symptoms in the context of the interaction between the woman and the health care professional. Although both the patient and the professional are participants in the clinical interview, the professional's understanding and perceptions of the woman's experiences take priority in determining a diagnosis of depression (Stoppard, 2000). Therefore, it is of the utmost importance to investigate women's subjective experiences of their depression and emotional distress, in order that health care professionals may develop a better understanding of depressed women's experiences (Stoppard, 2000).

Social constructionist feminists further emphasise that the social and cultural context of the depressed woman (including the often neglected political, economic and structural conditions) should form the background of the health care professional's interpretation of the interaction that takes place during the clinical interview (Stoppard, 2000). In this way, the health care professional may form a more holistic understanding of the depressed woman within her own social and cultural context.

To conclude, social constructionist feminists highlight that it is of the utmost importance for researchers and health care professionals to consider the following, if more adequate and appropriate interventions for depressed women are to be developed: (a) women's own accounts of their lived experiences of depression; (b) less-stigmatising and more affirming ways to understand women's experiences of depression; (c) the neglect of the political, economic and structural conditions in women's lives; and (d) the social and cultural context of women's everyday lives (Stoppard, 2000).

3. Literature Review

The main goal of this chapter is to provide an overview of existing South African literature regarding depression in women – especially mothers in South Africa. In other words, the focus will be on how psychological researchers conceptualised and wrote about depression in South African women over the past fifteen years (1998 – 2013).

In line with social constructionist grounded theory, the literature concerned with categories that emerged during data analysis will be discussed in the results and discussion chapter (Chapter 5) (De Vos et al., 2011).

In this chapter traditional conceptualisations of depression in women is discussed, followed by a discussion of the social constructionist feminist perspective on depression. The rest of the chapter will provide an overview of the recent South African literature (1998 to 2013) on depression in women.

3.1 Traditional Conceptualisations of Depression in Women

Three theoretical models have traditionally informed the study of depression in women: the psychological model, the socio-cultural model and the bio-medical model (Dukas, 2009; Ussher, 2010). Within these positivistic models, depression is conceptualised as a naturally occurring pathology in women caused by cognitions, life stress or biological factors (Ussher, 2010). The positivistic research paradigm view depression as a phenomenon internal to women, which implies uniform measurable symptoms in all depressed women despite their diverse social contexts (Ussher, 2010).

Psychological explanations highlight the different ways in which men and women react to stress (Lafrance & Stoppard, 2006). According to this model, higher rates of depression in women can be attributed to the tendency in some women to react more passively to stress when compared to men. For example, some women tend to dwell on their problems, rather than to take action to solve those problems (Nolen-Hoeksema, 2000).

Although the **socio-cultural model** conceptualises depression in women in terms of the social context in which women find themselves, with specific focus on poverty, violent intimate relationships, alcohol misuse and disease (Kagee, 2008; Kehler, 2001; Ramchandani, Richter, Stein, & Norris, 2009), this model still views depression as an individual state with uniform measurable symptoms.

According to the **bio-medical model**, depression in women is conceptualised as a disease occurring within the individual, as a result of, for example, genetic influences or

hormone instability (Pretorius-Heuchert & Ahmed, 2001; Ahmed & Pillay, 2004). Within the South African context, the bio-medical model is dominant in depression research.

3.2 Social Constructionist Feminist Perspective on Depression in Women

Within the social constructionist feminist paradigm, traditional positivist conceptualisations of depression are criticised. According to these social constructionist feminists, traditional positivist conceptualisations obscure the social and political contexts within which women become depressed (Lafrance & Stoppard, 2006; Ussher, 2010). This results in the pathologizing of individual women (Lafrance & Stoppard, 2006; Ussher, 2010). These researchers maintain that high levels of poverty, and sexual and other forms of abuse, as well as the gender role of care giving and performing household tasks, have all been identified as important contributing factors to the high rates of depression among women, and especially among mothers (Lafrance & Stoppard, 2006). Social constructionist feminist researchers further emphasise that the traditional positivist conceptualisations of depression in women may lead to biological reductionism, which may deny women's unique subjective experiences of depression (Cosgrove, 2000; Inhorn & Whittle, 2001). These feminist researchers have also criticised some psychological explanations of depression as "over-generalised and over-simplified" (Marecek, 2006, p. 298).

In the present study, while participants were diagnosed as clinically depressed by mental health workers, the feminist critique of the diagnosis of depression will be kept in mind. We will thus consider how children impact on the emotional distress of women and how the emotional distress of women impact on children – subsequently avoiding using the problematic construct of depression.

3.3 Overview of Literature on Depression in Women in South Africa

In her feminist social constructionist analysis of existing literature regarding depression in South African women, Dukas (2009) reviewed research on this topic published between 1998 and 2009. Dukas (2009) maintained that the research could be categorised as follows: research concerned with the phenomenological manifestation of depression; epidemiological studies; studies concerned with the causes of depression; studies concerned with correlational pathways; and treatment or prevention studies. Dukas' categorisation of depression research was utilised in this current follow-up review of the literature (2009 – 2013).

3.3.1 Phenomenological manifestations.

Within the field of psychiatry, phenomenology is understood as the clinician's identification and study of psychological symptoms and signs to develop an understanding of the individual's internal experiences (Sadock & Sadock, 2007).

In their review of the literature regarding the manifestations of depression in women in sub-Saharan Africa, Tomlinson et al. (2007) found that South African women with depression are likely to express their symptoms in a somatic manner – for example in the form of bodily sensations or aches – which may hamper the diagnosis of depression and subsequent treatment and/or therapy. This is in contradiction with developed Western contexts, where depression in women are typically expressed in the form of 'traditional symptoms', as contained in the DSM-5 (American Psychiatric Association, 2013).

The study by Rapmund and Moore (2000) forms part of a limited number of South African studies that regard depressed women themselves as experts on their own depression (Dukas, 2009). Rapmund and Moore (2000) conducted in-depth qualitative interviews with South African women who were diagnosed with depression, in order to explore how they subjectively experienced their depression. The constructionist approach that was utilised in their study allowed and invited the female participants to tell their own stories of depression (Rapmund & Moore, 2000). Rapmund and Moore (2000) highlighted that these stories provided an alternative reality to the traditional view of depression in women. The main themes that emerged from the participants' stories were that they felt as if they were torn into two different directions, as well as that they felt stuck most of the time, resulting in them feeling hopeless (Rapmund & Moore, 2000). According to the participants, their feelings of being stuck and without hope, maintained their depression (Rapmund & Moore, 2000).

Lochner (1999) conducted a qualitative study to investigate the ways in which psychological distress was articulated by South African female farm workers. Lochner (1999) analysed the verbal and non-verbal communications used by the participants to express their distress. Her main aim was to identify the specific discourses of the women's distress (Lochner, 1999). She was able to identify six distress discourses, namely: silence, the reporting and description of behaviour, somatisation, creation of narratives, use of idiomatic speech, and psychologisation (Lochner, 1999). Participants also reported that they articulated their distress by shouting, swearing and the use of physical violence (Lochner, 1999). Lochner concluded that traditional measures of depression, such as the BDI, may not fully capture all women's subjective experiences of distress (Lochner, 1999).

The fact that only a few South African studies have explored the subjective experiences of depression and emotional distress, from the perspectives of women themselves, is problematic. Clinical studies regarding phenomenology of depression highlight that South African women from specific races and classes may experience their depressive symptoms differently compared to depressed women in more developed countries (Dukas, 2009; Ngcobo & Pillay, 2008). This means that interventions are not specifically based on depressed South African women's own needs, experiences and understandings and are not as effective as they could be.

3.3.2 Epidemiological studies.

Epidemiology refers to the study of the prevalence, incidence, duration, distribution and determinants of a disease or mental illness (Sadock & Sadock, 2007). Epidemiological studies can also be used to compare the prevalence and incidence rates of diseases cross-culturally, as well as internationally (Sadock & Sadock, 2007).

Regarding the prevalence of depression in South Africa, Pillay and Kriel (2006) found that 21% of the 422 female participants in their study met the diagnostic criteria for depression. The participants of their study consisted of women with mental health problems who have attended district clinics in Pietermaritzburg (South Africa).

Stein et al. (2008) conducted a nationally representative household survey among South African adults from all ethnic groups between 2002 and 2004. They found that major depression was the DSM disorder that occurred second most (9.8 %) during the lifetime of South Africans. Tomlinson et al. (2009) specifically reported that the prevalence of depression among South Africans was significantly higher among female respondents, with women being 1.75 times more likely to experience depression over their lifetime, compared to men.

The possibility also exists that the higher rates in the diagnosis of depression among women may be partly due to the fact that, worldwide, women make more use of psychological services, compared to men (World Health Organization, 2006). For example, in a study conducted by Petersen (2004) regarding psychological services on primary level in South Africa, it was found that women (above 30 years of age) formed 86.1% of the patients who attended psychological consultations at a primary health care facility.

While the incidence, duration, distribution and determinants of depression in women are not yet well established in South African literature, the findings regarding the prevalence

of depression in South African women indicate that the international phenomenon of women showing a higher risk of developing depression over their lifetime, when compared to men, is also apparent in the South African context. It is therefore of the utmost importance to specifically investigate and explore South African women's experiences of their depression.

3.3.3 Studies concerned with the causes of depression.

In their study on the impact of social factors on the development of post-natal depression in women living in Khayelitsha (a low-income community in Cape Town, South Africa), Tomlinson et al. (2004) found a post-natal depression prevalence rate of 34.7 % among female participants. This rate was almost three times as high as the rate expected internationally (Tomlinson et al., 2004). Although Tomlinson et al. (2004) identified poverty as an important risk factor for the development of depression in female respondents, they also emphasised that this risk factor should rather be considered in combination with other psychosocial risk factors, including stressful life events, lack of support from family and family size.

In a study by Kehler (2001) regarding the experience of poverty among South African women, it was found that low-income women's limited access to resources, opportunities and education, is further exacerbated by unequal social and economic rights in their patriarchal family contexts, which may explain why women experience poverty more intensively than men (Dukas, 2009; Kehler, 2001). Given Kehler's (2001) viewpoint, namely that South African women's life experiences are strongly determined by race, class and gender-based access to opportunities and resources, it is possible that black and coloured low-income women may experience a double oppression in South Africa (Dukas, 2009). According to Dukas (2009), this may be due to the fact that they are female, as well as of colour. This might form a possible explanation for why women in low-income communities, especially black and coloured women, are more susceptible to depression than women in middle- and high-income communities (Burdette et al., 2011; Elliott & Masters, 2009; Havenaar et al., 2008; Levy & O'Hara, 2010; Nadeem et al., 2009; Stewart et al., 2010).

Moultrie and Kleintjes (2006) utilised existing epidemiological and etiological data in their overview of South African women's mental health difficulties, rather than women's own subjective explanations. The psychosocial explanations for the high prevalence of depression among South African women identified by Moultrie and Kleintjes (2006) included: gender inequality, violence, sexual abuse, HIV, poverty, unemployment,

overcrowded housing, crime and a lack of adequate service delivery. It is interesting that these factors did not emerge as significant in our own study concerned with women's subjective experiences of depression (Lourens & Kruger, 2013). Our initial findings demonstrated that depressed women identified the following factors, which according to their perspectives, contributed to the development and experience of their depression: their own negative experiences as a child (especially physical abuse); relationship problems (including the infidelity of a husband or partner); effects of a divorce (including single parenting and financial problems); the loss of a child and/or other loved ones; and various problems with children (including substance or drug misuse and school refusal) (Lourens & Kruger, 2013). It seems that all these factors are related to interpersonal relationships (Lourens & Kruger, 2013).

The larger implication is, however, that women's subjective experience of the causes of their depression seem to differ from causes reported in the majority of existing research, namely bio-medical factors and social factors (including poverty, race, abuse, deprivation and gender) (Dukas, 2009; Rapmund, 1999; Rapmund & Moore, 2000).

3.3.4 Correlational pathways.

Avan (2010) specifically investigated the association between depression in the mother and child problem behaviour and the growth of a child at two years of age, by means of a longitudinal cohort study in Johannesburg (South Africa). Avan (2010) found that depression in mothers was significantly correlated with child problem behaviour at two years of age, independently of the socio-economic status of the household. Children of the depressed women also showed an increased risk for stunted growth when compared to the children of non-depressed women (Avan, 2010). Avan (2010) found that the correlation between mothers' depression and child problem behaviour was significantly mediated by the child's stunted growth and came to the conclusion that it is of the utmost importance to consider the effects of mothers' depression on the child's mental and physical health together.

In their South African study regarding the impact of postnatal depression on the mother-child relationship, Cooper et al. (1999) found that depressed mothers showed significantly less sensitivity when they were in interaction with their babies, than non-depressed mothers.

Very few South African studies report on the correlational pathways regarding depressed women and their children. However, the existing local studies that do report on

correlational pathways mainly focus on the detrimental effects of the mother's depression on the child. As such, the majority of research in this field emphasise, and almost favour, child interests above the interests of the depressed mother, although both parties' interests are equally important and have to be treated with the same research interest and concern.

4. Methodology

The aim of this chapter is to provide a thorough description of the methodology used to conduct the current research study.

4.1 Design

The overarching **aim** of the larger research project, of which the current study forms part, is to develop a better understanding of low-income South African women's subjective experiences of depression. It was hoped that such an understanding may lead to more effective and appropriate psychological services to the specific target group (Lourens & Kruger, 2013). The present study aimed to provide a descriptive overview of how one group of low-income depressed South African mothers experience their relationships with their children.

The following **research objectives** were composed for the present study:

- To investigate how one group of depressed South African women experience their relationships with their children.
- To explore how the depressed women experience the relationships with their children to impact on the development and experience of their emotional distress.
- To explore how the depressed women themselves perceive their emotional distress to impact on their relationships with their children, their parenting and on the children themselves.

Consistent with social constructionism, the study was conducted within the **qualitative research paradigm** (De Vos et al., 2011). Qualitative researchers are concerned with and interested in meaning; how human beings make sense of their social context; and in how they experience real life events (Willig, 2001). Qualitative researchers are more concerned with the depth and richness of an experience in order to understand the meanings that research participants attribute to those experiences themselves, than to identify and prove relationships of cause and effect (Willig, 2001). The main objective of qualitative research, therefore, is to describe and, if possible, to explain subjective human experiences, with no intention of prediction. Consequently, it is necessary for qualitative researchers to study research participants in their natural environments, namely the contexts in which they live, work, love and express their emotions on a daily basis (Willig, 2001).

Camic, Rhodes, and Yardley (2003) stress that a valuable use for qualitative research is to explore a topic that has not been researched in depth before, and subsequently to develop

and build theory, in order to enhance a more comprehensive understanding of that specific topic or human experience.

Mason (2002) suggested that all qualitative research mainly rests on the following three key aspects: (a) how the social world is experienced, socially produced, understood or interpreted; (b) choosing and using data generation methods which are flexible and sensitive to the specific research context, rather than methods which are rigidly structured or standardised; and (c) the utilisation of data analysis methods which are focussed on the in-depth understanding of the social context and complexity of phenomena, in order to produce rich contextual understandings based on detailed and nuanced data.

The **feminist social constructionist perspective** used as the basic frame of reference (discussed in Chapter 2), as well as the qualitative methodology utilised to conduct the present study, are both relevant to and consistent with the abovementioned research objectives. Social constructionism specifically enabled the researcher to develop a better understanding of how the depressed women in the specific community construct the meaning of their subjective experiences of emotional distress in relation to their children (White, 2004; Willig, 2001). Consistent with the feminist perspective, the researcher focussed on how the women's subjective experiences of emotional distress are described and constructed by the women themselves (Dukas, 2009; Willig, 2001). Qualitative methodology is also deemed to be appropriate for the exploratory nature of the current study (De Vos et al., 2011). The researcher explored how the depressed women make sense of their emotional distress, specifically in relation to their children – a topic which has not been researched in depth before (Camic et al., 2003; Willig, 2001).

4.2 Participants

The Master's Programme in Clinical Psychology and Community Counselling at Stellenbosch University has a long-term relationship with the clinic in the semi-rural community where the research was conducted, as students from the Department of Psychology have been doing research and clinical work in this community for almost 15 years. The present study is based on the interview data collected from ten mothers who have been diagnosed with depression by a psychiatric nurse from the clinic. A relatively small sample size is indicated, since the qualitative research approach places more emphasis on an in-depth understanding of a phenomenon, than on statistical validity and the generalisation of results (Marshall, 1996).

Convenience sampling was used to recruit participants most suitable for the aims of the study (*APA Dictionary of Psychology*, 2007). The *APA Dictionary of Psychology* (2007) describes convenience sampling as the process to obtain a sample which is available and appropriate for the goals of the study, despite whether the sample is representative of the total population being investigated. As part of data analysis, which took place on the basis of social constructionist grounded theory (see below), theoretical sampling was also utilised (Charmaz, 1995). **Theoretical sampling** is a strategy which is often used in conjunction with convenience sampling (Charmaz, 1995). It entails the collection of further data after the selective and analytical coding of the data, as well as the writing of the memorandums, are completed, to ensure that the developing categories are saturated (Charmaz, 1995).

In order to determine whether a specific person was suitable for the specific aims of the research study, the following **inclusion criteria** were established:

- **Sex:** Only women were interviewed.
- **Age:** Only adults older than 18 years were included in the study.
- **Motherhood:** Only women with children were interviewed for the current study. Participants had between one and five children, with ages varying between 9 months and 43 years. It must be highlighted that, in some cases, the women also regarded their grandchildren as their own children, especially when they were the primary caregivers of their grandchildren.
- **Socio-economic status:** For the aim of this study, the socio-economic status of individuals was defined in terms of the Living Standards Measure (LSM) (Golding & Murdoch, 1992). According to this measure, the South African population is divided into 10 LSM groups, starting with group 1 (lowest living standard) and ending with group 10 (highest living standard). Individuals who fell within groups 1 to 5, were included in the study. Groups 1 to 5 mainly include low-income or unemployed individuals, with no secondary or tertiary education, and who live in informal housing (Golding & Murdoch, 1992).
- **Psychiatric diagnosis:** Only women diagnosed with major depressive disorder by a mental health or health care worker were included as participants. For the purpose of this study the term “depressed women” will be used to indicate women who have been diagnosed with suffering from a major depressive disorder as defined by the American Psychiatric Association (1994; 2013).
- **Treatment:** Individuals who currently receive treatment, individuals who have already received treatment, as well as individuals who have never received treatment, could be included in the study.

Exclusion criteria entailed the following:

- **Psychiatric diagnosis:** Diagnoses of schizophrenia and schizo-affective disorders were excluded, since the interview process with individuals who are diagnosed with a psychosis, would have been too complex.

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

Table 1

Demographic Details of Research Participants

Name	Age	Level of education (Grade)	Income per month	Number of children	Employment status	Relationship status	Religious affiliation	Years in specific community
Vané	41	5	R1840	3	Unemployed	Married	Christian	41
Cathy	49	9	R4785	2	Full time	Married	Christian	21
Patsy	36	12	R7500	2	Full time	Married	Christian	36
Dabbie	35	12	R790	1	Ile manne	Unmarried	Christian	12
Lilo	34	12	R980	2	Unemployed	Father of children died before marriage	Christian	14
Liza	22	12	R790	1	Unemployed	Not in relationship	Christian	22
Corrie	64	8	R2520	5	Pensioner	Married	Christian	42
Sterretjie	54	6	R4260	4	Part time	Married	Christian	50
Dezi	36	12	R15000	1	Full time	Divorced	Christian	32
Candice	49	10	R2400	4	Unemployed	Married	Christian	49

The participants were adult mothers of varying ages (between 22 and 64 years) with children in different developmental stages. The participants also differed regarding the history of their depression (first episode, onset of current episode, duration, medication or treatment received and family history of depression). Regarding refusal rate, none of the women who were approached to voluntarily participate in the present study, withdrew from the study or refused to participate.

4.3 Data Collection, Instruments and Procedures

Data were collected by means of in-depth semi-structured interviews. A semi-structured interview schedule (Appendix A) was utilised as data collection instrument, by which a degree of structure was provided to the interviews without limiting the participants' sharing of their subjective experiences of depression and emotional distress. The interviews were conducted by myself, a registered social worker with the South African Council for Social Service Professions. The duration of each interview was more or less 90 minutes. Only one interview was conducted with each participant. All the interviews took place in a private office at the local community centre. This venue was also easily accessible to the participants. Each interview was recorded by video camera, as well as by voice recorder, in order to ensure backup recordings. Each participant received R100 as remuneration for their participation in the study.

4.4 Data Management

The interviews were transcribed by me, another student on our research team who is also completing her Master's thesis in Psychology, and an independent transcriber. The translation of the data was managed by a professional translator.

The interview data were restricted to the use of the research team and only used for research purposes. Data were stored electronically. Once the interviews were transcribed, they were erased from the voice and video recorders.

4.5 Data Analysis

Social constructionist grounded theory was used to analyse the data (Charmaz, 1995). According to Charmaz (1995), as well as Henwood and Pidgeon (1992), the methods of social constructionist grounded theory consist of a logical set of inductive data analysis procedures, in order to develop a rich conceptual understanding and integration of all the identified categories into a coherent and systematic theoretical account. This means that the analysis of the data starts with the line-by-line coding of individual cases, after which more general and abstract conceptual categories are developed (Charmaz, 2008). This is done in order to understand and explain the collected data, as well as to identify patterns and relationships between different types of data (Charmaz, 2008). This form of data analysis is in line with the feminist social constructionist perspective, since social constructionist grounded theory is also aimed at describing, understanding and explaining the lived personal

experiences of the participants from their own perspectives (Charmaz, 1995).

Data-analysis, according to social constructionist grounded theory, started with the initial **open and descriptive line-by-line coding** of the data, by naming each line of the data by means of a specific and active descriptive code (Charmaz, 2006, 2008). A **focussed selective and analytical coding** of the data then took place, by selecting a limited amount of line-by-line codes which were prominent throughout the data set (Charmaz, 2006, 2008). The selected line-by-line codes were categorised according to specific categories and subcategories (Charmaz, 2008). The **writing of a memorandum** formed the intermediate step between the coding and the completed analysis of the data (Charmaz, 2008; Willig, 2001). This step enabled the researcher to expand on the processes, assumptions and actions contained under each code and to define how patterns were formed and how the different categories are associated with each other within the holistic process (Charmaz, 2006). Subsequently, **theoretical sampling** took place. This entailed the collection of more data, in order to ensure data and theoretical saturation (Charmaz, 2006, 2008; Henwood & Pidgeon, 2003; Willig, 2001). The **development of a conceptual analysis of the data** formed the final step of analysis, which entailed the comparison of my conceptual understanding with appropriate existing literature in the field of depression among mothers in low-income communities (Charmaz, 1995, 2006).

According to Henwood and Pidgeon (1992) and Charmaz (1995), data analysis by means of social constructionist grounded theory consists of three basic steps. The three steps include that (i) the researcher work systematically through the whole data set in order to generate labels to describe relevant abstract features and concepts as a means of developing data descriptive language; (ii) the researcher identify a set of categories based on one or more instances in the data set, in order to develop a rich conceptual understanding and integration of all the categories into a coherent and systematic theoretical account; after which the researcher move into (iii) theory building (Henwood & Pidgeon, 1992). According to Henwood and Pidgeon (1992), the scope of some studies only allows for the execution of the first two steps of social constructionist grounded theory. As the aim of the present study was to provide a descriptive overview of how one group of low-income depressed South African mothers experience their relationships with their children, only the first two basic steps of social constructionist grounded theory were implemented.

4.6 Ethical Considerations

Ethical approval for the larger study was obtained in 2011 (Protocol number: HS522/2011). We have also received renewed ethical approval from the Research Ethics Committee of the University of Stellenbosch for the continuation of the study during 2013.

The participants were assured that confidentiality would continuously be maintained throughout the study and that the information shared during the interviews would be used for research purposes only. The identities of the participants were protected by means of utilising pseudonyms, in order to adhere to the ethical principle of anonymity.

Informed consent was obtained from each participant before the start of each interview, in order to ensure every participant's self-determination, as well as to ensure the transparency of the research process (De Vos et al., 2011). Participants were informed about the nature and aims of the study. They were also told that they have the right to withdraw from the study at any time. After all of this information was conveyed and explained to participants, they were asked whether they wished to participate in the study and they then had to sign the informed consent form (Appendix B). Participants were given copies of the signed informed consent form.

Given the sensitive nature of the interviews and the material discussed, a referral system to an appropriate health care professional at the Welgevallen Unit for Psychology at the University of Stellenbosch was put in place. This was to ensure that participants had the opportunity to process difficult or uncomfortable emotions that could have been elicited during the interviews (De Vos et al., 2011). Most of the participants said that they were already in therapy with a mental health care worker at the community clinic and that a referral was not necessary. There was only one participant who asked whether it would be possible to have a follow-up interview with me, since she did not want to be referred to another health care professional. Subsequently, one follow-up interview was conducted with the specific participant, in order to enable her to process her uncomfortable feelings, as well as to make sure that she is emotionally stable. This specific interview was not used for research purposes.

4.7 Validity

The validity of the findings was considered in the following terms: participants' understanding, coherence, reader's evaluation, triangulation, and deviant-case analysis (Potter, 1996; Yardley, 2008).

A general criticism of data-analysis by means of social constructionist grounded theory is that there is no real check upon the researcher's interpretations (Potter, 1996). However, a very close and thorough investigation specifically focussed on the **participants' understandings**, which was the main focus in the current study, can be regarded as one kind of check (Potter, 1996).

Potter (1996) describes the aspect of **coherence** in terms of the validity of results, as a cumulative characteristic of a set of studies, with each new study building upon the results of the researcher's previous work and findings. This may serve as a further confirmation of the validity of the results of the studies of the specific researcher. The aspect of coherence is also relevant to my research, since various results of my study conducted among the same population group and in the same research context in 2011 (Lourens & Kruger, 2013) correlated with the results of the present study, which may provide confirmation of the validity of results.

A characteristic feature in the validation process of the results of qualitative research is the presentation of examples of rich data, for example in the form of a transcribed interview, that will allow the reader to evaluate the researcher's interpretation of the data, since the researcher's interpretation is presented in conjunction with a part of the original data set (Potter, 1996). This is known as **reader's evaluation** (Potter, 1996). Appendix C provides an example of one transcribed interview that formed part of the original data set of the present study.

According to the principle of **triangulation**, the perspectives of numerous researchers can validate and enrich the procedure of data analysis (Yardley, 2008). I have therefore continuously discussed the emerging codes and the interpretation of results throughout the process of data analysis, with my supervisor and the other Master's student who was also doing her research study in the specific community. According to Yardley (2008), the comparison of two or more researchers' coding is to triangulate their perceptions of the main categories that emerged from the data. This ensures that data analysis is not based on the perspective of only one researcher (Yardley, 2008).

Deviant-case analysis entails systematically looking for data that do not fit in with already identified themes or categories (Potter, 1996; Yardley, 2008). These disconfirming or deviant cases should be interpreted very carefully and always reported, if possible (Yardley, 2008). The reporting of deviant cases or examples ensures the reader that the researcher has not selected and presented the data that fit into his or her perspective, or the main identified themes and categories, but that all the data have rather been analysed and

presented (Yardley, 2008). The deviant cases may also highlight the limitations regarding the generalisability of the results of the present study (Yardley, 2008). As evident in the following chapter containing the results of this study and the discussion thereof in terms of relevant literature, all data were analysed and presented, including the disconfirming or deviant cases.

5. Results and Discussion

This chapter aims to provide a descriptive overview of how the participants – depressed women from a semi-rural low-income community in South Africa – subjectively experience their relationships with their children. The findings will also be compared to existing literature in the field of depression in mothers.

As mentioned earlier, the scope of some studies only allows for the execution of the first two steps of social constructionist grounded theory (Henwood & Pidgeon, 1992). As the aim of the present study was to provide a descriptive overview of how one group of low-income depressed South African mothers experience their relationships with their children, only the first two steps of social constructionist grounded theory were implemented. These steps included that (i) the researcher work systematically through the whole data set in order to generate labels to describe relevant abstract features and concepts as a means of developing data descriptive language; and that (ii) the researcher identify a set of categories based on one or more instances in the data set, in order to develop a rich conceptual understanding and integration of all the categories into a coherent and systematic theoretical account (Henwood & Pidgeon, 1992). The results and discussion thereof in terms of relevant literature are contained in this chapter.

Analysis of the data by means of social constructionist grounded theory resulted in two main categories and various subcategories. The two main categories are:

- (a) The impact of children on their depressed mothers; and
- (b) The impact of depressed mothers on their children.

The **first main category**, namely, the impact of children on their depressed mothers, includes the following subcategories:

- Child qualities and behaviour that contribute to depression in women;
- Child qualities and behaviour that protect against depression in women; and
- A “very good” mother-child relationship.

Within the **second main category**, namely the impact of depressed mothers on their children, the following three subcategories were identified:

- Feelings that depressed women have vis-à-vis their children;

- Behaviours that depressed women display vis-à-vis their children; as well as
- Depressed women's perceptions of the impact of their depression on their children.

It should be noted that, while speaking to the participants, it was clear that the women were very aware of how poverty and single motherhood impacted on their role as mothers and subsequently, on their experience of depression. These contextual factors and their impact on the depressed women will be discussed in a separate paper by Lourens and Kruger (forthcoming).

Regarding the reporting and discussion of results, a brief description of each main category and subcategory is provided, to be followed by the translated quotations of the research participants. The data are then analysed and compared with the relevant literature. While each subcategory is interesting and could have been discussed in much more detail, the goal of this thesis is to provide a comprehensive overview of how the mother-child relationship is experienced by one group of depressed South African women. Table 2 provides an outline of the two main categories and their associated subcategories.

Table 2

Two Main Categories and Their Associated Subcategories

Main Categories	Subcategories
<p>1. The impact of children on their depressed mothers</p>	<ul style="list-style-type: none"> • Child qualities and behaviour that contribute to depression in women • Child qualities and behaviour that protect against depression in women • “Very good” mother-child relationship
<p>2. The impact of depressed mothers on their children</p>	<ul style="list-style-type: none"> • Feelings that depressed women have vis-à-vis their children • Behaviours that depressed women display vis-à-vis their children • Depressed women's perceptions of the impact of their depression on their children

5.1 The Impact of Children on their Depressed Mothers

While the impact of the mother's depression on children has been extensively studied, the impact of the child on the mother's subjective experience of depression has, to a large extent, been neglected in existing literature. With regard to the impact of mothers' depression on children, elevated risks for impaired child development, development of internalising problems (especially in the daughters of depressed women) and externalising problems (especially in the sons of depressed women), as well as the development of depression and other forms of psychopathology in children (including conduct disorder, anxiety disorders, attention deficit disorder and substance abuse disorders), have been highlighted (Flykt et al., 2010; Najman et al., 2001; Turney, 2012; Watson, Potts, Hardcastle, Forehand, & Compas, 2012).

Although children's behaviour problems and internalised emotional problems appear to contribute and influence mothers' experience of depression, few studies have investigated the extent to which children's problems promote and maintain depression in mothers from the perspective of the depressed women themselves (Dix & Meunier, 2009). Elgar et al. (2003) indicated that depression in mothers increases the risk of behaviour and adjustment problems in children of depressed women (including disturbances in the child's social functioning, aggression and hyperactivity), but that the problematic behaviour and emotions of children may simultaneously also increase mothers' depressive symptoms. This mutual influence between the mother's experience of depression and child behaviour and emotional problems has been reported consistently in clinical studies (Dix & Meunier, 2009).

This category refers to how depressed women themselves experience their children. Unexpectedly, and contrary to the literature (Elgar et al., 2003; Elgar, McGrath, Waschbusch, Stewart, & Curtis, 2004), the mothers in the present study reported not only negative experiences of their children. Although they did report negative experiences with their children, the mothers also placed a lot of emphasis on the qualities and behaviours of their children that they felt were ameliorating factors in their depression. The following subcategories were identified: child qualities and behaviours that were thought to contribute to depression in women, child qualities and behaviour that were thought to protect against depression in women, as well as a "very good" mother-child relationship.

5.1.1 Child qualities and behaviour that contribute to depression in women.

Although the depressed women emphasised the positive experiences they had with their children, they also acknowledged that at times their experiences of their children

contributed to their emotional distress. In line with existing literature (Dix & Meunier, 2009; Elgar et al., 2003), the depressed women in the present study specifically identified the following child factors which they felt contributed to their emotional distress: child behavioural problems, personality of the child, disability of a child, loss of a child, as well as the child being a reminder of the mother's previous abusive relationship.

5.1.1.1 Child behavioural problems.

The depressed women referred to the following child behavioural problems which they felt had an impact on the development and experience of their emotional distress: substance abuse (including drugs, alcohol, cigarettes); criminal behaviour (including theft and murder); teenage pregnancy; as well as the child's disobedience.

5.1.1.1.1 Child's substance abuse.

Several participants brought up their children's substance use and abuse when asked about their depression:

Patsy²: *I saw him the other day saw him smoking for the first time. And he drinks, it's everything. But I do not say he does not do it, but...no. And he, friends...cigarettes, and there's buying again and so.*

Cathy: *See, he makes you talk so much, and he, he drinks...And he is still very young; I do not want this.*

They claimed that their children changed when intoxicated or high:

Corrie: *If I, like Justin, hey, he drinks, but he also only drinks when he has money. And that is at the end of the month only, or a friend comes over the weekend and says...but then he is at home for the whole weekend, when he has nothing. Then I can talk to him about anything, I can ask him anything, about this and that. But do not let him be drunk and I say, "I do not like that what you are doing"... "Yes don't do so to me..." Then he has that wild manner...*

Apart from cigarettes and alcohol, "tik" (methamphetamine) and "dagga" (cannabis) were the most common drugs used by the children of participants. Candice and Sterretjie

² Pseudonyms are used to ensure participant confidentiality and to protect the identity of the research participants.

respectively talked about feelings of anxiety and rage in response to their children's substance use:

Candice: *Just wait, quickly, there is one thing I just want to let out a little. I have a son. Ooh. That one, the second one whose father is dead, he is like that again...That is for sure, touch him...Sometimes when I speak to him he isn't...But he uses the nasty things. He uses tik...but when he comes knocking on the door I have to listen when the police is coming, understand?...That's the way it is...I don't want that. I talk to him a lot. It is all that helps a little. And now, like now I sleep hardly at all.*

Sterretjie: *I gave Austin a hiding on Thursday evening...When he came in, his eyes were blood red...and he had smoked cannabis then...And then I gave him a HIDING. I told him it was the FIRST and the LAST time that he would come through the door like that. I won't see you like that again! And then I said, do you know what cannabis does? It kills your brains. I told him you won't even know what an A and a B and an E and a Q is, so STUPID CANNABIS will make you.*

It is now...and Elrino who is on tik again. Ooh, I cannot handle it any more. I told him you would make...you would make me go to the madhouse. I'll go to Stikland or Lentegeur...And to think...I told him to think you were without drugs for a year and four months...he had done it previously...he was in rehab...and then he was without the stuff for a year and four months. And now he starts, he started again.

Sterretjie's feelings were so intense that she said to her son that she will go mad. She then relates how, when he was in the rehabilitation centre, he wrote a rap song that he dedicated to his depressed mother:

Sterretjie: *When I got to the rehab, that social worker told me...Then he told me he had danced for them there...and he rapped for them...He made a song on his own. About him, about himself. They said he had to take out my name, he must not use my name there. See?...And it is VERY nice. He rapped it for me, then I sat there, then he rapped it for me...The words hurt you...Because there are words in it:*

"I stole my mother's money,

I went to tik with my mother's money,

I touched a girl who was walking along the road,

I sat on a corner”

but this is how he includes everything now, these are things he did not do, but he did in this...

“And the police came and picked me up,

and took me down to the police station,

they went to lock me up in the cells, took me out,

interrogated me in the office,

and on coming out of the police station,

I saw the biggest flower,

and I picked it,

and I held it in my hand,

and the flower said to me,

you have HURT your mother’s heart,

but now you have to comfort her.”

Although Sterretjie emphasised that it was painful for her to hear the song, she also was perhaps trying to indicate that her son did repent and that she felt comforted by the song.

Corrie’s daughter, who used cannabis, also suffered from schizophrenia:

Corrie: *Then the child bought cannabis with friends and because she...don’t know how doctors explain about the brain, now she is schizophrenic.*

While numerous cohort studies indicate that cannabis use may have a possible causal relationship to schizophrenia (McLaren, Silins, Hutchinson, Mattick, & Hall, 2010), more methodologically robust research is needed to illustrate this relationship (McLaren et al., 2010). However, Corrie clearly links her son’s schizophrenia to his cannabis use and is thus suggesting that his drug use has had a very negative impact.

5.1.1.1.2 Child's criminal behaviour.

A number of participants reported that their children were involved in criminal activities, including theft and murder. For instance, Sterretjie, talked about her grandchild who killed someone:

Sterretjie: *See, as I said, the grandchild of mine, is involved in a murder. The murder happened two weeks ago, which was a big SHOCK and I was AT breaking point...I was at breaking point...Because my daughter and my sister-in-law were there, when they talked to me that Friday NIGHT to give me much courage. The police came to fetch my child, then I could not handle it...*

Her grandchild's involvement in the murder shocked and got her to "breaking point". She could not handle it. Sterretjie also talked about the pain and anxiety caused by her child stealing goods from her:

Sterretjie: *Because my thoughts just are...the child has tikked! What will he take next? He steals in the house. He steals things in the HOUSE...to sell for tik. Like my meat and you, you cannot sleep at night, because you are thinking what is the child going to take? What FOOD is that child going to take?*

I am the bread winner. That is what hurts me in the house. Then I say to them, they have to remember one thing, if Elrino stole meat in the house...last time he stole two packs of meat, then I was upset about it!

5.1.1.1.3 Teenage pregnancy.

Several participants were disturbed by the fact that their teenage daughters got pregnant. In the words of Cathy:

Cathy: *And then later I began better, when children were a bit bigger and they stressed me particularly and when my daughter began to be pregnant, I was disappointed actually and it seemed as if it worked on me...They were in high school. Look, when she was pregnant, I started the...stress a bit.*

She was in grade eleven...We did not have a problem with her...I also asked the teachers; she just was a very quiet child, that is why I could not understand it. When she was pregnant, hear, it felt as if there was a pair of scissors in my heart.

Because I did not know that she had a boyfriend. That's why it was a problem for me...I did not know at all. She always went to visit my sister and she met the boyfriend there but never told me of it...But he is like, he is a little wild, he drank a lot, and he is a little wild, that is why he was killed. He was much of a human being, such a person. And then she probably was ashamed, then she told me when it had already happened, she was pregnant already...It was, it was bad, yes...I brought Leila up as we were brought up, very strictly.

Cathy felt disappointed, stressed and hurt when she heard about her daughter's pregnancy. She seems to indicate that there was a side to her daughter that she did not know and that this was hurtful.

5.1.1.1.4 Child's disobedience.

Participants tended to talk a lot about their children's disobedience and how that impacted on their mood. According to the participants, it was particularly the disobedience of older children that was distressful. They expressed feeling disappointed about the fact that their children did not seem to adhere to their values:

Cathy: *And my son, he makes me worry, also, when he was growing up, he was a little disobedient, so I was just a little, it was much worse because he...like a grown-up. He started being disobedient, then he came late and then so on.*

He is a little disobedient, and then he goes. Sometimes when he has slept over with friends, he sleeps out with wrong friends.

Patsy: *When I get home tonight, oh, the house is full of girls...It is difficult and not what I had in mind for my 16-year-old child...I taught my child different values, but see, what now.*

Other mothers, like Sterretjie, expressed disappointment about the fact that their children did not help and support them:

Sterretjie: *Yes, I told them when school is out, I am at work, you come home. You see Dottie cannot look after you, because she has two children to her name. You're going to finish that work for me. When I come into my house, through my kitchen door, I do not want to see a FORK standing on the basin, for it upsets me when I come to my house and see a lot of dirty dishes, because I did not dirty it. Why should I clean it now?...These are things that upset you...And they are BIG. First, you make your beds before you go through the door. In the afternoon when you get home, undress, hang your school clothes there on that*

chair, put your bags on top of the cupboard...Like this morning I said to Chalton, rake the ground at the back smooth, hose it wet for me. Then he told me but I did it yesterday...I say I do not want to hear ANYTHING about yesterday, you do as I tell you NOW. It's a new day! You don't point to Austin or Elrino for me. I am not going to wait until school is out, until they come out. You are...you do not have class today, you DO it for me.

The child behavioural problems that the depressed women in the present study reported to have an impact on the development and experience of their emotional distress, included substance abuse by the child (including drugs, alcohol and cigarettes); criminal behaviour of the child (including theft and murder); teenage pregnancy; as well as the disobedience of the child. According to Feng et al. (2007), children with internalising and externalising problems are able to elicit both more negative and less positive emotions in their depressed mothers, and as a result exacerbate their mothers' depressive symptoms (Feng et al., 2007). Elgar et al. (2003), as well as Feng et al. (2007), emphasise the bidirectional influence of affective expression between the depressed mother and her child. According to these researchers, it is possible that problematic behaviour in children of depressed women may contribute to the mothers' experience of emotional distress, while the mothers' emotional distress and depressive symptoms may simultaneously elicit further behaviour problems in their children (Elgar et al., 2003; Feng et al., 2007).

Numerous studies show that children of depressed women may exhibit more problems with behaviour compared to the children of non-depressed women (Hoffman, Crnic, & Baker, 2006; Kim-Cohen et al., 2005; Turney, 2012). In the present study it was clear that child behaviours caused the participants great distress. They described feeling shocked, hurt, anxious, angry, insulted and hopeless about some of the behaviours their children engaged in. It also is of course possible that the dynamic is bidirectional and that the mothers' depression cause or exacerbate problematic behaviours in children.

5.1.1.2 Child personality.

Some of the participants related that certain characteristics of their children had a negative emotional impact on them:

Vané: *At first we two did not click for a while, because she is almost like a rebel. She wants to make and do as she wants to...And then another woman one day told me, I must let go, it is a phase they go through...*

She has that stubborn manner and if she tells you, “The thing is blue”, and she believes it is blue, you will not move her from that argument, “But it is blue”, now that, then it seems I could truly now...(shaking her fists)...If she says so, then it is so and no one and nothing will change it...But if I look at her, that cocky manner, I am just like that, I was like that, I’m like that still.

Vané specifically referred to how her child’s rebelliousness and stubbornness enraged her. Interestingly enough, she is aware of the fact that she also is rebellious and stubborn.

5.1.1.3 Child with a disability.

Four of the participants had children with disabilities. It was clear that this was emotionally taxing to participants, whether the child was physically disabled, mentally disabled or suffered from a chronic disorder.

With regard to physical disability, depressed women reported having children with the following disabilities or disorders: visual impairment, hydrocephalus, brain damage and epilepsy. The following responses were quite typical:

Vané: *He is blind...When he was born, he had hydrocephalus...in Afrikaans it is “waterhofie”...Damage to his brain...He’s blind. Shortened arm and right leg...And he gets the epileptic seizures...*

Sterretjie: *He is an epileptic sufferer...He is on medication, yes.*

Depressive symptoms have been identified among mothers of children with a physical disability (Shalowitz, Berry, Quinn, & Wolf, 2001). Kuster and Merkle (2004) explain that the physical and financial constraints, emotional impact and social isolation that accompany the care of a child with a chronic illness or physical disability may contribute to the relationship that exist between parent care-giving stress and depression. Care-giving stress is related to numerous demands placed on the parents who are responsible for the full-time care of a physically fragile child (Kuster & Merkle, 2004). In the context of the community in which the present study was conducted, it is in most cases the mother who has to take full responsibility for the care of a child with a disability, which may contribute to the specific mothers’ experience of depression. With medical and technological advances, it is also a fact that children with physical disabilities survive longer than in the past (Kuster & Merkle, 2004). In low-income communities, like the community in which the present study was

conducted, these children are exclusively cared for in the homes of their parents, since the parents cannot afford hospitalised care (Kuster & Merkle, 2004).

In their study of parenting stress in parents of children with epilepsy and asthma, Chiou and Hsieh (2008) identified possible explanations for the high levels of parenting stress experienced by these parents. These possible explanations included: discrimination; threat of seizures which are totally unpredictable; poor adaptation of the child; neurological dysfunction; the impact on the parent's health; and limitation of parental activities (Chiou & Hsieh, 2008). These explanations from Chiou and Hsieh (2008) might also be applicable to the mothers in the present study, like Sterretjie, who has a child who suffers from epilepsy.

Three of the research participants specifically referred to their children having a mental disability, including autism and schizophrenia. One of the mothers also said that her child is a psychiatric patient, although she could not tell exactly what his diagnosis indicated:

Candice: *And then my medication that I was drinking affected her brain, and I walked ten months with her.*

Interviewer: *But you said she was diagnosed with autism?*

Candice: *Yes.*

Interviewer: *So where did they diagnose her with it?*

Candice: *There at Tygerberg.*

Corrie: *...don't know how the doctors explain about the brain, she is schizophrenic now.*

My my Zalea, she was more than three years, three or four years, she was in Stikland.

She was, then she was there for three months. I said to the Lord: "Lord, heal my child, please." Because she was ill when she was at home, she uttered obscene words, she took stones and threw them at you, at me...She took the crockery one day and then she threw all of it outside, breaking it.

Sterretjie: *Because he is a psychiatric patient.*

Corrie specifically emphasised how her child with schizophrenia threw stones at her, smashed the crockery to pieces on the ground and swore a lot at home. She found it necessary to plead with God to heal her child from schizophrenia. This is in line with existing literature which highlights that mothers of children with psychiatric difficulties, for example autism and schizophrenia, are more likely to develop high levels of distress when compared to mothers of children without such difficulties (Baker, Blacher, Crnic, & Edelbrock, 2002; Hodapp, Ricci, Ly, & Fidler, 2003). Pisula (2011) specifically investigated parenting stress in the mothers and fathers of children with autism spectrum disorders. Pisula (2011) identified three groups of factors that may contribute to elevated parental stress in the mothers of children with autism: (a) behavioural symptoms associated with autism; (b) limited social, medical, educational and other professional support; and (c) stigmatisation of children diagnosed with autism.

Several studies also found that mothers of children with autism may experience greater distress, lower emotional well-being, and lower levels of coping than mothers of children with other disabilities (for example, Down Syndrome, cerebral palsy and intellectual disability) (Blacher & McIntyre, 2006; Eisenhower, Baker, & Blacher, 2005; Pisula, 2011). In addition, Dumus, Wolf, Fisman, and Culligan (1991) found that the mothers of children with autism spectrum disorders showed more depressive symptoms compared to mothers of children with other developmental delays. It seems as if there might be a possible correlation between having to care for a child with an autism spectrum disorder and depressive symptoms in mothers, which needs to be investigated further.

Two of the participants in the study reported having children and/or grandchildren with an irreversible disease, including Prader-Willi syndrome and HIV/Aids, with no hope of recovery. The irreversibility and hopelessness of these types of diseases might have contributed to the emotional distress experienced by the mothers of these children, as reflected in the following responses:

Vané: *And then he was diagnosed on the thirty-first of January with yet another syndrome: Prader-Willi syndrome...It is...his sexual organs do not grow, his hands do not grow, his feet do not grow, his forehead does not grow...I ehm must try to say it in Afrikaans...and he just puts on weight (showing to the front with her hand)...But it's nothing that no one...there is no pill or something. A syndrome is something that cannot be reversed...it just goes on and then it just goes like that; picking up weight, picking up weight (showing with the hand) until his heart cannot any more...and at the moment he weighs sixty-four. In January he weighed*

sixty-two; he now weighs sixty-four. And he grows; he does not grow tall, he just keeps growing fatter.

Regarding Prader-Willi syndrome, Vané placed a lot of emphasis on the hopelessness of recovery associated with this specific syndrome. She specifically referred to the fact that nobody can do anything about it and that no cure is available. It is possible that the characteristics of deterioration, irreversibility and hopelessness that are associated with this syndrome might have played a role in her experience of emotional distress. Very limited research is available regarding the effect of having to care for a child with Prader-Willi syndrome, most probably because it is a relatively rare disease compared to a syndrome like HIV/Aids.

Sterretjie: *...I have two grandchildren. Brendon is HIV, his girlfriend is HIV... Where the stress lies in me still, is the little baby... The oldest little one, when he was eighteen months, I myself took him for the last HIV test. There's nothing in him. Clean. But the problem, the worry is now with the little baby. The baby has now had the first test. Now, when she is six months old next month, she gets her second test. See? If that is clean now, then my heart will be a little calmer. Then, the third one is when she is eighteen months... Then, she is out of danger... eighteen months, yes. She can still be at risk, see? And she is such a cutie... It gnaws at you. It worries you. Oh, Lord, she is so cute. What if she has the ill[ness]? How long will she live? See, this is the battle in which you are... Yes, you think of it all the time – stays inside you.*

Sterretjie specifically highlighted the constant worry she experienced regarding her grandchild who might have been infected with the human immunodeficiency virus (HIV). She emphasised that she felt as if she was in a constant battle, since she was constantly worried. In this regard, Potterton, Stewart, and Cooper (2007) emphasise the fact that, in sub-Saharan Africa, HIV in children remains one of the continent's biggest challenges. Potterton et al. (2007) describe HIV/Aids as a multi-generational illness with life changing implications for the immediate and extended family, including grandmothers who, in most cases, take responsibility for the care of their grandchildren who suffer from HIV/Aids. They concluded that extremely high levels of parenting stress is experienced by the caregivers of children infected by HIV and that further investigation into this topic, as well as long-term management of the problem, is essential (Potterton et al., 2007).

The participants who had children with disabilities delineated several ways in which their children's disabilities impacted on them.

Vané and Candice specifically explained how they felt a mother's life can quickly start to revolve around the child with a disability only, leaving the other children to look after themselves:

Vané: *I AM FORTY-ONE years [old] and I do not have a life. MY life revolves around Lyndsay and Ashlyn...but not Ashlyn so much, because she is on her own mostly.*

Candice: *When she was seven, she was discharged from a nappy. I had to carry her.*

Participants also explained that looking after their disabled children on a full-time basis, meant that they could not take a paid job and earn an income.

Interviewer: *Do you yourself work Vané?*

Vané: *No, I look after Lyndsay...And this morning we talked about it again, then I said to my husband, I cannot work, because I have to take care of Lyndsay.*

Candice: *I, I cannot work now.*

Participants described how they were responsible for administering their children's medication:

Vané: *And he gets the epileptic seizures...So much so that I give him a drug...to get him under control...*

One of the participants experienced that she had to take sole responsibility for her disabled child as extremely unfair:

Vané: *I say to my husband, you go to work...I am at home...You go and work every Saturday...when you come back...I am at home...I JUST STAY AT HOME.*

Participants with disabled children clearly felt that having a disabled child had a life-changing impact on them. They described how their lives started to revolve around the one child with a disability, resulting in their other children having to almost care for themselves. Also, because they often had to look at disabled children on a full-time basis, they could not work for an income. Some participants experienced the situation as being unfair.

5.1.1.4 Loss of a child.

Three of the depressed women reported that they had experienced the loss of a child. For some the loss of a child was the main precipitating event in the development of depression:

Interviewer: *Now I want to hear, who first told you that you suffer from depression? Or that you are depressive?*

Dezi: *Ehrm, it was an ordinary doctor, it was after the death of my child.*

Participants described the loss of a child as having had a profound emotional impact on them. They referred to feelings of terrible pain and emptiness:

Corrie: *Falisa died...She got meningitis, you see, and a runny tummy... It hurt—much heartache. I also almost died, but so I mourned her.*

Patsy: *And my husband, after our baby's death, my husband started using drugs...I have nothing of the child, I have nothing left, I have nothing...and one's life goes on.*

DSM-IV-TR criteria for a major depressive episode did not include symptoms of mourning after the death of a loved one, except when the symptoms of grieving continued for more than two months or when the symptoms were characterised by a significant decrease in optimal daily functioning (Sadock & Sadock, 2007). However, the bereavement exclusion criterium of the DSM-IV-TR, has been removed in the DSM-5 (American Psychiatric Association, 2013). This change might prevent health care professionals from overlooking the symptoms of a major depressive disorder after the death of a loved one, including a child, and facilitates the opportunity for adequate treatment or therapy (American Psychiatric Association, 2013).

5.1.1.5 Child as reminder of previous abusive relationship.

Some participants reported that their children reminded them of a past abusive relationship with the father of their children. As a result, they did not want anything to do with their children, and sometimes blamed their children for what happened in their previous abusive relationships. This can be illustrated by the following responses from participants:

Liza: *I wanted to have nothing to do with him, because I felt like...I mean I look at his FACE actually...he looks just like his father...and I do not want to see him! I mean see what I had to go through and it is what he did to me...it is just not right.*

Dabbie: *Yes, and when we got home, I, for a week, she did not with me...I just breastfed her and then, now my sister took her further and so on, bathed her and so on, hmmm. I half blamed her for things that happened between her and my father (sniggers), and HER father. So, there actually wasn't any feeling for her...there was no bond...but I prayed every day to the Lord to help me, the Lord had to give me the power and strength to feel something for my child and today I love her very much.*

Liza specifically explained that, when she looked at her child, she saw the child's father who had previously abused her. Therefore, she did not want anything to do with her child and had not wanted to see him. He constantly reminded her of the earlier abusive relationship with his father.

Dabbie admitted that she wrongly blamed her child for everything that went wrong between her and the father of her child. She had no feelings for her child and was not able to form a bond with her. Eventually, she asked God to help her and to give her the strength to feel something for her child and to be able to love her.

Holmes (2013), referring to the psychodynamic model of depression, emphasises that depression may follow symbolic loss (for example, the deprivation of the ideal of a loving relationship) or actual loss (for example, of a husband or partner). Holmes (2013) further explains that both symbolic and actual loss may result in a lack of self-efficacy and feelings of failure. Additionally, Holmes (2013) emphasises that a depressed person's reaction to loss is sometimes "obscure and disproportionate" (p. 69). Because the lost object (for example, the mother's previous husband or father of her child) is perceived with mixed feelings (love, but also hatred due to being abused or abandoned), loss may be projected outward in disproportionate ways. In the present study, the mothers mainly directed their negative feelings of loss at their children. According to the depressed women, they specifically displayed a tendency to blame their children for what had happened in previous abusive relationships. Additionally, they felt as if they did not want anything to do with their children, as the children reminded them of those abusive relationships or of what they had lost. The loss experienced by a depressed mother may also be directed inward, however, and may manifest itself in the form of more depressive symptoms (Holmes, 2013; Sadock & Sadock, 2007). For example, if the child would be a further reminder of the previous abusive

relationship with the father of her child whom she had lost, the mother's depression may be exacerbated.

5.1.2 Child qualities and behaviour that protect against depression in women.

Most of the literature – in actual fact, almost all of the literature regarding depression in mothers and the impact of the child – emphasises how children may cause emotional distress in women (Coyne & Thompson, 2011; Dix & Meunier, 2009; Elgar et al., 2003; Feng et al., 2007; Hoffman et al., 2006; Kim-Cohen et al., 2005; Turney, 2012). Some researchers have reported a vicious cycle with a mother and child's mood mutually influencing one another (Coyne & Thompson, 2011; Dix & Meunier, 2009; Elgar et al., 2003). In the current study, however, it was found that participants also reported that their children often could also be considered to be ameliorating factors, somehow acting as buffers against the depressed mood of their mothers. Participants identified the following different positive roles played by their children:

- Attuned child;
- Understanding child;
- Child as source of pleasure and hope;
- Protective child;
- Comforting child;
- Partnering child;
- Loving child;
- Dependent child; and
- Child as God-given gift.

5.1.2.1 Attuned child.

Most of the research participants described how their children could literally sense when the mother did not feel well or when something was wrong:

Dezi: *She will say something to me [during] the week. Not just immediately. If she can find out that something is not right or I am, then she will tell me, "Mommy, let's do this...", or whatever. So she will [notice] it immediately. So I can see when she senses it.*

Liza: *Ehrm...if I could mention an example... ehrm...it always, I would say, then we were not...then I felt FAR away from him...like...then I just want to...I cannot understand him, just stay away from me...so – I actually felt like that. And he could have sensed [it]. It's almost like, my mother does not want me near her – what is going on? What did I do wrong? So.*

Patsy: *Like Friday evening, the children and my oldest son saw that I was unhappy and they said, “Never mind, don't worry, I'll see what there is to eat” and luckily there was something to eat then. Saturday evening, when I had the anxiety attack, my baby was there...She is ten now. She cried so terribly and carried on just because she saw what I looked like.*

Cathy: *My thing is, when I am very stressed, they sense it...Like now, I have recently found out about my husband having Alzheimers, then I stressed a lot...And then, when he does something, I scold a lot. And so it started, but they have seen, they know by now. They saw I did not feel well and I am not rested and so on...*

Participants state that their children seem to sense their mood, without them having to articulate it. They are implying that children know implicitly what they are feeling, even if they have not explicitly stated it. Also, when the children sense that their mothers are feeling down or worried, they tend to feel guilty and/or try to compensate.

5.1.2.2 Understanding child.

Many of the participants felt that their children understood them better than anyone else:

Dezi: *I now do not really find the words to describe it. But I think it probably goes without saying if you are only two people who share a home and share everything. And have also come through all the things together, for me it is like she's the one who knows me best. Better than my parents know me.*

For Dezi it was important to feel understood. The understanding that she got from her child was more profound than the understanding she received from her parents.

5.1.2.3 Child as source of pleasure and hope.

Almost all the participants felt that their children had a positive impact on their mood. Dezi described how her child lightened up her life:

Dezi: *She is like a sunbeam. She is. There are many things that she does that make me smile and which I now try to learn to do. Because I am so occupied, she does many things that can help lighten it, that I cannot do, because I am now too busy to think about what I should do. Sometimes when I am sitting down, it is then that [those things] make me a laugh, or I do not always allow myself to. It's one of those things that I want to try to do. To more allow myself to experience it myself. Because sometimes I am very serious about the daily things that have to be done and I do not allow myself to let go a little and to relax and just to enjoy life. And one thinks that it's always big things that will make you change, but then it is the little things that you do not even think of and she is very funny and...Yes, like that. Yes, she actually lightens it.*

Other participants described how their children brought them happiness and pleasure through conversation and laughter:

Sterretjie: *Many times, many times then I feel sad, then they will make me happy - the little one especially...That is for me...how could I say? My pleasure.*

Sterretjie: Most of the time they then...like last night my grandchild and I had a good time chatting and I could have a good laugh at all the things that he was telling me.

Yes, like one, he is very funny and jokey and so.

Now they start, but the AUSTIN! I laughed [so] that I could not [laugh any more]! Then my daughter came, she and her friends were seated inside, then she came, she said her friends asked, what is happening there? Hear how your mother is laughing. Then I said, Aussie tells us (we just call him Aussie), do you know what Aussie just said to me? Aussie says he cannot see my spine [all the way] to my ankle...Ooh! (Laughing) Then I said, your spine does not run down to your ankle! (Laughing)...Then this one said, but my back looks like a river. (Laughing) Then I said, stop. Stop! (Laughing) Do you want to make a joke of me? (Laughing) Leave off joking! (Laughing)...Ooh! The one says, "look...all the fat!" (Laughing)

Candice: *They help me in many ways. They will put me to bed, or say "Mummy, rest a while", or talk a little or they joke with me...and then all is over. Then in front we sit together pleasantly... and chat. They just talk about those days and those days and then this takes me away and then it takes me to a new person...Yes, a lot, then I laugh with*

pleasure!... But it is better to laugh than when I go about all day with a long mouth and have my mouth long [pouting].

If was also clear that participants felt that their children gave them purpose in life and thus provided them with hope:

Liza: *Because...ehrm...I mean if I look now he and I, I am very close to him. He is the only human being who is very close to me now and now I live for him, I would say so. So, he actually brought me out of it. He made me realise but we have a future and I do not have to feel like that. So, he actually helped me much more.*

Because sometimes, the cute thing about him is (smiling), if he might look at me and I am just not feeling so good that day, then he comes and gives me a little kiss and then I think, dear me...Then, I feel so special! (Smiling) Then I feel better. Then I get...okay...I do not have to feel like that...Yes, he helps me a lot. And he is with me every single day.

Many participants reported that they have been actively suicidal, but the fact that they had children meant that they could not follow through:

Vané: *I sometimes think of suicide, but will not be able to do it.*

Sterretjie: *There is nothing else...but, because I have tried very hard (referring to the marriage relationship), so I just live for myself and my children now.*

I sometimes think of suicide, but will not do it...My children...The children and I have a strong bond.

Patsy: *I am not, I said to him the other day, do you know it's just some days I feel, I cannot carry on any longer, then I just want to make an end to it, but it stops just there, because I think I still have two children...I THINK no FURTHER than thinking of my children. I do not have, there is only one thing that I'll not, I'll never have a tendency to take my own life...I am worried about my children. But is not that it is in my thoughts either. I have sympathy for people who commit suicide. But I have said, everyone has debt, everyone has problems. I am not going to kill myself.*

Liza: *And I think that is also the reason why I am not dead and I have a child to take care of. What would happen if I were gone? What would happen to him?*

Participants clearly felt that their children did not only give them a sense of purpose and a reason for living, but that they also had a responsibility towards their children – a responsibility that, in many instances, kept them alive.

It seems that, for the participants in this study, their children are sources of light, happiness and pleasure. They bring purpose and hope to lives that often feel empty and hopeless. It seemed clear that participants often felt as if they were staying alive for the sake of their children.

5.1.2.4 Protective child.

Several participants highlighted that their children generally were very protective towards them:

Corrie: *They were, how should I say it, they were very quiet behind me... they were very protective of me.*

Sterretjie: *And ehm many times when the problem was [there], then he would hold me so TIGHT (indicating with hands). He says, "Mommy, don't scold, mommy don't cry" (whispering). "He will murder you, then he will come and kill you!" (Referring to her husband) So, that attitude...Even though he was only three years old.*

Yes, because she...I came out of the room, then I heard her say to my sister-in-law, I have to be the strong one in the house now, because my mom is weak. I cannot cry and carry on now, because I will make my mother worse. Because when the police went through that door with that child, I collapsed. I collapsed, then I screamed, for then I could not take it.

The depressed women spoke of several ways in which their children were protective towards them. Sterretjie specifically explained how her child gave her a big hug when she experienced a problematic situation. Her child also warned her against her violent husband, as her child did not want her to get hurt. Additionally, she reported that her children tried to be strong, since they perceived their depressed mother as weak.

5.1.2.5 Comforting child.

Participants spoke about the ways in which their children tried to calm and comfort them when they felt down and when they were crying:

Vané: *There are some days when I just start weeping, then I sit and weep and weep. And then it upsets him, because he then strokes me or he calls, “Mommy mommy mommy”. And he lies with his head tight against me and says, “Mommy, little Lyndsay loves mommy”.*

Candice: *Or sometimes when I feel like that I take her and we lie down for a little while. Then she falls asleep with me. When we get up I feel much better and so.*

Sterretjie: *Especially when there are problems, then...see they are big, then they will say to me: ...“Don’t stress like that! Be calm. Let go. Don’t think of those things!”*

Then he said, “Don’t cry”. He says, “MOMMY, DON’T CRY”. “I am very happy here where I [am]!”...He says, “Mommy mustn’t cry!” He says, “Mom, why is my mother crying?” “Mommy mustn’t cry, I am happy”... see, then I felt very happy, because I know now, he is happy where he is.

It hasn’t changed, because why, there’s many times when I lie in bed, then he comes, then he comes to lie with his hand like that round my body or he comes to lie with his head on my lap or comes to sit next to me, then he puts his hand round my body. Then he lies with his head on my shoulder – now this is proof for me – he loves me very much.

Lilo: *It has, yes...ehrm...as I have said, when I was so ill, they were with me constantly, they did not leave me alone for a single minute, they were, good grief, if I went to town, the two of them went with me, they did not want me to go on my own, and this is when I one day went for treatment by taxi, I left here in the taxi, had the attack in the taxi, see how...I just wanted to jump out the window ...and my children did, I sat right here, someone else sat here and the two little ones sat next to that person and they saw me with tears in my eyes, “Mother, what do you do?” Then they keep asking me, “Is mommy alright, are you alright?”*

Participants talked about the different ways in which their children tried to comfort them when they were feeling down. This included physical closeness and verbal reassurances.

5.1.2.6 Partnering child.

Some of the research participants placed great emphasis on the fact that they feel that their children alleviate loneliness:

Liza: *He is there all the time and there is never when he, I do not have to feel I am alone, because I have my child.*

Sterretjie: *If I now want to go and eat out, I have to take a child of mine along. Then I take my baby child or I take one of my grandchildren with me. Then I tell him, I feel like going to the Spur today, come along.*

When the participants were asked to explain how they experienced the relationship with their children, it was clear that some of the depressed women searched for love from their children – especially when they did not experience love from their partners or their own parents:

Sterretjie: *As I sit with my children and I say to them, I want you to give me that love. You must give me that happiness, because I desire it. I need it in life. And as a child I went through a hard life. I lived a HARD life. I always still say, you see what your father says to me, does not BEAT me any more, but...the words that he says to me, makes me, Ooh! I cannot...that man says to me, oh my, big dangerous words that hurt me DEEPLY. Sometimes I sit and weep. Sometimes I start crying just because of the words he says to me.*

With this narrative, Sterretjie expressed her need to feel loved and to experience happiness. She specifically described how she asked her children to provide her with the love and happiness which she had not experienced as a child or in her intimate relationship with her partner. She emphasised how she suffered a hard life as a child, as well as how deeply her husband hurt her with his harsh words.

5.1.2.7 Loving child.

The majority of depressed women emphasised how important the loving bond with their children was. This love was either demonstrated physically or articulated verbally:

Vané: *Now he calls me...he sits on our bed, now he says I must come and sit here. And now he carries his arm round my neck and he kisses me THREE times and he tells me...eh... “Lyndsay loves mommy VERY much”.*

Candice: *He will just walk with is hand round my neck in the market or whatever...*

Sterretjie: *Then he lies with his head on my shoulder – and this is proof for me – he loves me very much.*

Thus, the aforementioned need of the mother to feel loved is, in many instances, answered by her children. According to the depressed women, the loving behaviour which their children displayed towards them, definitely played a major role to protect them against symptoms of depression.

5.1.2.8 Dependent child.

More than one depressed mother explained how she and her child were dependent on each other, which specifically entailed that it was difficult for them to cope without one another, and also, that they never went anywhere without each other:

Candice: *When I became ill they had to bring her to me...because she could not [cope] without me...If I sometimes, if I go to another place as I am here now, then I cannot be relaxed if she is not with me.*

Dezi: *Ehrm, she for instance won a competition and she is very spontaneous. And she told me everyone sees her as a mature, spontaneous child. But she tells me she cannot do it if I am not near her. Like they have now won the KFM and Justin Bieber competition for her...So, ehrm. Yes, then she told me now that she does not feel so comfortable among other people, it comes more naturally or easier when I am nearby.*

Liza: *Well, ehrm we actually are...I am very close to my child. We are very close – terribly. He goes nowhere without me, and I go nowhere without him...I cannot even...if I go away from the house... I must...I cannot stay away more than two hours...He misses me terribly.*

Dezi: *I do not go out easily without her. Otherwise I just stay at home. Ehrm, she will, if I go out she will phone me and tell me to be safe or whatever. We cannot [be] so long without one another any more.*

But I think it is more the case of us doing much together. We most of the time are except for school and work we are together all the time.

Participants speak about a mutual neediness, with both mother and child needing to be close to each other, especially during stressful times.

5.1.2.9 *Child as God-given gift.*

Many participants perceived their children as gifts from God:

Vané: *Lots lots, and I a::³lways said, one day if the Lord gives me children...*

Candice: *But the Lord showed me He gave that child to me...She has come into my life now, I made the Lord acceptable. I said...The day I got her I said, “I do not want the child”, because I did not know I was going to get such a child. But when the child was with me, I did not feel like that any more.*

Corrie: *I am very [fond] of them; I say to them, they are gifts.*

In a sense, the perspective of the depressed women, namely, that their children were God-given gifts, seemed to help them to appreciate their children even more.

Although numerous literature searches were done at different stages of the present study, the literature concerned with the positive and protective aspects of the relationship between a depressed mother and her child was very limited. The results of this study may therefore play a role in breaking the stereotype of the depressed mother, who is almost always portrayed in existing literature as not able to form a close bond with her child; having children with behavioural and emotional problems; and having “parentified” children (Feng et al., 2007; Hoffman et al., 2006; Kim-Cohen et al., 2005; Turney, 2012). The depressed women in the present study, to the contrary, also experienced their children in very positive ways. They also reported very strong loving mutually dependent relationships with their children. The ways in which participants construct the mother-child relationship will be discussed in the next section.

5.1.3 “Very good” mother-child relationship.

Surprisingly, given the existing literature, participants in the study highlighted “very good” mother-child relationships and close connectedness between themselves and their children. Almost all of the research participants described their relationship with their children as “good” or “very good”:

Cathy: *I have a very good relationship with my children.*

³ Colons indicate degrees of elongation of the prior sound; the more colons, the more elongation.

Corrie: *My relationship with them is very good.*

Sterretjie: *The two of us have a good relationship. I have a very good relationship with my children.*

Candice: *Good. We get along very well.*

Participants' perception of a "good" relationship with their children involved good communication, doing things for each other, physical closeness and strong bonding.

5.1.3.1 Child as communicator.

Participants felt that their relationships with their children were open. They felt that they could talk about anything or everything:

Patsy: *But one little thing, I and my little daughter have a very good understanding... a very good understanding. We can talk about ANYTHING, about anything. Anything. She comes home from school, she comes from wherever and my friends say she gossip with me. That is how...so close we are to one another. And she will tell me anything. And I also. I shall tell her everything.*

Vané: *But we two have a very open relationship; talk about sex, talk about everything; boyfriends; all these things.*

Sterretjie: *Yes I can speak openly about ANYTHING to them.*

Dezi: *Because I also think we share terribly much. Simply because it is only the two of us at home. Like sometimes we talk about anything...And ehm. So many times. Okay, this is an example now and then it is, how can I say we talk about everything with one another. She will come and tell me everything. And sometimes...See, I just am someone who will say things about why I do not have a husband, then I will make comments about a man or whatever. And she also does it like that now.*

Dabbie: *It's...hmmm...she again will tell me everything, and I again will tell her everything, because I feel that she will tell me how she feels about a thing. She will tell me: "Mommy but, this and this happened at school today", or "I feel a little my heart is sore"... Or such type of things, so I think there is a great difference...I. Can I say, she finds it easy to communicate*

with me and I find it easy to communicate with her...Very open relationship. She hides absolutely nothing from me. As far as I know.

5.1.3.2 Child as help.

Many participants felt that the relationship with their children was “good” when the child was doing things for them or was helping them practically with domestic duties:

Vané: *And the Lord is my witness, when I wash Lyndsay in the morning, she fetches him a nappy. We don't have hot water, now she says, “Mommy must I put the kettle on?” and I say, “Wait Zane, first see if there is water in [the kettle]”. Now she will tell me, “Yes mommy, there's water in the kettle”. Then she switches on, she fetches the bath [from] outside. The other day she said, “Mommy must not put boeta's sink so high, because I cannot reach”. SHE'S INCREDIBLE. Clean the kitchen for me quickly, as old [young] as Lezzane is, Lezzane dries, she packs away, she wipes the cupboard, she wipes the microwave...when I do the laundry...When I look Lezzane is hanging up ALL the panties and the socks, all the underwear she hangs up, in her way. If I fetch the laundry, she helps me. SO NEATLY SHE FOLDS the washing. It's too good to be true.*

Dabbie: *There are many tasks that I had to do in the past with which she helps me now, perhaps when I do the laundry, and she sees I am a little tired, she will say: “Mommy, come, I'll help Mommy”, so on.*

Candice: *He is a boy who so, he helps me with everything, everything. He will help me do the laundry. He will clean the house for me, so.*

They help me with everything... I could now, as I am here, I have not done anything at home, honestly. That girl does everything. For me they are not, they know their mother is tired.

If I say wash the laundry, his friends may see what he is doing outside, how he hangs up the laundry. He does it...Then I say also clean the dishes, or so, make the beds. That child does it.

Corrie: *If I perhaps am unable to do that thing, [not feeling like it] or just feeling down, then they always support me and then they will do things for me and so – always help.*

The practical support provided by children was experienced in very positive ways.

5.1.3.3 Physical closeness.

Several participants also described the mother-child relationship as “good” when the mother and child were physically close, especially when the mother did not feel well:

Dezi: *Like we share one bed...Which was not really necessary...We have the garage...See she does not have a bedroom now. It used to be her bedroom. The car now slept outside. In the winter now she came to sleep with me. Ehrm, but now it is just a habit.*

Cathy: *And then we usually chatted, and she comes to lie by me. She still does it...If she is at home, she comes to lie with me on the bed until she is asleep, and then I go and sleep in her room.*

Lilo: *Ooh, dear, he is very close to me, especially when I feel bad, then just he comes to lie on my lap...*

5.1.3.4 Strong bond between the mother and her child.

The depressed women also perceived the fact that they have a strong bond with their children as part of a “good” mother-child relationship:

Sterretjie: *The children and I have a strong bond.*

Vané: *I am VERY [taken] by him.*

Contrary to expectations then, participants in the study constructed the relationships between them and their children as very positive. They describe relationships that are mutually supportive, loving, open and close. These strong bonds were described as manifesting in physical closeness as well. Strong bonds were reported despite the fact that the women in the study were all diagnosed with depression. This finding is unusual, because previous studies about depressed women and children found that the relationships with children were mostly compromised. The vast majority of literature regarding the relationship between the depressed mother and her child only emphasises the detrimental effect of the mother’s depression on her children (including child developmental problems, child problem behaviour, child emotional problems, learning difficulties, insecure attachment and impaired social skills) and how the child’s problem behaviour and emotional experiences may contribute to the mother’s depression (Coyne & Thompson, 2011; Dix & Meunier, 2009; Elgar et al., 2003; Flykt et al., 2010; Lazear et al., 2008; Najman et al., 2001; Treutler & Epkins, 2003). It is possible that in other studies mothers themselves were not asked and the

strength of the bonding was determined by the researchers. It may also be that the participants in the present study wanted to convince the researcher (and perhaps also themselves) that they were good mothers and therefore presented their relationships with their children as positive. However, the participants, despite talking about positive aspects of having children were also remarkably open about negative feelings they have about their children.

Although most of the aforementioned negative aspects of the relationship between a depressed mother and her child definitely are a reality regarding the depressed mother-child relationships in the present study, the depressed women also reported numerous positive and protective aspects that also formed part of the relationships they have with their children. It can be suggested that, although health care professionals should empower depressed women to give recognition to and to identify the detrimental effects of their depression on the mother-child relationship, these professionals also need to help depressed women to identify the protective factors, strengths and positive aspects of the mother-child relationship that already exist. By doing this, health care professionals might have a greater sustained impact regarding the empowerment of depressed women – for example to discipline their children effectively – than by only focussing on the detrimental aspects of the depressed mother-child relationship.

5.2 The Impact of Depressed Mothers on their Children

Most of the literature regarding depression in mothers and the relationship between the depressed mother and her child emphasise the detrimental effects of the mother's depression on the child (Flykt et al., 2010; Lazear et al., 2008; Najman et al., 2001; Siefert et al., 2007; Trapolini, McMahon, & Ungerer, 2007; Treutler & Epkins, 2003; Turney, 2012; Watson et al., 2012). These detrimental effects may include child developmental problems, child problem behaviour, child emotional problems, learning difficulties, insecure attachment and impaired social skills (Flykt et al., 2010; Lazear et al., 2008; Najman et al., 2001; Siefert et al., 2007; Trapolini et al., 2007; Treutler & Epkins, 2003; Turney, 2012; Watson et al., 2012). Elevated risks for impaired child development, the development of internalising problems (especially in the daughters of depressed women) and externalising problems (especially in the sons of depressed women), as well as the development of depression and other forms of psychopathology in children (including conduct disorder, anxiety disorders, attention deficit disorder and substance abuse disorders), are specifically highlighted (Flykt et

al., 2010; Najman et al., 2001; Turney, 2012; Watson et al., 2012). As such, depression in mothers constitutes a high risk factor for impaired healthy development in children, including serious behavioural and health consequences, as well as adjustment problems (Flykt et al., 2010; Lazear et al., 2008; Siefert et al., 2007; Treutler & Epkins, 2003; Turney, 2012).

The mother's depression is also one of the most important risk factors for the development of depression in children and adolescents (Lieb, Isensee, Höfler, Pfister, & Wittchen, 2002; Rishel, 2012; Spence, Najman, Bor, O'Callaghan, & Williams, 2002; Turney, 2012). Children of depressed women are six times more likely to develop depression when compared to children of non-depressed women (Beardslee, Versage, & Gladstone, 1998; Rishel, 2012). Other forms of psychopathology in children, including conduct disorder, anxiety disorders, attention deficit disorder and substance abuse disorders, have also been associated with depressive symptomatology in mothers (Najman et al., 2001).

While these well-established facts cannot be denied, we must also ask ourselves the question whether children of so-called non-depressed mothers may not also experience child developmental problems, child problem behaviour, child emotional problems, learning difficulties, insecure attachment or impaired social skills, to a greater or lesser degree.

Similar to the first main category of the impact of children on their depressed mothers, the participants in the present study again reported a whole range of feelings and behaviour towards their children, ranging from negative to positive: from being violent towards their children to being caring, supportive and protective.

This second and last main category entails all the feelings, behaviours and perceptions of the depressed women in relation to their children. This category specifically contains the following three subcategories: feelings that depressed women have vis-à-vis their children; behaviours that depressed women display vis-à-vis their children; and, lastly, mothers' perceptions of the impact of their depression on their children. Regarding the depressed women's perceptions of the impact of their depression on their children, the impact of their depression on the mother-child relationship; on parenting; and on the child him/herself, will be discussed.

5.2.1 Feelings that depressed women have vis-à-vis their children.

The literature suggests that, compared to non-depressed mothers, depressed mothers express less joy and more sadness, anger, irritability, emotional unavailability and flat affect when they are in interaction with their children (Dix et al., 2004; Feng et al., 2007; Hoffman et al., 2006; Raikes & Thompson, 2006; Shay & Knutson, 2008). In contradiction to the

majority of existing literature regarding the relationship between the depressed mother and her children, the depressed women in the present study did not report on the negative feelings they have vis-à-vis their children only. They also placed strong emphasis on the positive feelings they have towards their children. According to the perspective of the depressed women, the negative feelings they have towards their children, included: feeling isolated, feeling stuck or trapped, feeling overwhelmed, feeling stressed, feeling irritated, feeling like a failure, feeling resentment towards their children, feeling detached from their children, and feeling guilty. On the other hand, the depressed women also reported that they feel protective, attuned, understanding and loving towards their children. These feelings were very prominent throughout the mothers' life stories, without being asked directly to identify their feelings regarding motherhood.

5.2.1.1 Feeling isolated.

From the narratives of the research participants it was clear that they felt isolated. The depressed women mostly identified two reasons for feeling isolated. On the one hand, mothers of children with disabilities complained that their children kept them at home on a full-time basis. According to these mothers, this does not allow them to go anywhere, except when they have to go out to fulfil the needs of their children. This can be illustrated by the following narratives of the mothers looking after a child with a disability:

Dabbie: *We two always never go out.*

Vané: *I do not go out. I just stay here. I only go out if Lyndsay [gets] pay here in Stellenbosch and when he goes to Tygerberg.*

Candice: *I do not go about with her. If I am with someone, even if you just cough a little, we hardly step outside and she is limp... We only go to church and come back.*

The second reason is that a single mother cannot leave her child alone at home, because of safety factors. It is difficult for the depressed mother to think of solutions. Therefore, it is easier to stay at home with the child:

Dezi: *Like I for instance will not want to go out and leave her alone at home because it is unsafe ...I also don't want to, ehm. It also is not easy to leave her with my mother and them. Then I have to fetch her late at night...So it's all those things that make me having to think of*

solutions. How can we do it. So it sometimes makes me very tense. So then I rather prefer to stay at home.

5.2.1.2 Feeling stuck or trapped.

It was also evident that several of the depressed women, besides feeling isolated, felt stuck or trapped, especially when they were responsible for the full-time care of a child with a disability. The feeling of “stuckness” also included that the mother feels as if she is not able to move forward in life; that she does not have a life; as well as that she wants to break free. This prominent feeling of being stuck is very clear in the following narratives:

Vané: *I- I- I feel I must be freed a little somewhere because... Lyndsay is almost twelve and for twelve years, I am like someone who is squashed between four walls.*

Ye:::s ALTOGETHER trapped.

I am caught up, I am stuck up 24/7.

Uhm and these are things that make it very difficult for me. Because, because if I look at young married women who help their men with work, they go forth in life. For me it is almost like, I am almost married for 12 years, I am JUST there. Because I did not go forward, also not backward, I just stay there where I am.

Several mothers emphasised the fact that they felt as if they did not have a life, mainly because of the circumstances in which they found themselves, as well as the fact that they did not have any time for themselves. This can be illustrated by the following statements:

Vané: *I do not have a life...And the circumstances under which I am; I do not have a LIFE.*

Patsy: *Now in the evening when I get home I just put down my bag, I sometimes just want time to just drink a cup of tea...But I am busy in the kitchen, I must still think about food, I only think about food: what can I make tonight? And when I get home, I have to start...I get home at six o'clock. Five past six I already have to have the food on the stove. There is not enough time to sit and rest or just a five-minute rest to drink my cup of tea.*

Perhaps because most of the depressed women felt stuck or trapped, they also highlighted the fact that they almost had an “urge” to just break free. They described a need to get out of the house or to work, in order to see other people. The way in which most of them dealt with this need, was that they just walked out on their own, just to get out, which

normally made them feel better. This complex feeling is also illustrated best by the following statements by Vané:

Vané: *It's almost since Friday that I feel I have to work; I must find myself a job, just to GET AWAY a little or get among people.*

Then on...WEDNESday...morning, I got up and I was TERRIBLY irritated. I said, I I I have to get out of the house, I must walk...and I said to my husband, I said I am just walking. I walk down Daffodil Street...just to get AWAY. JUST TO get OUT. And when I got back, I feel extremely well...better.

When I feel depressed, then I walk; just to get OUT...TRULY, just to get out, I walk, I walk, I walk, because...I do not want to be around people – I want no one around me. I just want to be on my own. I walk for an hour, or hour-and-a-half.

The depressed women's descriptions of feeling isolated and feeling stuck or trapped, are psychologically closely related. The depressed mother's feelings of isolation due to her responsibility to look after a child with a disability on a full-time basis, as well as the fact that she cannot leave her house for reasons of safety, may further cause her to feel stuck or trapped. As a result, the depressed mother may feel as if she does not have a life and consequently, may develop an "urge" to just break free.

Feeling isolated, as well as feeling stuck or trapped, are feelings which are not included as part of the criteria for a major depressive episode in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) (American Psychiatric Association, 2013).

The study by Rapmund and Moore (2000), which entailed in-depth qualitative interviews with depressed South African women, is one of the few South African studies that regard women themselves as experts in their own understanding and experience of their depression (Dukas, 2009). The main themes that emerged from the depressed participants' stories, were that they felt as if they were torn into two different directions, with the result of finding themselves in a hopeless situation, as well as that feelings of being stuck maintained their feelings of depression (Rapmund & Moore, 2000).

That the majority of depressed women in the present study reported that they usually feel isolated and stuck or trapped, to some extent, correspond with Rapmund and Moore's (2000) findings. Their feelings of being stuck may prevent them from seeing any potential escape. This may further exacerbate their feelings of depression. According to Rapmund and Moore (2000), a vicious cycle can be identified, in which feelings of being stuck may play a

role in maintaining the mother's depression, while depression simultaneously succeeds in maintaining the mother's feelings of isolation and of being stuck.

5.2.1.3 Feeling overwhelmed.

Feeling overwhelmed is something most of the research participants have experienced in one way or another. They described this feeling in several ways. Candice explained that, for her, everything just builds up:

Candice: *That is where it came from. From their fathers and the shooting of the one boy's father. It worked on me too much. And then I went to work for my children...My thoughts are not there, I work but my thoughts wander...Yes, why my child, then, why my child's father died, why then did he stab me with...Such things go through a person, and it builds [up]...Everything builds!*

Patsy described that it was not possible for her to hold back her feelings any longer:

Patsy: *It came out and I could not keep it in any longer.*

Vané highlighted that she feels overwhelmed by domestic duties and that everything just gets too much for her:

Vané: *I am in the house or I have to be at the house. And it's doing the laundry and it's making food and it's cleaning the house...and at the present moment yes, I feel it is just too much...and (shaking her head)...YES. AT THE MOMENT it feels as if it's too much. It is too much.*

5.2.1.4 Feeling stressed.

Most of the depressed women emphasised that they experience a lot of stress and that, in some instances, their children are a major source of their stress. The women also said that they stress very quickly, which, in some cases, may lead to an anxiety attack. Some of the participants also received treatment for their stress or anxiety in the past.

Sterretjie described in detail how she feels when she is stressed and what she does to handle her stress. It was interesting to see that, although her children are sometimes the source of her stress, she also asks them to help her to relieve her stress, for example by massaging her:

Sterretjie: *And now, is it the itch that I am getting now. The itch was gone from December month, January I still had it and afterwards it was gone. Now just now and then, then I got it, but then I discovered last week, with what had happened...it is TERRIBLE. Like last night, then it seemed I could go MAD. Then I told the child, take the brush and SCOUR my back, because I can't handle it...Because it sometimes feels as if my heart could stop...the way my body itches.*

It helps when you feel tense, then you move your arm. (Illustrating what she does with her arm.) First your left arm. Now I have the leaflet [showing] how your arms must make the movement and I must say it helps me, especially when my shoulders...see my my my nerves contract. My muscles at the back contract. I feel how it contracts and it is pain in your neck...Your your shoulders feel pulled up. Then I ask one of the children, just come and massage me quickly. Take the oil over there and rub me that my muscles can relax a little.

Corrie explained that stress caused her hair to fall out:

Corrie: *It was, that was the time at Môreson when my hair broke off.*

Interviewer: *Sho::: Is this it, from all the stress?*

Corrie: *Ye:::s that's how I looked that time.*

Vané's husband could see immediately when she was under stress:

Vané: *And he looks at me and he says to me you are full of stress again.*

Several participants recognised that their children, in different ways, are a major source of stress to them, but especially because of the use of drugs and disobedience. This can be illustrated by the following narratives of the participants:

Sterretjie: *The afternoon. When he came in and I just looked at him ...I did not ask him anything...all that I said, Lord, do not let my child fall back on tik...he came off it, because that time was a stressful LIFE for me.*

Candice: *But just that tik that the friends use...That, now that works me up a little...because when he comes to knock on the door then I have to hear when the police come, understand?...Those ways are it...I do not want that. I talk to him a lot. It's only that that works a little. And now, like now I almost do not sleep any more.*

Cathy: *You stress when they are disobedient. You do not know where they go, and all that stuff...and they [caused me] stress especially when my daughter became pregnant, I was disappointed and it seems to me as if it affected me...So stress actually starts when your children are growing up.*

Sterretjie also admitted that she becomes stressed very quickly:

Sterretjie: *I stress very soon, very quickly...The doctor has said I must count from one to ten. Then I said doctor I have not even said one, then I am on the stress level.*

Patsy explained that her stress sometimes gets to the point where she experiences an anxiety attack:

Patsy: *It was bad for me, I even had an anxiety attack on Saturday evening.*

Cathy admitted that she had previously received treatment for her stress or anxiety for a period of five years:

Cathy: *When I stressed, I received stress treatment for five years.*

5.2.1.5 Feeling irritated.

Several research participants emphasised that they felt more irritated than usual, specifically with their children. When asked what they usually do when they feel irritated, they described unique ways of dealing with their irritation. Lilo described that she just wants to be on her own when she feels irritated. She usually takes a book to read or listens to music:

Lilo: *I am more irritated than usually...When I feel so irritated, I normally take a book, then I sit at some place now, then I read, then I feel I relax a little, or I put on my earphones and listen to music.*

Vané stated that she usually makes an irritated sound or she just walks for a while or smokes a cigarette to get rid of her irritation, but according to her, she does not take out her irritation on her children:

Vané: *I am more irritated than usually.*

Interviewer: *Okay. And tell me, when you are irritated, what do you do with that irritableness?*

Vané: *Oo:::::!* (Laughing) *Like I now (throwing her hands in the air, making fists and an irritated sound) “Llll:::::” ...So I just say “L:::::!”*

Interviewer: *Okay then, do you take it out on your children or do you keep it to yourself?*

Vané: *No, I do, I just scream so “L:::::!”*

Interviewer: *You just scream, yes.*

Vané: *Then I just walk out.*

Interviewer: *Then you must, yes. Do you just take the road and then come back after a while?*

Vané: *Yes. And I light a cigarette.*

Although Vané stated that she does not take out her irritation on her children, she highlighted that she sometimes does become very irritated with her children, especially when they do not want to do what she wants them to do:

Vané: *YOU cannot tell me, “But mommy I want my hair loose or make a bun for me” or “I don’t know WHAT you are looking for” ...You have to do what I tell you, because you, she is still a child.*

5.2.1.6 Feeling disappointed in themselves.

Participants who had their first babies while still at school stated that having children is associated for them with feeling disappointed in themselves and feeling like failures. Having a child implied that they were unable to realise their dreams or reach their full potential:

Lilo: *I finished matric, yes. With a baby in my tummy! (Laughing)*

Ehrmmm...is...with my children ...I did, I did not ...how can I say, I did not expect that I would at, at, at such a young stage be sitting with two children.

I am disappointed with myself...Ehrmm...to tell the truth, I had many, I actually saw a bright future for myself, yes, before I had my first baby, I always told myself, I’ll sit in an office one day, I’m going to...yes, I’m going to just make a good bright future, but then it did not happen for me AT ALL! Then I was sitting with two children! (Smiling)

Dezi: *When I became pregnant before I was married, yes. I was nineteen when I became pregnant...And it is, it is the strangest thing for me, because no one ever expected it, because I was so exemplary and did not have boyfriends at all...So, when the first and it was as in my first case where I really had a serious relationship...One would think the kind of person I am, I'm going to be honest now and say that I had never in my young life thought of marriage or of children. It was never even part of my dreams. I saw myself as a very ambitious person, and who would concentrate on my career, and have pretty things, and I really have not ever. And I know they often say one dreams of your wedding from when you are young. I never dreamt it. So all the things came so unexpectedly and they were things of which I had never even thought...So here I had to go through it suddenly. And it was a major disappointment when I found out I was pregnant, because I never expected it. Never, not in my wildest dreams.*

5.2.1.7 Feeling resentment towards child.

One depressed mother emphasised the fact that she felt as if she did not want her child near her when she was feeling depressed:

Liza: *My child had to stay FAR away from me.*

And...ehrm...the thing about depression is...well it happened with me...my child is with me all the time and I am just...I all the time had no desire for him...I just wanted to be ALONE...you want to be alone, no one must be around you. You do not feel like [being with] people, you do not feel like talking.

Ehrm depression definitely made my relationship with my child a little unpleasant, so there were times that I did not want to be with him. So, not wanting to have anything at all to do with him...

5.2.1.8 Feeling detached from child.

One of the participants admitted that it was very difficult for her to share in the excitement of her teenage daughter when she felt depressed, mainly because she was afraid of being disappointed and because she did not have the energy to be excited. Sometimes, she literally felt detached from her child:

Dezi: *Ehrm, because she is a child, there are many things that are exciting for her and that make her excited. And she sometimes wants me to share in the excitement with her. But it is*

not that easy...Like I cannot be happy just immediately about anything that happens. I first want to be sure...Yes, it takes a bit longer than...I can never just shout immediately or be glad or whatever. I first want to be dead sure it is that...because I think I also am afraid of disappointment. And ehm, I think it sometimes is actually bad to be like that because... Take it as it comes...So it is that enjoyable moment that you have now. But those are not such big things that the disappointment will really be so big if you think about it now. If she did not do so well in her school work. It's not...it's not so big. It is not a case of having to stay behind in her grade or something like that. One can still do something about that. Ehm, but now I half want to hold it back, because I am afraid, so it actually isn't so necessary.

As I say the excitement or that immediate sharing in something at that moment is missing. And that, ehm, and not having energy to do things.

Although the definition of depression in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) (American Psychiatric Association, 2013) probably carries the greatest authority within the bio-medical model of depression (Crowe, 2002), the subjective feelings that the depressed women in the present study have vis-à-vis their children - including, feeling overwhelmed, feeling stressed, feeling irritated, feeling like a failure, feeling resentment towards their children, as well as feeling detached from their children - are not described or referred to in the DSM-5 (American Psychiatric Association, 2013).

This holds an important implication for the training of professionals within the context of mental health (including psychologists, psychiatrists, and psychiatric nurses), as well as the primary health context (including doctors and medical nurses), in the sense that they should also be trained in terms of the possible atypical symptoms and feelings that depressed women in low-income communities in South Africa may have vis-à-vis their children. With such training, these health-care professionals may be able to make a correct diagnosis and be better able to offer more adequate psychological services to these depressed women and their children.

5.2.1.9 Feeling guilty.

Most of the participants in the research study reported that they experienced feelings of guilt with regards to their children. Some blamed themselves when things went wrong with their children, but some also felt guilty about not having wanted children; having neglected their children in the past; and isolating their children.

Corrie and Patsy blamed themselves for the mental disability of a child and the death of a baby, respectively:

Corrie: *Yes, but I actually blame myself, I gave myself the blame; those eight years that I, because I was at home for two or three years after being paid off, not paid off, after I finished [working] at OK. Then I worked at RFF, in that time she was in the high school. But there were times when I wasn't there with her, ironing for Wonderland – you work by day and you work at night. You're tired when you get home. You hardly have time for your child or so. I say, I always said, but not with remorse any more, I say, I am the cause of my child's going astray. Then the child started buying cannabis with friends and because she...[I] don't know how doctors explain about the brain, she is schizophrenic now.*

Patsy: *And I told you and I told everyone, "I blame myself". I take full responsibility, because I did not want the child. I blame myself for it. That which happened is because I said that I did not want the baby.*

Patsy and Lilo especially felt guilty about the fact that they did not want their children. Lilo even tried to abort her child:

Patsy: *As I tell you, it is not that I'll now become totally depressed over the child that was dead, but I feel guilty about it...If I did not say what I said, it might not have happened.*

Lilo: *Ooh, I feel very bad, especially when I look at my son like that, then I think, goodness, why and for what reason, I mean he got in all those types of things I was drinking, but there were no after effects, yes, and then, sometimes I reproach myself that I wanted to do it, but then I think ...oh, life goes on, and one just has to, that is the past, and carry on. Let that be in the past, yes.*

Liza experienced a lot of guilt feelings because of the fact that she has neglected her child:

Liza: *I feel just like I, I neglect my child. It isn't right. What I do is wrong.*

Dabbie felt guilty about the fact that she was likely to isolate her child:

Dabbie: *So perhaps there is somewhere, I don't know now, if that is a problem or not, for her, because she frequently wants to go to a place, then I say no to her, we are going nowhere, then, so I think there, it must have an impact of...I make myself guilty. I am also*

selfish in some ways, then if she wants to go somewhere, perhaps to a fun day or [something like that], what [is it that] I feel I do, if she wants to, I don't want to take her.

The depressed women thus reported feeling guilty about several aspects of the relationship with their children, including blaming themselves for the mental disability or death of a child and feeling guilty about the fact that they did not want children, neglected their children, and isolated their children. This can be seen as the only pure traditional or typical symptom of depression that was expressed by the mothers in the present study, compared to the traditional criteria for a major depressive disorder contained in the DSM-5 (American Psychiatric Association, 2013). This correlates with feelings of excessive or irrelevant guilt almost all the time, as described in the DSM-5 (American Psychiatric Association, 2013).

5.2.1.10 Feeling protective towards child.

Several respondents described how they wanted to protect their children against negative influences or experiences, for example against burglars and bullies:

Patsy: *If I have said I do not have, I have a very bad sleep pattern, I did not have a good sleep pattern, but now, I might, there may be some days when I wake up at night, but it probably is because I, where I live. My little daughter's room is the very last room...And sometimes I am afraid, because many bergies [tramps] move about there by us, it isn't very safe there, but... I am afraid that someone will climb through the window. Then I am awake for one or two hours, but then I say to myself I have to sleep, because tomorrow I have to go to work again.*

Candice: *And what he now...But sometimes I can become just so angry. I do not like her to be outside when school is out...And...Children are different, though...And, and...I saw the boy one day and he shouted "Waaa! You don't go to school". But she does not understand of course, but I as a mother am worried now...Then I went to his mother and said to her, "I got a child like her and you have to tell your child that he must be glad that you got a child that is [alright]".*

One of the participants described how her need to protect her child sometimes led her to become overprotective. She admitted that her overprotectiveness might have a negative influence on the child's development, especially the child's social development:

Dabbie: *Hmmm... she has a couple of friends, but there are many times when I do not want her to go to her friends, because I am a little overprotective, because there in that small place where we also stay, so many things happen, then I just want her to just keep playing outside and not go to play further [away]. I know it's wrong, she must communicate with other children.*

5.2.1.11 Feeling attuned, understanding and loving towards child.

Several mothers also explained how they felt attuned to their children and how they could sense when something was wrong with their children:

Cathy: *See they know me, they will now a little, if they have something, then I will, I soon realise when something is the matter with them. And then I always ask them. Sometimes they will not tell me immediately, but later I keep at it until they tell me.*

If something is wrong with my children, then I'll see that they are not as they normally are. Then I will ask them. They either go to lie down in their rooms, and, but they do not tell me ...Then I go and I worry them until they tell me. Then they tell. My son is like that still. He will tell me, "That has happened now and this is what has happened". Then I talk to them.

When my daughter was pregnant with her, I even got morning sickness. She did not get morning sickness, I did. Then I thought, "But I cannot be pregnant, I am too old for pregnancy". Then the woman where I work said I should go. Perhaps I was pregnant and a miracle had happened! And then she was pregnant.

I dreamt it, that she was pregnant. And then I told my mother, "She did not look right". Then she still kept arguing with me and the next day I went to work and then I just said, "Something is wrong with my child". Because we are so close, I sense when something is not right.

In Cathy's case, the intuitive connection with her daughter manifested in her experiencing somatic symptoms of pregnancy.

Participants also indicated that they understood their children better than anyone else:

Vané: *But he is not completely normal now, his brain is just a little slow now...So other people won't, will not understand him.*

Participants reported that they felt love towards their children:

Vané: *Now I say, “Mommy loves you just as much”, I said then.*

However, some reported that even while they felt love for their children, their children did not always experience that. For instance, in Sterretjie’s case her love for her child manifested in her setting up some boundaries and her child experienced this negatively:

Sterretjie: *Ooo, that child screamed. I shouted to my neighbour for help. He told me, “Mommy I’ll never forgive you for what you are DOING to me”. I told him, “I love you, that is why I do it”. He told me, “You do not love me, if mommy loved me, mommy would not do THIS to me”. I say, “But it is because I love you, this is why I want to help you”. And he thought he was going to a reformatory, he did not know it was the rehab. It was a struggle for my two sons THAT morning to get him into Miss Carrollissen’s van.*

Other participants stated that although they felt love for their children, they were unable to show love:

Patsy: *Yes, and ehm, so we began, my son and I, our bonding began. But I love him very much, EVEN THOUGH I DO NOT SHOW HIM THAT I LOVE HIM (emphasising every word), but I will go to my uttermost for my child.*

Participants in the current study thus expressed many positive feelings about their children i.e. feeling protective, feeling attuned, feeling understanding and feeling loving towards the child. These reported positive feelings are in sharp contrast with the majority of existing literature regarding the nature of the relationship between the depressed mother and her child. Most of existing literature portrays the depressed mother as unresponsive to her child’s needs, emotionally unavailable, self-absorbed and not able to form a secure bond with the child (Coyne & Thompson, 2011; Dix & Meunier, 2009; Elgar et al., 2003; Feng et al., 2007). Although the depressed women in the present study did not deny the negative feelings they have vis-à-vis their children, they also placed great emphasis on the positive feelings they have regarding their children. It is thus clear that the depressed women in the present study felt that they were able to feel positive, protective, caring and loving towards their children.

5.2.2 Behaviours that depressed women display vis-à-vis their children.

Participants in the present study reported a whole range of behaviours towards their children, ranging from negative to positive. According to the narratives of the depressed women, the negative behaviours which they display towards their children, included unresponsiveness, abandonment, neglect and withdrawal; being physically aggressive or violent towards their children; as well as being verbally aggressive towards their children. Positive behaviours, however, were also displayed i.e. self-sacrificing behaviours, motivational behaviours, supportive behaviours and coping behaviours.

5.2.2.1 Unresponsiveness, abandonment, neglect and withdrawal.

Several mothers explained that when they felt depressed, they just ignored or withdrew from their children, or did not respond to their children's needs. This, according to them, affected the relationship with their children in a very negative way. It was also clear that the participants felt bad about this abandonment and neglectful behaviour:

Dezi: *Because I cannot just have an off day then I do not want contact with any thing or anyone. Yes, so it is for me...Then I ignore it or my child.*

Liza: *Ehrm there are times when he and I are alone at home, then ehrm he would perhaps try to say, "Mommy I am" ...he cries, he cannot speak, he cries when he wants to tell me what he wants, then I would just, I do not FEEL for him, but then he starts. He cries, he cries all the time and then it feels to me I am going to go off my HEAD, because I just want to be away, but then he cries all the time. I'll be watching him, I SWEAR I have given my child a look. I still do not know what was happening to me. I sat and looked at him. He CRIES, he SCREAMS to me, but I just sit there, I look at him. For me it was like: I was not worried about him. That's how I felt.*

Ehrm usually he cries and shows me he wants to come to me, but I do not want him ...He screams hysterically yes...I just left him. And that was wrong of me.

It is well established that depression has a very negative effect on the quality of interaction between a depressed mother and her child, especially in terms of the depressed mother's sensitivity towards her children's physical and emotional needs and signals, which are mainly non-verbal (Arteche et al., 2011; Campbell et al., 2004; Dix et al., 2004; Goodman & Gotlib, 1999; Kohl, Njeri Kagotho, & Dixon, 2011; Murray & Cooper, 1997;

Trapolini, Ungerer, & McMahon, 2008; Van Doesum, Hosman, Riksen-Walraven, & Hoefnagels, 2007; Vik & Braten, 2009).

Maternal sensitivity entails various maternal qualities, including timing, acceptance, affect, conflict negotiation, flexibility, and the mother's awareness of her children's signals, as well as adequate responsive behaviour (Van Doesum et al., 2007). Low maternal sensitivity may have a negative effect on different aspects of child development (Van Doesum et al., 2007).

Flykt et al. (2010) specifically investigated the role of prepartum and postpartum depressive symptoms, as well as the maternal attachment style in the prediction of the nature of the interaction between the depressed mother and her child. Mothers who have experienced both prepartum and postpartum depression were found to be highly unresponsive in their interaction with their children (Flykt et al., 2010). It was also found that prepartum depressive symptoms were a stronger determinant of maternal unresponsiveness than postpartum depressive symptoms (Flykt et al., 2010).

Research regarding attachment has repeatedly found evidence in terms of an association between unresponsive and less sensitive parenting, and an increased rate of insecure mother-child attachment (De Wolff & Van Ijzendoorn, 1997; Greig & Howe, 2001; Van Doesum et al., 2007). However, Van Doesum et al. (2007) also highlighted the fact that, despite relatively low levels of maternal sensitivity displayed by depressed mothers, researchers reporting on the effects of mothers' depression on children found that a substantial percentage of children of depressed women did not show significant dysfunction. The implication is that there might be considerable variance in terms of maternal sensitivity among depressed women from different backgrounds, which, in turn, may be associated with a variety of developmental effects on their children (Van Doesum et al., 2007). Consequently, it may also be the case that, apart from depression in mothers, other contextual, maternal and child factors may also play a role in the variation of maternal sensitivity among depressed women from different social contexts (Van Doesum et al., 2007).

5.2.2.2 Physical aggression or violence.

Most participants stated that they were physically aggressive or violent towards their children. They also made it clear that they felt very bad about such behaviour. Some of the mothers explained that they were trying to avoid reprimanding their children in a physical way, because they were afraid of what they might be capable of in a moment of stress and

frustration. It was very apparent that stress, anger and frustration often manifested in violence directed specifically at children. Violent behaviours directed at children included throwing an object at the child; chaining the child to a bed; hitting the child; and burning the child's hands:

Vané: *Because I know myself and when I have to bea:::t, then...like Lezzann:::e. It was one Friday. Now I said to Lezzane, "Come now that Mommy can do your hair so that we can go to town". Now SHE wants to tell me how I must do her hair and I grab her and PUSH her like this (showing with hands). Now the girl screams, "Mommy no!" "Mommy will break her BACK!" And IMMEDIATELY I feel VERY very bad, and I explain and tell her, she is four years old. "If I tell you, I must plait your hair, your hair has to be plaited".*

Because I want nothing and no one around me. So the best is to walk and so you get rid of that...see depression causes you to sometimes become aggressive. You want to do things that you must NOT do. So, to walk is best...If you believe in the Lord, then talk to the Lord. I say, "Lord I don't want to, I do not want to!" My children cannot suffer harm through this thing...The best is to talk to the Lord, just walk, just walk. You feel better, one feels better if you are on your own and walk in a direction and you come back and I felt like a new person.

Sterretjie: *I HIT! I just take a stick...I hit him in front of his mates with the stick.*

Candice: *If it still had to continue, then I would probably have lost my children. Honestly. Because it will affect my children...It would cause that I may not have my children around me...That the welfare would keep them away...But my children were more with my mother...So I did not at that time have a chance to...them so...Its only that one time that I threw [...] at her.*

But now she says, "But Mommy, it's Mommy's things, Mommy did...", and I grab the thing and throw it at her.

Sterretjie: *I chained him to a BED...Just that he could not go out of the house...He is almost like someone who...he isn't himself. Like, like that that tik makes him. I beat him, I burnt his hands – nothing helped.*

When I took out my frustration on them ...if I told Chalton now, "Chalton I am in the depression" and I say to him, "Go to the shop for me" and he said, "I am not going now, I'm going to this and that", now then there is an outburst...Then he runs through the

door...Then, he goes to the shop. Because I GRAB just any thing. And then I say, "I'll hit you OVER the head with the thing or over your back". I tell them, eh eh do...if I now say, "Wash the dishes for me! ... Pack it away!" And they take...delay longer, then there is an outburst.

Participants also reported fantasies of killing their children and threatening their children that they will kill them:

Vané: *Like...it was two weeks ago now. I think...my daughter was at school, my husband was at work, now there was nothing to do in the house, now I wonder whether the best thing would not be to kill myself and Lyndsay and Lezzane and if they would come there now... But then I thought by myself it isn't worth the trouble, perhaps I survive, then I reproach myself if Lyndsay and Lezzane would perhaps be dead or I perhaps go to jail.*

I don't care what I say, I don't care what I do. I have gone as far as to say, "I'll kill you, I'll kill the lot of you!" And I say then the four-year-old little one looks at me and I say but I cannot do it and actually I abuse my whole family.

Existing literature indicates that depression in mothers may be related to a high risk of harmful parenting behaviours, including harsh punishment and displaying physically aggressive or abusive behaviour towards children (Kohl et al., 2011). Lyons-Ruth, Wolfe, Lyubchik, and Steingard (2002) found that, compared to non-depressed women, depressed women are more likely to have mother-child interactions characterised by conflict, including hitting the child or harming the child physically. The mother's depression also increases the likelihood of the mother displaying harsh physical punishment towards her child (Chung, McCollum, Elo, Lee, & Culhane, 2004; Kohl et al., 2011; Shin & Stein, 2008). Additionally, studies have also shown that the presence of depression in mothers may increase the risk of child abuse (Kohl et al., 2011). For example, Chaffin, Kelleher, and Hollenberg (1996) found that the depressed respondents, in their study of the onset of physical child abuse and neglect, were more than three times as likely as non-depressed participants to report that they physically abuse their children.

In Patterson's model of coercive discipline (1985) (as cited in Shay & Knutson, 2008), two crucial contributing factors to a consistent pattern of escalation in physical abuse by a depressed mother, in response to child violations, could be identified. The first one is the negative reinforcement of highly violent attacks over time (Shay & Knutson, 2008). The second one is the build-up of aggression due to a combination of the initial violent act,

negative child attributions, and feelings of irritation experienced by the depressed mother (Patterson, 1985, as cited in Shay & Knutson, 2008). Consistent with coercion theory, Shay and Knutson (2008) theorise that feelings of irritation, which are associated with depression, may be a mediating factor contributing to the escalation of physical discipline and violent behaviour displayed by the depressed mother in response to child violations.

The physical externalisation of the mother's anger and frustration, in the form of violent behaviour, was also found in studies by Lochner (1999), Lourens and Kruger (2013), and Taylor (2011). Lochner (1999) specifically found that most of the participants in her study reported violent behaviour. According to Lochner (1999), this externalisation of anger and frustration may be perceived as ways in which the women of the specific community communicate their distress and needs. However, the participants in Lochner's study did not indicate that they were specifically physically violent towards their children (Lochner, 1999).

In terms of depressed women's subjective experiences of how their depression manifest in their behaviour, Lourens and Kruger (2013), as well as Taylor (2011), specifically found that the depressed women in the same low-income South African community reported physical externalisation of their anger towards their children. The physical externalisation of their anger especially entailed being physically violent towards their children, for example hitting the child with a fist or knocking the child's head against the pavement (Lourens & Kruger, 2013; Taylor, 2011).

It is thus of the utmost importance that appropriate community interventions be developed and implemented in order to address and prevent further violence towards children that may lead to serious physical abuse of the children of the depressed women in the specific community. It can also be argued that, if depression can be successfully treated in mothers whose depression manifests in the form of externalisation of anger or physical violence towards their children, the physical abuse of their children may potentially be prevented or reduced.

It is possible that such violent behaviour by depressed women towards their children may also occur in other population groups, which may lead to physical child abuse in those communities as well. The implication is that future research in terms of how depression in mothers manifests itself in various population groups and communities is needed.

5.2.2.3 Verbal aggression.

Most of the mothers reported that they were likely to be verbally aggressive or abusive towards their children. The most common verbal aggressive behaviours of the depressed women included unnecessary scolding, screaming and swearing at their children:

Candice: *I scolded them a lot, truly.*

The bed that...stand, but now there are things on it. But they are my things. I put it there. And then I said to that girl of mine, "But go, man! Fetch the bloody things!" I said to her.

Cathy: *Yes, I just scold them, I scold a lot. I scold about anything they do, if they make any little mistake, then I scold them.*

Vané: *When I freak out sometimes, then I'll scold and curse in the house and then and then, it seems – everyone is shocked, no one says nothing, then it seems as if everyone is afraid of me.*

There are times when I [...] her unnecessarily...or I shout at her: "I TELL YOU BLOODY WELL I HAVE NOT!" or whatsoever...I CURSE, I scold. I don't care what I say to them.

Sterretjie: *Because I SHOUTED at my children a lot. So, if someone hits my child, he will not come and tell me, because he is at that stage – he's afraid...to come and tell me, because he knows I have an outburst inside me.*

I shout and CURSE right away, for then I am VERY cross.

I just become SO EXTREMELY upset and now...then I cannot find rest. Ooh, I can't, I'm going to scold now, CONTINUOUSLY. (Clapping with hands) And anyone who COMES past me, I ask, COME OUT.

In a social-cognitive analysis by Tenzer, Murray, Vaughan, and Sacco (2006) the mechanisms underlying the association between mothers' depression and verbal behaviour were specifically investigated. As these researchers hypothesised, depression was significantly correlated with the mother's negative verbal responses towards her child during mother-child interaction (Tenzer et al., 2006). They also concluded that the relationship between depression and the mother's negative verbal behaviour was mediated by the mother's negative affective reactions towards her child, as well as her negative trait perceptions of her child (Tenzer et al., 2006).

While participants in the present study reported many negative interactions with their children, they also spoke about more positive interactions, interactions in which they displayed self-sacrificing behaviours, motivational behaviours, supportive behaviours and coping behaviours.

5.2.2.4 Self-sacrificing behaviours.

Several participants talked about placing the needs of their children before their own, especially with regard to the basic needs of their children:

Vané: *I can ask Sister Coetzee at the clinic...there are SOME TIMES when I still have nightclothes underneath, with my normal clothes on top and I must run to the clinic because... or he has a seizure. The last one was...last month. When I got up, mornings when I get up, before I do anything, I wash and...he still wears a nappy...When I undressed him, I saw but he had BOILS. His back...and bumps on his leg...And I said to the girl, quickly pass clothes for him...NO dress him quickly...I can dress myself quickly. And when I finished dressing myself...then I quickly went to the clinic...then sister helped him immediately. Then she said, “Vané, yo, you do not worry about anything”. Someone said, “The woman did not even comb her hair!”*

Patsy: *I couldn't do anything, I couldn't even make anything to eat for my children. I have to think of my children...I just remained standing and afterwards...gave to my children...I did not worry, as long as they just had food in their tummies, I did...As long as they just food. And yesterday I ate at my mother. And last night I went home and my children and here I sit, I did not worry about it. It just becomes a problem for me.*

I am not bothered for myself, I am bothered for my children.

To tell the truth, I went to bed on the Friday without food, Saturday I got up without food, just took care of my children, I came to eat for the first time yesterday at my mother.

5.2.2.5 Motivational behaviours.

Several participants also reported that they play a big role in motivating their children for the future, both in terms of work and relationships:

Sterretjie: *I say to him, “Elrino, my child you must not do it, you must not do that.” I feel hurt because of it...and I sketch a picture for him and then I tell him, “Do you know, mommy sees such a future for you ahead in your life and I want you to PERSIST in it.” Then I say, “I want people to look up to you.” People must be amazed, is this Elrino? They must not be able to believe that it is Elrino, so.*

Yes, now this, I encourage him in those things, as I say now, “Elrino you could go and dance on the TV.” If they go away now, South Africa...Then I said, now there was a boy from Pniel who was in last year. When we sat in front of the TV that evening, he recognised the boy, then they jumped up, because they could not believe the child was there...then I said, “You can also”.

Vané: *Because I asked her last year, I said, “Jinne my child, what is going to happen with your life? You told me that you wanted to become a social worker...now what has happened with the social worker?”...I said to her, “My child in today’s life, look, a boy who drops out of school becomes a GANGSTER and a girl who drops out of school becomes a PROSTITUTE”...I say, “I do not know. I shall not, I am not going to put pressure on you to go, but I just want to say to you, I don’t know, I’ll die, we all will die...then you stay behind...You told me, one day if...you want to work so that you can take care of Lindsay or look after Lezzane.”*

Now I tell her, “Do you know, I am VERY proud of you, because you are my very first, my OLDEST child”, and a mother, every mother wants just the best for her child. I say to her, “You won’t be sorry, because you do not do it for me, you do it for yourself.”

Candice: *You are growing up now. You must take a wife. And you must be able to help them [to do] right. Go and work for them.*

5.2.2.6 Supportive behaviours.

Participants also related several ways in which they supported their children:

Vané: *Because it was her third year in grade nine...and she now. Then he said to me but, “Aunt Liezel must go and hear herself”, then I went to the College. Luckily she wore her school clothes the next day. I came, I said to the College teacher...won’t you give her another chance? The school did not want to accept her any more.*

Sterretjie: *And then it was that they had to go and dance in the final and then I had to collect jackets and money again and they left for Worcester bitterly early on the Saturday morning and we in the...the bus picked us up. The bus made many stops to pick up people, parents of children who were in the high schools, who also were in the dance groups. Sorry. And then it was that they lost there by two points.*

5.2.2.7 Coping behaviours.

Many of the participants described how they pretended to cope in order not to show their children how distressed they were. For instance, they would refrain from crying in front of their children:

Patsy: *Sometimes I am sick for her...Even though I feel as I feel I cannot any more, I do not feel for anything today, but I am not going to show her that I feel as I am feeling or that I look as I feel...And I do not want her to be hampered by it...*

Like I say now, for Preston his school work has deteriorated but I put on a brave face...I also do not want them to see that I do not feel well and that I am sore. That I am full of problems and so on.

Lilo: *I want to keep myself strong, because I cannot let them ...I can see the two of them...and I keep myself so strong, my head is so drunk already, because it seems to be the time for me to die now, but I said nothing, as I saw the expressions on their little faces and I kept myself very strong...*

...when I started becoming depressed, I usually cried a lot and did not want them to see how I cried, then they cried with me and I did not want that, so I always went into the room and then I lay down and yes, with my face in my pillow so that they could not see...

Cathy: *...I do not want them to find out that I cry or so on. I always did, when I cried I cried at work...At work, yes. Because I am on my own then.*

In the existing literature depressed mothers are largely constructed as “self-absorbed” and “self-centred” (Coyne & Thompson, 2011; Dix & Meunier, 2009; Elgar et al., 2003; Feng et al., 2007; Vik & Braten, 2009). While participants in the current study also describe instances of self-absorption and self-centredness, they also relate many ways in which they put their children first and spend time on motivating and supporting them. The literature

emphasises the negative impact of depressed women on their children. For instance, according to Vik and Braten (2009), the self-centred mindset of the depressed mother may cause distress and avoidance behaviour in the child and consequently hamper the child's development.

In their study of the affective structure of supportive parenting in depressed mothers, Dix et al. (2004) found that maternal supportive behaviours only occur when the mother's emotions and concerns are child-oriented. When the mothers' depressive symptoms increased, they reported fewer concerns and fewer positive emotions regarding their children, as well as more self-oriented negative emotions (Dix et al., 2004). As a result, the depressed women in their study displayed less positive and supportive behaviour towards their children (Dix et al., 2004). Dix et al. (2004) explain that depression and distress especially increase focus on the mother's own needs, which may increase emotions and concerns regarding the self and, consequently, decrease emotions and concerns regarding the child. The implication is that it is possible that the mother's depressive symptoms may override her intentional structures to display supportive behaviour towards her child (Cummings & Davies, 1994; Dix et al., 2004; Downey & Coyne, 1990).

While the depressed women in the current study reported many positive ways of interacting with their children, they also reported negative interactions such as not wanting to be near their children, as well as abandoning, neglecting, withdrawing from, as well as physically and verbally abusing their children. In the current study, a much more complex picture of a depressed mother is emerging: depressed women are not always bad mothers and do not always have only bad experiences of their children. Conversely, their experiences are not only positive either and they do have negative interactions with their children.

5.2.3 Women's perceptions of the impact of their depression on their children.

This subcategory specifically entails what the depressed women themselves thought the impact of their depression was on their children. Specific attention is given to the depressed women's perceptions of the impact of their depression on the mother-child relationship, on parenting, as well as on the child him/herself.

5.2.3.1 Depressed women's perception of the impact of their depression on the mother-child relationship.

According to the perspectives of the participants, their depression definitely had a detrimental effect on the mother-child relationship. This included misunderstandings and disconnection between the mother and her child, child withdrawal, as well as child anxiety. On the other side of the spectrum, some depressed women reported that they had such a close relationship with their children, that their children were likely to imitate their feelings and/or behaviour. Some of the depressed women also reported that their depression in actual fact played a role in bringing their children closer to them. This is in contradiction with the stereotype of a depressed mother who is portrayed in the literature as not able to form a close bond with her child (Coyne & Thompson, 2011; Dix & Meunier, 2009; Elgar et al., 2003; Feng et al., 2007). However, a few of the depressed women reported that their depression did not necessarily have an impact on the mother-child relationship.

5.2.3.1.1 Misunderstandings and disconnection.

Liza specifically explained that she felt distant from her child and unable to understand him when she was depressed:

Liza: *Then I felt FAR away from him...like...then I just wanted to [...] him...I cannot understand him...*

According to Coyne, Low, Miller, Seifer, and Dickstein (2007), mothers' empathic understanding of their children's thoughts, motives and feelings influences the mothers' behaviour and the nature of the mother-child relationship. Empathic understanding can be defined as the ability to take into account the perspective of one's child, which includes, (a) the reflection on and the understanding of the motives of one's child, (b) the ability to have a relatively detailed and full view of one's child, and (c) the acceptance of new information into the existing view of one's child (Coyne et al., 2007; Oppenheim, Koren-Karie, & Sagi, 2001). In their study of depressed women's empathic understanding of their children, Coyne et al. (2007) found that mothers who had higher depression scores illustrated lower empathic understanding of their children. The mothers' depressive symptoms were thus inversely related to the mothers' empathic understanding of their children (Coyne et al., 2007). Coyne et al. (2007) emphasised that the mother's experience of depressive

symptoms may hamper her capacity for the empathic understanding of her child, as the case might be of the depressed women in the current study.

5.2.3.1.2 Child withdrawal.

Another reaction of the child towards the depressed mother, which was highlighted by the participants themselves, is that the child is sometimes likely to ignore the depressed mother or to withdraw from her. This is reflected in the following response:

Dabbie: *Then she is cross with me all day...Ehrmm...she ignores me completely, rather goes to play with friends or so, comes back again when it is bath time.*

Children of depressed women tend to mimic their mother's avoidant interactive behaviour, which may include showing lower responsiveness, more withdrawal behaviour and ignoring the mother (Flykt et al., 2010; Hoffman & Drotar, 1991). The depressed women may also find it more difficult to interpret their children's behaviour signals, which, in conjunction with the abovementioned avoidant interactive behaviour, may result in a vicious cycle of mutual rejection by the depressed mother and her child (Flykt et al., 2010; Murray et al., 1996). This may further exacerbate mother-child interactional problems and the mother's experience of depression (Flykt et al., 2010; Murray et al., 1996).

5.2.3.1.3 Child anxiety.

Participants reported that their children were likely to experience separation anxiety, as well as that their children were sometimes afraid to share difficult issues with them.

While some children ignored their depressed mothers or withdrew from them, other children did not want to be separated from their depressed mothers. In some instances, it was not just a case of "not wanting to be separated from the mother", but the child showed clinging behaviour or cried hysterically when the mother was not close by:

Liza: *Because he wants to go to no one...he still struggles...he will not just go to anyone. Not even my family, so...I can...he knows them, but he just does not want to go...he just wants to stay with his mother. He holds me ALL THE TIME. I just cannot leave him alone, because he...he will become hysterical. He is like that.*

Vané: *I tell him, “Boeta, mommy is going out now”, then he says to me, “Don’t be long”. I tell him, “No boeta, mommy is not going to be long”.*

One of the participants also reported that her children were afraid of leaving her alone, especially when they could sense that she was not feeling well:

Lilo: *And my children have...jinne they were at school, they then, they would not let me be on my own, I told them, “You have to go to school, you cannot keep coming after me, I know I do not feel well, mommy will be alright”, I always spoke to them like that. Sometimes they did not want to go to school, and then my sister had to sit here with them on her hands, just so that they could see that I had become a little better and so on.*

In his book about the clinical applications of attachment theory, Bowlby (1988) describes separation anxiety as a child’s fear or anxiety of becoming separated from or losing his or her care-giving or attachment figure, in this case, the depressed mother. Bowlby (1988) explained that man, like other animals or species, responds with fear to threatening situations, not because these situations have the potential to carry a high risk of danger or pain, but rather because they may pose an increased risk to their survival. Conceptualising separation anxiety as a basic human attitude or disposition makes it easier to understand that a depressed mother’s non-verbal threat of abandoning her child or leaving her child alone, may be so terrifying to her child that it may further intensify separation anxiety in the child (Bowlby, 1988). Having said this, it may be possible that some of the children of the depressed women in the present study may have interpreted being separated from their mother for a while as a threat of abandonment. This may be due to the development of an insecure attachment with their depressed mothers, which might have influenced the formation of their negative internal working models. As Greig and Howe (2001) emphasised, the child’s sense of loss is considered a key factor, especially when depression may increase the psychological unresponsiveness of the mother during her experience of depressive symptoms, which may result in the development of an insecure mother-child attachment. Additionally, Greig and Howe (2001) explain that separations, absences, losses and emotional unresponsiveness of the depressed mother are believed to play a large role in the shaping of children’s internal working models.

Although most of the participants emphasised that their children told them everything, as highlighted under the participants’ perception of a “good” mother-child relationship, one

of the mothers admitted that her children were sometimes afraid to share difficult issues with her:

Cathy: *She told me everything, except before she became pregnant, she did not tell me, because she was a little afraid. I had to discover it afterwards...I did not know at all. She always visited my sister and met the boyfriend there of whom she never told me.*

See they can for me, they would now a little, if they have something, then I will, I will find out quickly if something is wrong with them. And then I always ask them. Sometimes they do not want to tell me immediately, but later I keep [asking] until they tell me.

In their study of depression in mothers, the mother's locus of control and the mother's emotion regulatory strategy as predictors of children's internalising problems, Coyne and Thompson (2011) found and explained that mothers who reported high levels of depressive symptoms also reported more feelings of being out of control of their parenting role. Consequently, it is easier for them to rely on avoidance as a coping mechanism and emotion regulatory strategy. They also found that mothers who reported higher scores regarding depressive symptoms also reported more internalising symptoms in their children (Coyne & Thompson, 2011). Coyne and Thompson (2011) suggested a possible conceptual framework to better understand the abovementioned mother-child interaction: mothers who adopt avoidance as emotion regulatory strategy may fail to model adequate emotion regulatory strategies for their children. Additionally, depressed women may be unable to assist children to regulate their negative emotions, like anxiety, because they find it difficult to regulate their own negative emotions themselves (Coyne & Thompson, 2011). This may potentially contribute to their children internalising their anxiety or preventing their children from sharing difficult issues with their mothers who struggle to regulate their own difficult emotions themselves.

5.2.3.1.4 Modelling.

Several depressed women have explained that they had such a close relationship with their children, that their children imitated their feelings and behaviour:

Liza: *Ehrm it was a little difficult at the beginning also now, because ehrm I could see from him...how frustrating I was...*

Yes, ehrrm just say...sometimes when you...part of depression is you may now and again have outbursts of anger, then I become terribly angry or so, but I do not get that any more. It is coming right. But later then...then he becomes a little difficult again, then he starts to scream and scream...or he just wants to...he jerks up or he throws himself on the ground ...so then my mother always says to me: "Do you see, you have just done that"...so this is part of [it]...

Children of depressed women do not only imitate their mother's interactive behaviour, as mentioned earlier; they may also mimic their depressed mothers' less positive and more negative emotions, compared to children of non-depressed women (Cohn, Campbell, Matias, & Hopkins, 1990; Flykt et al., 2010). As the depressed mother may experience difficulty in regulating her own emotions and consequent behaviour (Coyne & Thompson, 2011), her children may provide her with a "mirror", which enables her to literally see what she feels and how she behaves. This may have the potential to help her to identify and regulate her own emotions and, if possible, to adjust her behaviour accordingly.

5.2.3.1.5 Closeness.

One of the participants particularly highlighted that her depression actually played a role in bringing her children closer to her emotionally, rather than hampering the relationship she has with her children. She specifically emphasised that her depression caused her children to be more worried about her and that they showed more interest in her as a mother. This perception is reflected in the following response:

Interviewer: *We have said you have two children...what impact do you think your depression has had on your relationship with your children? Did it influence your relationship at all? The mother-son relationship?*

Lilo: *No, no not at all, it just brought them closer to me...to be more concerned, more interested in me and so on, yes.*

This response of one of the depressed women in the present study contradicts almost all of the existing literature with regard to the impact of the mother's depression on the mother-child relationship, which mainly emphasise that depression weakens the mother-child bond and causes an insecure attachment between a depressed mother and her child (Arteche et al., 2011; Benvenuti et al., 2001; Boyd, Zayas, & McKee, 2006; Edhborg et al., 2001;

McMahon et al., 2006; Meredith & Noller, 2003; Perry, Ettinger, Mendelson, & Le, 2011; Vik & Braten, 2009).

5.2.3.1.6 No impact on mother-child relationship.

A few participants felt that their depression did not necessarily have an impact on the relationship they have with their children. This was evident in the following responses:

Interviewer: *Okay, I quickly want to hear, do you think that your depression had an influence on your relationship with your children? Like the mother-child relationship? The relationship with a son or a daughter, do you think that your depression influenced it?*

Sterretjie: *No.*

Candice: *No, not her... I was there already. I have been since, ooh jinne, sjoe...I have been like this for many years.*

Cathy: *I think, it has not actually bothered them yet, so...I don't know. I behave myself around them, except that I now begin to rage, but I do not want them to find out that I cry and so on. I have always done, if I cry, then I cry at work.*

The fact that some participants thought that their depression did not impact on the mother-child relationship in a negative way, is in contradiction with the existing literature. Existing literature maintains that maternal mental health is an important determinant of the early mother-child relationship especially (Van Doesum et al., 2007; Flykt et al., 2010). Kub et al. (2009) specifically found that from a clinical perspective, maternal depressive symptoms not only impair the mother's wellbeing, but may also have a strong negative influence on all other significant persons with whom the mother is in a relationship, especially her children. From the existing literature it is clear that the relationship between the depressed mother and her child is typically characterised by the mother's emotional unavailability and unresponsiveness; insecure attachment between mother and child; the child's strong sense of loss; and an internal working model characterised by poor expectations of self and of others (Flykt et al., 2010; Greig & Howe, 2001; McMahon et al., 2006).

It possibly was difficult for participants in the current study to acknowledge directly that their depression had an influence on their relationships with their children. However, the data of the current study suggest that it is not clear that depressed women simply are bad for their children. The results of the present study also highlight the importance of perceiving each depressed mother as a person with unique qualities, as well as someone who has the potential to form a relatively “good” relationship with her children, despite her depression.

5.2.3.2 Depressed women’s perception of the impact of their depression on parenting.

It is well established that depressive symptoms in mothers are consistently related to low levels of parenting competence (Dix & Meunier, 2009). It has been found specifically that, as mothers’ depressive symptoms increase, mothers tend to become less responsive and positive towards their children; more disengaged and negative; and inconsistent when disciplining their children (Cummings & Davies, 1994; Dix & Meunier, 2009; Lovejoy et al., 2000). Dix and Meunier (2009) highlight that, despite established evidence that indicates a relation between depressive symptoms and poor parenting competence, the mechanisms underlying this relation are not yet thoroughly understood.

Three participants in the present study reported that their depression did not have an influence on their role as mothers. On the other hand, and in line with existing literature, other participants reported that depression definitely compromised their roles as mothers. The depressed women especially highlighted the following:

- Inadequate mothering;
- Uninvolved mothering;
- Substitute mothering; and
- Compromised discipline.

5.2.3.2.1 No impact on mothering role.

According to three of the mothers in the study, their depression did not have an influence on their role as mothers. This perspective is reflected in the following responses:

Interviewer: *Do you think your depression has had an impact on your role as a parent? Such as being a mother?*

Cathy: *No, not really.*

Corrie: *No, I believe not. I became a mother early, before I was married, I already was a mother. So for me it was not...it did not have an impact.*

Patsy specifically referred to her ability in putting her feelings of depression aside and still being a “good” mother for her children:

Patsy: *As I said, no, because I can still shift all that happens and all the feelings aside and be a good mother for my children. I can still take care of them and even when they can see that I am ill, I am there for my children. So I do not think that it...I can still shift it aside and be a mother.*

5.2.3.2.2 Inadequate mothering.

Most of the mothers felt that they were not able to execute their duties as mothers, for example to prepare food for their children; to change nappies; to wash or bath their babies; to spend quality time with their children; and to make choices in terms of their children, when they were depressed. Most of the depressed women found it difficult to attend to the basic needs of their children:

Liza: *Well, then I did not do what I had to do for most of the time, so ehm...yes you are not yourself...so you do not do the things you should do. Then there are times when I did not have any desire perhaps to make food for him or dry him or clean him, to wash or so. I just do not feel like it...Then I did not do it, but I eventually had to do it, because it was my DUTY to do it. He cannot do anything for himself, so I have to, but one...you want to do nothing...I just feel like I, I am neglecting my child. It is not right. What I do is wrong.*

Lilo: *Yes, because I could not do for them what I should have done...For example ...ehmmm...we usually are, in the evening we tend to...ehmm...play games.*

Interviewer: *Board games?*

Lilo: *Yes, I could not do it any more then, I could not make a sandwich for them, and especially, they were very fond of tea, jinne, I could, these types of things I could not do for them. It has had rather an impact on them, because sometimes when my sister did this type of thing for them, they were actually not satisfied with it, because I, they expected me to do it and, now I could not do it any more, this is why they continuously started to become so close to me...*

Dezi: *I find it difficult to make decisions. Sometimes I think ehm, I should be able to think on my feet, and I should be able to give answers and to say. And if I do not do it, I think she might get the feeling that she can take chances and it remains important for me to show that I am the mother and I have to take the decisions. And this does not come as easily when you are in the depressed state, because you cannot immediately think of everything...Look, repercussions are related to it and because I cannot think of it so quickly the result is that I may say I should perhaps have made a concession. That I may later regret a little or I...I would make a concession and later be sorry that I had.*

5.2.3.2.3 Uninvolved mothering.

Several participants referred to the fact that their feelings of depression resulted in them not being involved parents, including that they never wanted to go anywhere with their children. This perspective of the depressed women is reflected in the following response:

Dabbie: *Ehrmmm...as I said before, I think not actually...I do not know if I am an involved parent at the moment, because I, the two of us always never go out, so perhaps somewhere there is, I don't know now, if that is a problem for her or not, because she often wants to go to some place, and I say no, we're not going anywhere, then, so I think there, it must have an impact...*

5.2.3.2.4 Substitute mothering.

In many instances the grandmother took over the responsibility of caring for the children of the depressed mother. This happened especially in cases where the mother was very young; when the mother was aggressive or violent towards her children; or when the mother was not able to fulfil the basic needs of her children:

Patsy: *I became pregnant in the wrong way, I was still young and then I had the child and I just wanted (movements as if she wanted to push him out)...He actually grew up with my mother. I was there, but my mother had full supervision and everything over him...I took it like - I was young. I had just turned 21, when he turned one, I turned 21. I cannot [sit] with a child now, no...And eh so I just [...] him aside a little...*

Candice: *I, jinne, I cannot, really. But my children were with my mother more...She helped me a lot by, because if I still had my children around me, I would not have been right*

[normal]...Because I would certainly have assaulted my children, because I become furious, hysterically,...That time. They had to stay with my mother for three months.

Liza: *My mother is always there. If my mother had not been there, I WOULD HAVE taken him, but he then would keep screaming. But the thing is also, I think what I did wrong, was when he was like that, I always just let him...suckle again, so that was wrong...he should, he should not have suckled me. Then it caused worse.*

5.2.3.2.5 Compromised discipline.

Most of the participants reported that their depression had a negative impact on the way in which they disciplined their children. This included that the mother did not always discipline her children herself, but rather left it for somebody else to do, as she was afraid of what she might be capable of; or that she would be too harsh when disciplining them:

Dabbie: *Ehrmm...I don't correct her at all any more, hear, because once I speak loudly, I almost get...I get a pain in my head or so, I'd rather say my mother must sort her out. But I leave her alone.*

Interviewer: *So you do not handle discipline at all any more?*

Dabbie: *No, I can't ...I am afraid, if I start hitting, I go further than normally...so I rather avoid it and rather have my mother disciplining her, and often I just tell my mother: "Mom, okay I am not going to deal with the [issue], Mommy must handle it".*

Patsy: *Because he is big already. He is 16, he turns 17 this year...So I cannot tell him, you cannot do it, you may not do it, because he has grown up already...The time when I...should have done that, then I say to myself, I did not do it. So I feel I am not going to bring him up like my little one now. I can still tell her, this and that are wrong, this and that are wrong. But he is too big already...I just feel, I don't know if I'm right or wrong, but I feel I will not be able to teach him now any more, "Do this, this is wrong, do that, this is right" and so on ...because he is a teen already.*

...I scold him a lot. I want to scold Preston, then he will say, later: "How did the woman again"...meaning it as a joke. One moment we scold and shortly we are mother and son again.

Vané: *Last evening I was scolding her. She taunts Lezzane. Taunts and taunts and she taunts...*

One of the participants also recognised that she and the father of her children did not discipline their children in the same or in a consistent way, which might have been confusing to their children:

Vané: *But then her father heard Lezzane say, she said, “Voetsek!”. Then I said, “No, dogs do not live in our house”. Then her father said to me, “But I am going to beat you”. Then I said, “But you do not know what Ashlyn does!” Ashlyn taunts and taunts and taunts Lezzane.*

Only one of the participants reported that she disciplined her children in the same way as before she was diagnosed with depression:

Cathy: *It is the same...Look, if they do something, I punish them so. I, I do not give them pocket money, for a certain time, then I tell them, you are disobedient now so I don't give pocket money, or I do [not] do that specific thing that they want as extra. I do not do it for them.*

A review of existing literature regarding the effect of depression in mothers on parenting, led Dix and Meunier (2009) to conclude that maternal depressive symptoms are associated with various parenting behaviours that have been related to a variety of child developmental problems. Dix and Meunier (2009) could discern four ways in which depression impacted on parenting. Firstly, maternal depressive symptoms may predict maternal withdrawal from the children; low responsiveness to the children's needs; and limited involvement with the children (Dix & Meunier, 2009), which was also reported by several depressed women in the present study. Secondly, depression may predict intrusiveness on the part of the mother (Dix & Meunier, 2009; Field, Healy, Goldstein, & Guthertz, 1990). The third category identified by Dix and Meunier (2009) entails that maternal depressive symptoms may predict flat affect; high levels of negative emotional expression; and lower levels of positive emotional expression towards her children (Dix & Meunier, 2009; Feng et al., 2007). Fourthly, depression in mothers may predict ineffective, harsh, inconsistent and manipulative disciplining of children (Dix & Meunier, 2009; Leung & Slep, 2006; Lovejoy et al., 2000), also apparent in the present study. In general, it can be said that participants in the present study acknowledged parenting deficits in all four categories,

even though they also were in touch with the fact that at times they actually were good mothers.

5.2.3.3 Depressed women's perception of the impact of their depression on the child him/herself.

Almost all participants felt that their depression had a negative impact on their children. They talked about how their depression impacted on the emotions, behaviour, development and personalities of their children.

5.2.3.3.1 Impact on emotions and behaviour.

The majority of participants were able to identify the impact of their depression on the emotions and behaviour of their children. The different ways in which they felt their depression had an impact on their children's emotions and behaviour, as identified by the depressed women, included that, the child experienced sleeping problems; the child did not socialise with his/her peers; the child became anxious, worried and sensitive; and that the mother's emotional state directly influenced the child. Liza, very astutely observed how her child had to absorb her depression by breast feeding:

Liza: *Ehrm for him also, he is very little still, so...ehrm...I don't know...ehrm...how he feels certainly. The things he does – he does not know what is right and what is wrong yet, so he could also perhaps emotionally it could also affect him...or I don't know now...because he still drinks from me, so he knows exactly how I feel and then he can also not drink it...so emotionally it could perhaps or...I don't know...his behaviour can perhaps be touched by it now and so on. And this may be why he is like that, because he...he won't just go to someone.*

Cathy specifically reported that her child experienced sleeping problems:

Cathy: *I don't know for my son...my son has sleeping problems...*

Liza also recognised that her child did not socialise with other children or people:

Liza: *Ehrm perhaps as he grows older, he will perhaps more, perhaps he will not be able to socialise better...perhaps not or ehrm...because I can already see he wants to go to no one so he will not laugh easily. He won't be just happy go lucky, like my sister's children...He takes a little longer. So, perhaps he won't...he has to adapt first. So, he won't adapt quickly. So, I*

can see that. Because I am actually scared to send him to the crèche, because I don't know how he will ehm...he looks for all the attention, so he will take a long time before he will become interactive with other children, I would say.

Dezi and Cathy described their children as anxious and worried. Dezi also explained that her child became very sensitive, like her herself, which caused her child to overreact in many instances:

Dezi: *I think she is unnecessarily worried about things sometimes and she worries about things about which she does not need to, but then it is exactly as a result of her seeing that she is uncertain. I do not have that self-confidence or I do not project that confidence to be able to say ehm, "Don't worry!" I do it a lot, but I sometimes think it is my own situation that has nothing to do with her that she may be picking up. Where she also starts to do the same and she, her nature is also generally very sensitive. And her father is also like that and I am also like that. And at another level she is. And so, it is her nature but I think I do not help it on, because I do not reflect it myself. And I think it has an influence on her, because she can ehm overreact awfully about the smallest things. And it is perhaps easy for me to say this, but perhaps she sees it in me.*

Cathy: *But luckily my mother saw it and later she began to be stressed and she began chewing her nails.*

She was four years old...She received treatment for a year, but later she became normal again, to manage without treatment. She's alright now...I don't know what it was. It was a small pill, because she always chewed nails, because she is nervous...Because she always [...] so, one can see that she is nervous.

With regard to the impact of depression in mothers on the emotions and behaviour of the child, Elgar et al. (2003), in their study regarding maternal mood and child adjustment problems, found that a significant relationship exists between maternal depressive disorders and emotional and behavioural disorders among the children of depressed women. They specifically found that the presence of maternal depressive symptoms more than doubled the rates of aggression, hyperactivity and emotional problems in children (Elgar et al., 2003). This may explain why some depressed women in the present study reported that their children experienced sleeping problems, did not socialise with peers, and became anxious, worried and sensitive.

Trapolini et al. (2007) also found that children who were exposed to chronic depression in their mothers, showed significantly more problematic internalising and externalising behaviours, according to their parents' reports. According to Feng et al. (2007), children with internalising and externalising behaviours specifically experience problems in regulating their negative emotions. Children who experience more problems with internalisation, typically experience high levels of anxiety and sadness, while children who mostly experience externalising problems, generally experience difficulties with the regulation of their anger (Denham et al., 2000; Feng et al., 2007).

Children of depressed parents are at elevated risk for the development of internalising and externalising disorders and symptoms (Watson et al., 2012). Extensive research has also shown consistently that gender differences exist with regard to the prevalence of internalising and externalising problems in the general population, with females showing a higher risk for internalising symptoms (for example feeling states of anxiety and depression), while males show a heightened risk for externalising symptoms (for example delinquent and aggressive behaviour) (Najman et al., 2001; Watson et al., 2012). According to Watson et al. (2012), these gender differences regarding rates of internalising and externalising problems may be even more evident in the children of depressed parents. In other words, daughters of depressed women may be even more vulnerable to the internalisation of symptoms and their sons to the externalisation of symptoms, as a result of exposure to their mothers' depression (Essex, Klein, Miech, & Smider, 2001; Najman et al., 2001; Watson et al., 2012).

Several participants also were acutely aware of the fact that their emotional state definitely had a direct impact on their children. For instance, when the mother is crying or feeling depressed, it usually upsets her children to the point that she needs to first calm and contain herself, before her children will calm down:

Liza: *And he can sense. My child can sense everything, because I mean he still drinks from me, so how I feel...touches him also.*

All the times that I...I first calmed myself and then I calmed him, so that he could see mamma is calmed...so it is still okay, so it's alright.

Vané: *"I love you myself", I say. Then I try to calm down or to stop crying, because it upsets him. Or in the end he also starts to cry.*

Several depressed women also explained that their children became upset or cried, especially when the mothers became physically or verbally aggressive towards them:

Vané: *She's, one can see, it upsets her completely, say for instance she has done something and I become like that, and then she comes crying to me and she says to me, "Sorry mommy, sorry mommy" and she cries or says sorry until, until I say it's alright. She says so until I say something, "Mommy is also sorry". And she cries until...and she says sorry until I say, "Sorry Lezzane" to her.*

It upsets them...For Ashlyn, she's big already, for her, it upsets her totally...

Candice: *A lot, then they just sit and cry.*

In their study of the emotional exchange in mother-child dyads, Feng et al. (2007) emphasised that the quality of mother-child interactions is crucial for the social and emotional development of children. One way in which the mother may impact on her children's social and emotional development, is by their dyadic interaction, during which emotion is a very important medium through which mothers and children communicate (Feng et al., 2007). Depressed women's affective expression sets the emotional context to which children are exposed and, subsequently, may influence their children's emotional state and affective expression (Feng et al., 2007), as was also the case in the current study. Emotional exchange between mothers and their children seems to play a large role in the development of children's emotion regulatory strategies, which may become problematic when the depressed mother finds it difficult to regulate her own and her children's emotions (Feng et al., 2007). Overall, Feng et al. (2007) found that depressed women and their children seemed to have a differential effect on each other's emotional states and affective expression, with depressed mother's emotional expression appearing to have a more critical effect on their children's subsequent emotional states and affective expression, than vice versa.

5.2.3.3.2 Impact on development.

Several participants felt that their depression interfered with child development, for instance hampering their children's learning ability and school work:

Candice: *The girl could not learn any more...She could not learn any more at school, because the mother at home was not right [normal].*

Truly. My big children, it really affected them. They failed that year.

Patsy: *His school [work] was affected a lot. He has been in grade nine for three years now.*

Vané: *Because it was her third year in grade nine...and she now...The school now did not want to accept her any more.*

These narratives from the depressed women in the present study are in line with literature that indicates that depression in mothers has a negative impact on child developmental outcomes, including language delay; learning disorders; cognitive deficits; and school failure (Beardslee & Gladstone, 2001; Brennan, Hammen, Katz, & Le Brocque, 2002; Halligan, Herbert, Goodyer, & Murray, 2007; Lovejoy et al., 2000; Manuel, Martinson, Bledsoe-Mansori, & Bellamy, 2012).

Several mothers also admitted that their overprotectiveness in terms of their children's safety definitely had a negative impact on the development of their children's social skills:

Dezi: *I think what makes me very tense is the fact that she many times does not make as much contact socially as I would like her to, or go out with me...Or not...And, and often I think very big. Like I do not know how to handle it because I think it often also has to do with safety...*

According to Bowlby's (1988) attachment theory, when a child has such a close relationship with his or her depressed mother, as many of the mothers in the present study reported, he or she may sometimes find it difficult to develop a social life outside his or her family. He described this relationship as "symbiotic" (Bowlby, 1988, p. 31). Developing a social life outside the protective context of the family, based on the depressed mother's overprotectiveness, may cause an incredible amount of anxiety for the child, as this is totally out of his or her comfort zone. This may explain why several depressed women in the present study reported that their overprotectiveness definitely had a negative impact on the development of their children's social skills.

It was clear in the current study that the mother's depression had an impact on both of the child's work and relationships.

5.2.3.3.3 Impact on personality.

The majority of depressed women also explained how their depression had an impact on the formation of their children's personalities. The participants specifically highlighted

that their children were likely to develop a “parentified” and/or over responsible personality.

The depressed women specifically indicated that their children sometimes took over the role of the parent when the mother was very depressed – almost becoming a “parentified” child. In the role of parent, the child usually disciplines or corrects the mother. This reaction of the children of the depressed mothers in the present study is reflected in the following responses:

Vané: *Ashlyn puts me in my place very quickly. If I begin to scold, Ashlyn then says, “Mommy no no no”... “No one in the house drinks, no one in the house uses drugs, because our brains must not be influenced. DON’T REACT LIKE THAT, because it isn’t nice. I don’t like it that mommy curses like that or I don’t like that mommy carries on like that”...then she tells me, “Mommy that is not how mommy should talk”.*

Candice: *I scolded them a lot, really...Lots, then they just sat and cried...And afterwards I feel so pained. But then I am right again, then the girl of mine says, “Mommy, just take a pill, please.” Because she knows by now if I have taken a pill then I am...then I am much better.*

And when I am like that, I want to forget what is happening around me. Then I forget to take my pills...But that girl of mine...She reminds me.

Several depressed women reported that their depression caused their children to become over responsible:

Dabbie: *How can I say it now, she has handled more things than a normal child. Many children are just playful and so on and she has often had to when I was not feeling well, okay, but she must do this and she must do that, without me needing to have to say anything to her, so I think it makes her more responsible.*

Dezi: *Although she is a very understanding mature child...Ehrm, but I also think it is all the events in her life that caused [it]. She lost her little brother, her father does not live here any more. Her father is married to his third wife already...So these are all things to which she had to adjust. I think these are all things that made that she is like this...And also because we two...Because I teach her how to do certain things...And to do the things for herself...Where other parents for instance do things for their children, I do not do it for her. And I want her to do it herself.*

The child developing a “parentified” and/or over-responsible personality can also be understood in terms of attachment theory (Bowlby, 1988). Bowlby (1988) explained that, in the majority of cases, the cause of the mother’s overprotectiveness can be traced back to the depressed mother who may have grown up anxiously attached herself because of a difficult childhood. As a result, she may now seek to make her child her attachment figure (Bowlby, 1988). The child may then become responsible for having to care for his or her own mother (Bowlby, 1988). In other words, the child becomes a “parentified” child, as well as becoming over responsible, as evident from the narratives of the majority of depressed women in the present study. In these cases, the typical relationship of care-giving parent to attached child, is totally inverted (Bowlby, 1988). This may leave the child to care for his or her depressed mother and being responsible for numerous maternal duties.

This study certainly suggests that while growing up overprotected may have a negative impact on children’s development, it may also be beneficial to children to learn from early childhood that they have to be sensitive to and take care of their primary attachment figures e.g. their mothers.

6. Conclusion

The present research study formed part of a larger longitudinal project concerned with low-income South African women's subjective experiences of depression. This longitudinal project was initiated to develop a better understanding of how the women subjectively experience their depression, with the hope that the results will inform more effective and appropriate psychological services to the specific target group (Lourens & Kruger, 2013).

Given the finding that relationships were pivotal in women's experiences of depression, the present study focussed on how depressed women experienced their relationships with their children. The present study aimed to provide a descriptive overview of how one group of depressed South African women experience their relationships with their children, as well as to compare the findings with existing literature.

The following specific aims were formulated:

- To investigate how one group of depressed South African women experience their relationships with their children.
- To explore how the depressed women experience the relationships with their children to impact on the development and experience of their emotional distress.
- To explore how the depressed women themselves perceive their emotional distress to impact on their relationships with their children, their parenting and on the children themselves.

I have thus explored how the relationship with their children may have contributed to, as well as may have protected against, the depressed mothers' experience of emotional distress. Conversely, I have also explored how the depressed women perceived their emotional distress to impact on their relationships with their children, their parenting and on the children themselves. While numerous researchers have examined and identified the important negative effects of depression in mothers on their children, a very limited number of studies have focussed on the opposite direction of the depressed mother-child relationship. In other words, very few studies have examined how relationships with children may influence the development and subjective experience of depression and emotional distress in mothers, as well as, on the other hand, protect against their experience of depression and emotional distress (Dix & Meunier, 2009; Flykt et al., 2010; Greig & Howe, 2001; Leung & Slep, 2006; Lovejoy et al., 2000; McMahon et al., 2006; Rishel, 2012; Turney, 2012). While attempting to address this literature gaps, it was also hoped that the current study will contribute to the development of more appropriate and effective therapeutic interventions for

mothers burdened with depression in low-income communities in South Africa.

Semi-structured interviews were conducted with ten depressed women from a semi-rural, low-income community in the Western Cape (South Africa). These interviews specifically focussed on the depressed women's subjective experience of the relationship with their children. Each interview was recorded on a voice and a video recorder. Data-analysis took place by means of social constructionist grounded theory. Social constructionist grounded theory is focussed on the lived personal experiences of the participants from their own perspectives (Charmaz, 1995). According to Henwood and Pidgeon (1992) and Charmaz (1995), data analysis by means of social constructionist grounded theory consists of three basic steps. The three steps include that (i) the researcher work systematically through the whole data set in order to generate labels to describe relevant abstract features and concepts as a means of developing data descriptive language; (ii) the researcher identify a set of categories based on one or more instances in the data set, in order to develop a rich conceptual understanding and integration of all the categories into a coherent and systematic theoretical account; after which the researcher move into (iii) theory building (Henwood & Pidgeon, 1992). According to Henwood and Pidgeon (1992), the scope of some studies only allows for the execution of the first two steps of social constructionist grounded theory. As the aim of the present study was to provide a descriptive overview of how one group of low-income depressed South African women experience their relationships with their children, only the first two steps of social constructionist grounded theory were implemented.

Data analysis by means of social constructionist grounded theory yielded two main categories and various subcategories. The two main categories were: (a) The impact of children on their depressed mothers; and (b) The impact of depressed mothers on their children.

Regarding the first main category, namely the impact of children on their depressed mothers, three subcategories were identified:

- Child qualities and behaviour that contribute to depression in women;
- Child qualities and behaviour that protect against depression in women; and
- A “very good” mother-child relationship.

Within the second main category, namely the impact of depressed mothers on their children, the following three subcategories were identified:

- Feelings that depressed women have vis-à-vis their children;
- Behaviours that depressed women display vis-à-vis their children; and
- Depressed women's perceptions of the impact of their depression on their children.

Most of the literature – in actual fact almost all of the literature – regarding depression in mothers and the relationship between the depressed mother and her child, emphasise the detrimental effect of the mother's depression on the child (including child developmental problems; child problem behaviour; child emotional problems; learning difficulties; insecure attachment; and impaired social skills), as well as how the child's problem behaviour and emotional experiences may contribute to the mother's depression (Coyne & Thompson, 2011; Dix & Meunier, 2009; Elgar et al., 2003; Feng et al., 2007; Flykt et al., 2010; Najman et al., 2001; Turney, 2012; Watson et al., 2012). While the depressed women in the present study did report numerous ways in which their depression had a detrimental effect on their children, as well as how their children contributed to their experience of depression, a more complex picture emerged in the current study.

Regarding the **impact of children on their depressed mothers**, the women reported a whole range of child qualities and behaviour, specifically ranging from child qualities and behaviour that contribute to their depression to child qualities and behaviour that protect against their depression. With regard to child factors that contribute to their depression, the depressed women specifically reported:

- child behavioural problems;
- the personality of the child;
- the disability of the child;
- the loss of a child; and
- the child being a reminder of a previous abusive relationship.

The depressed women specifically reported that the following child behavioural problems had an impact on their experience of depression: substance abuse (including drugs, alcohol and cigarettes); criminal behaviour (including theft and murder); teenage pregnancy; as well as the disobedience of the child. The depressed women also identified specific personality characteristics of their children that were difficult for them to cope with, including rebelliousness and stubbornness. Several participants reported that the disability of

a child had a major impact on their experience of depression. The disabilities of the children of the depressed women in the present study could be divided into three categories, namely physical disability, mental disability, and irreversible disease. The depressed women in particular emphasised the impact on the mother's life of having to care for a child with a disability. This included that the mother's life started to revolve around the child with the disability; that the mother has to look after this child on a full-time basis; that the mother has to administer the child's medication herself; and that the mother also experiences feelings of unfairness. The depressed women also identified the loss of a child as an important contributing factor to their experience of depression. In addition, the depressed women reported that, in some cases, their children were a reminder of their previous abusive relationships. As a result, the specific participants did not want to have anything to do with their children, and blamed the children for what happened in their previous abusive relationships.

On the other hand, the depressed women also described child qualities and behaviours that, according to their perspectives, comforted and protected them against emotional distress. The depressed women specifically reported that the following qualities and behaviours of their children played a protective role against their experience of emotional distress:

- the attuned child;
- the understanding child;
- the child as source of pleasure and hope;
- the protective child;
- the comforting child;
- the partnering child;
- the loving child;
- the dependent child; and
- the child as a God-given gift.

Surprising also, most of the participants constructed their relationships with their children as "very good". The depressed women specifically described the mother-child relationship as "good" as they felt that there was good communication, good mutual support, physical closeness and strong emotional bonds.

Regarding the **impact of depressed mothers on their children**, the mothers in the present study also reported a whole range of feelings and behaviours vis-à-vis their children, which ranged from being violent towards their children to being caring, supportive and protective. Existing literature constructs the depressed mother as unresponsive to her child's needs, emotionally unavailable, self-absorbed and not able to form a secure bond with her child (Coyne & Thompson, 2011; Dix & Meunier, 2009; Elgar et al., 2003; Feng et al., 2007). Although the depressed women in the present study did report negative feelings vis-à-vis their children, they also placed great emphasis on the positive feelings they have regarding their children. The negative feelings they have with regard to their children specifically included:

- feeling isolated;
- feeling stuck or trapped;
- feeling overwhelmed;
- feeling stressed;
- feeling irritated;
- feeling disappointed in themselves;
- feeling resentment towards the child;
- feeling detached from the child; and
- feeling guilty.

However, the depressed women also reported positive feelings such as:

- feeling protective towards the child;
- feeling attuned to the child;
- feeling understanding towards the child; and
- feeling loving towards the child.

The depressed women in the present study therefore felt that they were able to feel positive, protective, caring, understanding and loving towards their children.

As in the case of the feelings that the depressed women have vis-à-vis their children, the participants in the present study also reported both negative and positive behaviours towards their children. On the one hand, the negative behaviours which the depressed women displayed towards their children, included:

- unresponsiveness, abandonment, neglect and withdrawal;
- physical aggression or violence; and
- verbal aggression.

On the other hand, the depressed women in the present study reported the following positive behaviours which they felt they were likely to display towards their children:

- self-sacrificing behaviours;
- motivational behaviours;
- supportive behaviours; and
- coping behaviours.

These reported positive behaviours are in direct contrast with the aforementioned negative behaviours towards their children. The positive behaviours reported by the depressed women are also in strong contrast with existing literature regarding the nature of the depressed mother, which describes her as “self-absorbed” and “self-centred” (Vik & Braten, 2009). It thus seems as if the depressed women in the present study felt that they were able to sometimes place the needs of their children before their own, to support and motivate their children and to pretend to be all right for the sake of their children, despite their depressive symptoms. It must also be highlighted that, at the same time, the participants also reported not wanting to be near their children, as well as abandoning, neglecting, withdrawing from, as well as physically and verbally abusing their children. This supports the notion that being a depressed mother is rather complex: depressed mothers are not all bad; their experiences of having children are not all bad; but the depressed women and their experiences of their children are not all good either.

The impact of depressed mothers on their children specifically entailed the participants’ perceptions of the impact of their depression on the mother-child relationship, on parenting, and on the child him/herself.

Regarding the impact of the mother’s depression on the mother-child relationship, the depressed women specifically highlighted:

- misunderstandings and disconnection between the mother and the child;
- child withdrawal;
- child anxiety; and

- modelling, or the child imitating the mother's feelings and behaviour.

On the other hand, some women felt that their depression in actual fact played a role in bringing their children closer to them, which contradicts the stereotype of a depressed mother who is not able to form a close and secure bond with her child (Coyne & Thompson, 2011; Dix & Meunier, 2009; Elgar et al., 2003; Feng et al., 2007). A few mothers also reported that their depression did not necessarily have an impact on the mother-child relationship.

Regarding the depressed women's perceptions of the impact of their depression on parenting, only three of the participants in the present study reported that their depression did not have an influence on their role as parents. On the other hand, and in line with existing literature, the majority of depressed women reported that depression definitely compromised their role as mothers, especially because of:

- inadequate mothering;
- uninvolved mothering;
- substitute mothering; and
- compromised discipline.

The depressed women specifically explained that they were not able to do what they were supposed to do as mothers; that they were not involved parents; that the grandmothers had to take over the responsibility to care for the children in many instances; as well as that their depression had an impact on the disciplining of their children.

Lastly, according to the perception of most of the depressed women, their depression definitely had an impact on the children themselves. They specifically reported that they felt that their depression had an impact on:

- the emotions and behaviour of the child;
- the development of the child; and
- the personality of the child.

With regard to the impact of the mothers' depression on the emotions and behaviour of their children, the depressed women specifically highlighted that their children experienced sleeping problems; did not socialise with peers; and became anxious, worried and sensitive. They also emphasised that the mother's emotional state directly influenced the child's emotions. Regarding the impact of the mother's depression on the development of the

child, the depressed women reported that their children were compromised in terms of work and relationships. With regard to the impact of depression in mothers on the formation of the child's personality, the depressed women specifically referred to the fact that their children became "parentified" (disciplining and taking care of the mother), and became over responsible (responsible for duties typically done by mothers themselves). Although most aspects of depression in mothers definitely have a detrimental effect on the emotions, behaviour, learning ability and social development of children, more evidence is needed to confirm whether it is that detrimental to a child to learn from early childhood to take care of loved ones, like a depressed mother, and to be responsible for duties typically performed by mothers themselves.

The depressed women in this study revealed that they, as well as their children, may be different from the stereotype of the depressed women and children reported in the literature. Depressed mothers are typically portrayed as not able to form a close and secure bond with their children, while the children of depressed women are almost always portrayed in the literature as showing behavioural and emotional problems, as well as being "parentified" (Coyne & Thompson, 2011; Dix & Meunier, 2009; Elgar et al., 2003; Feng et al., 2007; Flykt et al., 2010; Najman et al., 2001; Turney, 2012; Watson et al., 2012). To the contrary, the participants in the present study also revealed a brighter picture of depressed women, as well as of having children.

Although the detrimental aspects of the nature of the relationship between a depressed mother and her child, as highlighted in existing literature, were definitely a reality to most of the depressed women and their children in the present study, the participants also placed strong emphasis on the positive and protective factors which they associated with having children, as well as their self-reported ability to feel positive, protective, caring, understanding and loving towards their children.

The implication is that low-income depressed women could be empowered through community workshops or parental guidance groups to identify the detrimental effects of their depression on the mother-child relationship, as well as, on the other hand, to further develop the protective factors of the mother-child relationship that may exist already. In this way, psychologists might play a larger role to empower depressed women in developing a secure bond with their children, than only focussing on the detrimental aspects of the depressed mother-child relationship.

6.1 Limitations

As the aim of the present study was to provide a descriptive overview of how one group of depressed South African women experience their relationships with their children, as well as to compare the findings with relevant existing literature, it was not possible to provide in-depth analyses of the findings. Future studies should focus on a more in-depth investigation of the specific aspects of South African low-income depressed women's subjective experiences of the mother-child relationship. This may inform more effective psychological services to this specific target group.

Although I have continuously discussed the emerging codes and the interpretation of results with my research team, it is possible that other researchers might have identified other categories and subcategories from the same data set.

6.2 Future Studies

Suggestions for future studies include that, similar qualitative studies with depressed women in other contexts, for example middle- or high-income households, can also be conducted to explore the nature of the depressed mother-child relationship in higher-income households. The results may then be compared to the results of studies conducted in low-income communities, including the present study. Similar qualitative studies in which children of depressed women are asked the same questions are also needed, in order to explore whether the subjective perspectives of the depressed women and their children correlate or not. Considering the impact of contextual factors, further research studies can also explore how depressed women think poverty impacts on their parenting, regardless of their diagnosis of depression.

It may also be necessary to focus future research on the relationship between non-depressed mothers and their children. The results may then be compared with the results of the present study, in order to explore whether all mothers do not perhaps experience the relationship with their children in the same way as depressed mothers do. The main conclusion is that we cannot simplify the relationship between a depressed woman and her child as *only* being good or bad. The present study suggests that the depressed mother-child relationship, at least in this context and from the perspectives of the depressed women themselves, may be far more complex than this.

References

- Accortt, E. E., Freeman, M. P., & Allen, J. B. (2008). Women and major depressive disorder: Clinical perspectives on causal pathways. *Journal of Women's Health, 17*, 1583-1590. doi: 10.1089/jwh.2007.0592
- Ahmed, R., & Pillay, A. L. (2004). Reviewing clinical psychology training in the post-apartheid period: Have we made any progress?. *South African Journal of Psychology, 34*(4), 630-656.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*. Washington, DC: American Psychiatric Association.
- Arteche, A., Joormann, J., Harvey, A., Craske, M., Gotlib, I. H., Lehtonen, A., . . . Stein, A. (2011). The effects of postnatal maternal depression and anxiety on the processing of infant faces. *Journal of Affective Disorders, 133*, 197-203. doi: 10.1016/j.jad.2011.04.015
- Avan, B. (2010). Maternal postnatal depression and children's growth and behaviour during the early years of life: Exploring the interaction between physical and mental health. *Archives of Disease in Childhood, 95*, 690-695. doi: 10.1136/adc.2009.164848
- Baker, B. L., Blacher, J., Crnic, K. A., & Edelbrock, C. (2002). Behavior problems and parenting stress in families of three-year-old children with and without developmental delays. *American Journal of Mental Retardation, 107*(6), 433-444.
- Beardslee, W. R., & Gladstone, T. R. (2001). Prevention of childhood depression: Recent findings and future prospects. *Biological Psychiatry, 49*(12), 1101-1110.

- Beardslee, W. R., Versage, E. M., & Gladstone, T. R. G. (1998). Children of affectively ill parents: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37(11), 1134-1141.
- Belle, D. (Ed.). (1982). *Lives in stress: Women and depression*. Beverly Hills: SAGE.
- Benvenuti, P., Valoriani, V., Guerrini Degl'Innocenti, B., Favini, I., Hipwell, A., & Pazzagli, A. (2001). Postnatal depression and the impact on infant-carer attachment strategies: A case report. *Archives of Women's Mental Health*, 3(4), 155-164.
- Blacher, J., & McIntyre, L. L. (2006). Syndrome specificity and behavioural disorders in young adults with intellectual disability: Cultural differences in family impact. *Journal of Intellectual Disability Research*, 50, 184-198.
doi: 10.1111/j.1365-2788.2005.00768.x
- Bohan, J. S. (2002). Sex differences and/in the self: Classic themes, feminist variations, postmodern challenges. *Psychology of Women Quarterly*, 26, 74-88.
doi: 10.1111/1471-6402.00045
- Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory*. London: Routledge.
- Boyd, R. C., Zayas, L. H., & McKee, M. D. (2006). Mother-infant interaction, life events and prenatal and postpartum depressive symptoms among urban minority women in primary care. *Maternal and Child Health Journal*, 10, 139-148.
doi: 10.1007/s10995-005-0042-2

- Brennan, P. A., Hammen, C., Katz, A. R., & Le Brocque, R. M. (2002). Maternal depression, paternal psychopathology, and adolescent diagnostic outcomes. *Journal of Consulting & Clinical Psychology, 70*(5), 1075-1085.
- Burke, L. (2003). The impact of maternal depression on familial relationships. *International Review of Psychiatry, 15*, 243-255. doi: 10.1080/0954026031000136866
- Burdette, A. M., Hill, T. D., & Hale, L. (2011). Household disrepair and the mental health of low-income urban women. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 88*, 142-153. doi: 10.1007/s11524-010-9529-2
- Camic, P. M., Rhodes, J. E., & Yardley, L. (2003). Naming the stars: Integrating qualitative methods into psychological research. In P. M. Camic, J. E. Rhodes, & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 3-15). Washington, DC: American Psychological Association.
- Campbell, S. B., Brownell, C. A., Hungerford, A., Spieker, S. J., Mohan, R., & Blessing, J. S. (2004). The course of maternal depressive symptoms and maternal sensitivity as predictors of attachment security at 36 months. *Development and Psychopathology, 16*, 231-252. doi: 10.1017/S0954579404044499
- Chaffin, M., Kelleher, K., & Hollenberg, J. (1996). Onset of physical abuse and neglect: Psychiatric, substance abuse, and social risk factors from prospective community data. *Child Abuse & Neglect, 20*(3), 191-203.
- Charmaz, K. (1995). Grounded theory. In J. A. Smith, R. Harré, & L. van Langenhove (Eds.), *Rethinking methods in psychology* (pp. 27-49). London: SAGE Publications.

- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: SAGE Publications.
- Charmaz, K. (2008). Grounded theory. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 81-110). London: SAGE Publications.
- Charvet, J. (1982). *Feminism: Modern ideologies*. London: J. M. Dent & Sons Ltd.
- Chiou, H. H., & Hsieh, L. P. (2008). Parenting stress in parents of children with epilepsy and asthma. *Journal of Child Neurology*, 23, 301-306.
doi: 10.1177/0883073807308712
- Chung, E. K., McCollum, K. F., Elo, I. T., Lee, H. J., & Culhane, J. F. (2004). Maternal depressive symptoms and infant health practices among low-income women. *Pediatrics*, 113(6), e523-e529.
- Cohn, J. F., Campbell, S. B., Matias, R., & Hopkins, J. (1990). Face-to-face interactions of postpartum depressed and nondepressed mother-infant pairs at 2 months. *Developmental Psychology*, 26(1), 15-23.
- Cole, J., McGuffin, P., & Farmer, A. E. (2008). The classification of depression: Are we still confused?. *The British Journal of Psychiatry*, 192, 83-85.
doi:10.1192/bjp.bp.107.039826
- Cooper, P. J., Tomlinson, M., Swartz, L., Woolgar, M., Murray, L., & Molteno, C. (1999). Postpartum depression and the mother-infant relationship in a South African peri-urban settlement. *British Journal of Psychiatry*, 175, 554-558.
doi: 10.1192/bjp.175.6.554

- Cosgrove, L. (2000). Crying out loud: Understanding women's emotional distress as both lived experience and social construction. *Feminism & Psychology, 10*, 247-267.
doi: 10.1177/0959353500010002004
- Coyne, L. W., Low, C. M., Miller, A. L., Seifer, R., & Dickstein, S. (2007). Mother's empathic understanding of their toddlers: Associations with maternal depression and sensitivity. *Journal of Child & Family Studies, 16*, 483-497.
doi: 10.1007/s10826-006-9099-9
- Coyne, L. W., & Thompson, A. D. (2011). Maternal depression, locus of control, and emotion regulatory strategy as predictors of preschoolers' internalizing problems. *Journal of Child & Family Studies, 20*, 873-883. doi: 10.1007/s10826-011-9455-2
- Crowe, M. (2002). Reflexivity and detachment: A discursive approach to women's depression. *Nursing Inquiry, 9*(2), 126-132.
- Cummings, E. M., & Davies, P. T. (1994). Maternal depression and child development. *Journal of Child Psychology and Psychiatry, 35*(1), 73-112.
- Denham, S. A., Workman, E., Cole, P. M., Weissbrod, C., Kendziora, K. T., & Zahn-Waxler, C. (2000). Prediction of externalizing behavior problems from early to middle childhood: The role of parental socialization and emotion expression. *Development and Psychopathology, 12*(1), 23-45.
- De Vos, A. S., Strydom, H., Fouché, C. B., & Delpont, C. S. L. (2011). *Research at grass roots: For the social sciences and human service professions (4th ed.)*. Pretoria: Van Schaik Publishers.

- De Wolff, M. S., & Van Ijzendoorn, M. H. (1997). Sensitivity and attachment: A meta-analysis on parental antecedents of infant attachment. *Child Development, 68*(4), 571-591.
- Dix, T., Gershoff, E. T., Meunier, L. N., & Miller, P. C. (2004). The affective structure of supportive parenting: Depressive symptoms, immediate emotions, and child-oriented motivation. *Developmental Psychology, 40*, 1212-1227.
doi: 10.1037/0012-1649.40.6.1212
- Dix, T., & Meunier, L. N. (2009). Depressive symptoms and parenting competence: An analysis of 13 regulatory processes. *Developmental Review, 29*, 45-68.
doi: 10.1016/j.dr.2008.11.002
- Donovan, W. L., Leavitt, L. A., & Walsh, R. O. (1998). Conflict and depression predict maternal sensitivity to infant cries. *Infant Behavior and Development, 21*(3), 505-517.
- Downey, G., & Coyne, J. C. (1990). Children of depressed parents: An integrative review. *Psychological Bulletin, 108*(1), 50-76.
- Dukas, C. J. (2009). *Misunderstanding depression in South African women: A feminist social constructionist analysis of the literature* (master's thesis). Department of Psychology, University of Stellenbosch, South Africa.
- Dumus, J. E., Wolf, L. C., Fisman, S. N., & Culligan, A. (1991). Parenting stress, child behavior problems, and dysphoria in parents of children with autism. *Down Syndrome, Behavior Disorders and Normal Development Exceptionality, 2*(2), 97-110.

- Edhborg, M., Lundh, W., Seimyr, L., & Widström, A. M. (2001). The long-term impact of postnatal depressed mood on mother-child interaction: A preliminary study. *Journal of Reproductive and Infant Psychology, 19*, 61-71. doi: 10.1080/02646830020032300
- Eisenhower, A. S., Baker, B. L., & Blacher, J. (2005). Preschool children with intellectual disability: Syndrome specificity, behaviour problems, and maternal well-being. *Journal of Intellectual Disability Research, 49*, 657-671.
doi: 10.1111/j.1365-2788.2005.00699.x
- Elgar, F. J., Curtis, L. J., McGrath, P. J., Waschbusch, D. A., & Stewart, S. H. (2003). Antecedent-consequence conditions in maternal mood and child adjustment: A four-year cross-lagged study. *Journal of Clinical Child and Adolescent Psychology, 32*(3), 362-374.
- Elgar, F. J., McGrath, P. J., Waschbusch, D. A., Stewart, S. H., & Curtis, L. J. (2004). Mutual influences on maternal depression and child adjustment problems. *Clinical Psychology Review, 24*, 441-459. doi: 10.1016/j.cpr.2004.02.002
- Elliott, L., & Masters, H. (2009). Mental health inequalities and mental health nursing. *Journal of Psychiatric and Mental Health Nursing, 16*, 762-771.
doi: 10.1111/j.1365-2850.2009.01453.x
- Enns, C. Z. (2010). Locational feminisms and feminist social identity analysis. *Professional Psychology: Research and Practice, 41*, 333-339. doi: 10.1037/a0020260
- Essex, M. J., Klein, M. H., Miech, R., & Smider, N. A. (2001). Timing of initial exposure to maternal major depression and children's mental health symptoms in kindergarten. *British Journal of Psychiatry, 179*, 151-154. doi: 10.1192/bjp.179.2.151

- Feng, X., Shaw, D. S., Skuban, E. M., & Lane, T. (2007). Emotional exchange in mother-child dyads: Stability, mutual influence, and associations with maternal depression and child problem behavior. *Journal of Family Psychology, 21*, 714-725.
doi: 10.1037/0893-3200.21.4.714
- Field, T., Diego, M., & Hernandez-Reif, M. (2006). Prenatal depression effects on the fetus and newborn: A review. *Infant Behavior and Development, 29*(3), 445-455.
- Field, T., Healy, B., Goldstein, S., & Guthertz, M. (1990). Behavior-state matching and synchrony in mother-infant interactions of nondepressed versus depressed dyads. *Developmental Psychology, 26*(1), 7-14.
- Flykt, M., Kanninen, K., Sinkkonen, J., & Punamäki, R. L. (2010). Maternal depression and dyadic interaction: The role of maternal attachment style. *Infant and Child Development, 19*, 530-550. doi:10.1002/icd.679
- Gergen, M. (2008). Qualitative methods in feminist psychology. In C. Willig, & W. Stainton-Rogers (Eds.), *The SAGE handbook of qualitative research in psychology* (pp. 280-295). London: SAGE Publications.
- Golding, P., & Murdoch, G. (1992). Culture, communications and political economy. In J. Curran, & M. Gurevitch (Eds.), *Mass media and society* (pp. 178-237). London: Edward Arnold.
- Goodman, S. H., & Gotlib, I. H. (1999). Risk for psychopathology in the children of depressed mothers: A developmental model for understanding mechanisms of transmission. *Psychological Review, 106*(3), 458-490.

- Greig, A., & Howe, D. (2001). Social understanding, attachment security of preschool children and maternal mental health. *British Journal of Developmental Psychology*, *19*, 381-393. doi: 10.1348/026151001166164
- Halligan, S. L., Herbert, J., Goodyer, I., & Murray, L. (2007). Disturbances in morning cortisol secretion in association with maternal postnatal depression predict subsequent depressive symptomatology in adolescents. *Biological Psychiatry*, *62*(1), 40-46.
- Havenaar, J. M., Geerlings, M. I., Vivian, L., Collinson, M., & Robertson, B. (2008). Common mental health problems in historically disadvantaged urban and rural communities in South Africa: Prevalence and risk factors. *Social Psychiatry Epidemiology*, *43*, 209-215. doi: 10.1007/s00127-007-0294-9
- Henwood, K. L., & Pidgeon, N. F. (1992). Qualitative research and psychological theorizing. *British Journal of Psychology*, *83*(1), 97-111.
- Henwood, K. L., & Pidgeon, N. F. (2003). Grounded theory in psychological research. In P. M. Camic, J. E. Rhodes, & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 131-155). Washington, DC: American Psychological Association.
- Herrera, E., Reissland, N., & Shepherd, J. (2004). Maternal touch and maternal child-directed speech: Effects of depressed mood in the postnatal period. *Journal of Affective Disorders*, *81*(1), 29-39.
- Hodapp, R. M., Ricci, L. A., Ly, T. M., & Fidler, D. J. (2003). The effects of the child with down syndrome on maternal stress. *British Journal of Developmental Psychology*, *21*, 137-151. doi: 10.1348/026151003321164672

- Hoffman, C., Crnic, K. A., & Baker, J. K. (2006). Maternal depression and parenting: Implications for children's emergent emotion regulation and behavioral functioning. *Parenting: Science and Practice, 6*(4), 271-295.
- Hoffman, Y., & Drotar, D. (1991). The impact of postpartum depressed mood on mother-infant interaction: Like mother like baby?. *Infant Mental Health Journal, 12*, 65-80. doi: 10.1002/1097-0355(199121)12:1
- Holmes, J. (2013). An attachment model of depression: Integrating findings from the mood disorder laboratory. *Psychiatry, 76*(1), 68-86.
- Inhorn, M. C., & Whittle, K. L. (2001). Feminism meets the "new" epidemiologies: Toward an appraisal of antifeminist biases in epidemiological research on women's health. *Social Science & Medicine, 53*, 553-567. doi: 10.1016/S0277-9536(00)00360-9
- Jacob, T., & Johnson, S. L. (1997). Parent-child interaction among depressed fathers and mothers: Impact on child functioning. *Journal of Family Psychology, 11*(4), 391-409.
- Jewkes, R., Abrahams, N., & Mvo, Z. (1998). Why do nurses abuse patients? Reflections from South African obstetric services. *Social Science and Medicine, 47*(11), 1781-1795.
- Kagee, A. (2008). Symptoms of depression and anxiety among a sample of South African patients living with a chronic illness. *Journal of Health Psychology, 13*, 547-555. doi: 10.1177/1359105308088527

- Kehler, J. (2001). Women and poverty: The South African experience. *Journal of International Women's Studies*, 3(1). Retrieved from [www.iiav.nl/eazines/web/JournalofInternationalWomensStudies/Vol3\(2001\)Nr1\(Nov\)/bridgew/kebler.pdf](http://www.iiav.nl/eazines/web/JournalofInternationalWomensStudies/Vol3(2001)Nr1(Nov)/bridgew/kebler.pdf)
- Kessler, R. C. (2003). Epidemiology of women and depression. *Journal of Affective Disorders*, 74, 5-13. doi: 10.1016/S0165-0327(02)00426-3
- Kim-Cohen, J., Moffit, T. E., Taylor, A., Pawlby, S. J., & Caspi, A. (2005). Maternal depression and children's antisocial behavior. *Archives of General Psychiatry*, 62(2), 173-181.
- Kohl, P. L., Njeri Kagotho, J., & Dixon, D. (2011). Parenting practices among depressed mothers in the child welfare system. *Social Work Research*, 35, 215-225. doi: 10.1093/swr/35.4.215
- Kub, J., Jennings, J. M., Donithan, M., Walker, J. M., Land, C. L., & Butz, A. (2009). Life events, chronic stressors, and depressive symptoms in low-income urban mothers with asthmatic children. *Public Health Nursing*, 26, 297-306. doi: 10.1111/j.1525-1446.2009.00784.x
- Kuster, P. A., & Merkle, C. J. (2004). Caregiving stress, immune function, and health: Implications for research with medically fragile children. *Issues in Comprehensive Pediatric Nursing*, 27(4), 257-276.
- Lafrance, M. N., & Stoppard, J. M. (2006). Constructing a non-depressed self: Women's accounts of recovery from depression. *Feminism & Psychology*, 16, 307-325. doi: 10.1177/0959353506067849

- Lazear, K. J., Pires, S. A., Isaacs, M. R., Chaulk, P., & Huang, L. (2008). Depression among low-income women of color: Qualitative findings from cross-cultural focus groups. *Journal of Immigrant Minority Health, 10*, 127-133.
doi: 10.1007/s10903-007-9062-x
- Leadbeater, B., Bishop, S. J., & Raver, C. C. (1996). Quality of mother-toddler interaction, maternal depressive symptoms and behavior problems in preschoolers of adolescent mothers. *Developmental Psychology, 32*(2), 280-288.
- Leung, D. W., & Slep, A. M. S. (2006). Predicting inept discipline: The role of parental depressive symptoms, anger, and attributions. *Journal of Consulting and Clinical Psychology, 74*(3), 524-534.
- Levy, L. B., & O'Hara, M. W. (2010). Psychotherapy interventions for depressed, low-income women: A review of the literature. *Clinical Psychology Review, 30*, 934-950. doi: 10.1016/j.cpr.2010.06.006
- Lieb, R., Isensee, B., Höfler, M., Pfister, H., & Wittchen, H. U. (2002). Parental major depression and the risk of depression and other mental disorders in offspring: A prospective-longitudinal community study. *Archives of General Psychiatry, 59*(4), 365-374.
- Lochner, C. (1999). *Women on farms: Discourses of distress* (master's thesis). Department of Psychology, University of Stellenbosch, South Africa.
- Lourens, M., & Kruger, L. (2013). Die subjektiewe ervaring van depressie onder Suid-Afrikaanse vroue in 'n lae-inkomste gemeenskap. *Social Work/Maatskaplike Werk, 49*(2), 248-270.

- Lourens, M., & Kruger, L. (forthcoming). *Impact of poverty and single motherhood on maternal depression*. Unpublished manuscript, Department of Psychology, University of Stellenbosch, Stellenbosch, South Africa.
- Lovejoy, M. C., Graczyk, P. A., O' Hare, E., & Neuman, G. (2000). Maternal depression and parenting behavior: A meta-analytic review. *Clinical Psychology Review, 20*(5), 561-592.
- Lyons-Ruth, K., Wolfe, R., Lyubchik, A., & Steingard, R. (2002). Depressive symptoms in parents of children under age three: Sociodemographic predictors, current correlates, and associated parenting behaviors. In N. Halfon, K. T. McLearn, & M. A. Schuster (Eds.), *Child rearing in America: Challenges facing parents with young children* (pp. 217-259). New York: Cambridge University Press.
- Macleod, C. (2002). Deconstructive discourse analysis: Extending the methodological conversation. *South African Journal of Psychology, 32*(1), 17-25.
- Manuel, J. I., Martinson, M. L., Bledsoe-Mansori, S. E., & Bellamy, J. L. (2012). The influence of stress and social support on depressive symptoms in mothers with young children. *Social Science & Medicine, 75*, 2013-2020.
doi: 10.1016/j.socscimed.2012.07.034
- Marecek, J. (2006). Social suffering, gender, and women's depression. In C. L. Keyes, & S. H. Goodman (Eds.), *Women and depression: A handbook for the social, behavioural and biomedical sciences* (pp. 283-308). Cambridge: Cambridge University Press.
- Marshall, M. N. (1996). Sampling for qualitative research. *Family Practice, 13*(6), 522-525.

- Mason, J. (2002). *Qualitative researching (2nd ed.)*. London: SAGE Publications.
- McLaren, J. A., Silins, E., Hutchinson, D., Mattick, R. P., & Hall, W. (2010). Assessing evidence for a causal link between cannabis and psychosis: A review of cohort studies. *International Journal of Drug Policy, 21*, 10-19.
doi: 10.1016/j.drugpo.2009.09.001
- McMahon, C. A., Barnett, B., Kowalenko, N. M., & Tennant, C. C. (2006). Maternal attachment state of mind moderates the impact of postnatal depression on infant attachment. *Journal of Child Psychology and Psychiatry, 47*, 660-669.
doi: 10.1111/j.1469-7610.2005.01547.x
- Meredith, P., & Noller, P. (2003). Attachment and infant difficultness in postnatal depression. *Journal of Family Issues, 24*, 668-686. doi: 10.1177/0192513X03252783
- Moultrie, A., & Kleintjes, S. (2006). Women's mental health in South Africa. *South African Health Review, 21*(Oct), 347-366.
- Murray, L., & Cooper, P. (1997). Postpartum depression and child development. *Psychological Medicine, 27*, 253-260. doi: 10.1017/S0033291796004564
- Murray, L., Stanley, C., Hooper, R., King, F., & Fiori-Cowley, A. (1996). The role of infant factors in postnatal depression and mother-infant interactions. *Developmental Medicine and Child Neurology, 38*(2), 109-119.
- Nadeem, E., Lange, J. M., & Miranda, J. (2009). Perceived need for care among low-income immigrant and U.S.-born black and Latina women with depression. *Journal of Women's Health, 18*, 369-375. doi: 10.1089/jwh.2008.0898

- Najman, J. M., Williams, G. M., Nikles, J., Spence, S., Bor, W., O'Callaghan, M., . . . Shuttlewood, G. J. (2001). Bias influencing maternal reports of child behaviour and emotional state. *Social Psychiatry & Psychiatric Epidemiology*, *36*, 186-194.
doi: 10.1007/s001270170062
- Ngcobo, M., & Pillay, B. J. (2008). Depression in African women presenting for psychological services at a general hospital. *African Journal of Psychiatry*, *11*(2), 133-137.
- Nolen-Hoeksema, S. (2000). The role of rumination in depressive disorders and mixed anxiety/depressive symptoms. *Journal of Abnormal Psychology*, *109*(3), 504-511.
- Oppenheim, D., Koren-Karie, N., & Sagi, A. (2001). Mothers' empathic understanding of their preschoolers' internal experience: Relations with early attachment. *International Journal of Behavioral Development*, *25*, 16-26. doi: 10.1080/01650250042000096
- Perry, D. F., Ettinger, A. K., Mendelson, T., & Le, H. N. (2011). Prenatal depression predicts postpartum maternal attachment in low-income Latina mothers with infants. *Infant Behavior and Development*, *34*, 339-350. doi: 10.1016/j.infbeh.2011.02.005
- Petersen, I. (2004). Primary level psychological services in South Africa: Can a new psychological professional fill the gap?. *Health Policy and Planning*, *19*(1), 33-40.
- Pillay, A. L., & Kriel, A. J. (2006). Mental health problems in women attending district-level services in South Africa. *Social Science & Medicine*, *63*, 587-592.
doi: 10.1016/j.socscimed.2006.01.031

- Pisula, E. (2011). Parenting stress in mothers and fathers of children with autism spectrum disorders. In M. R. Mohammadi (Ed.), *A comprehensive book on autism spectrum disorders*. doi: 10.5772/18507
- Potter, J. (1996). Discourse analysis and constructionist approaches: Theoretical background. In J. T. E. Richardson (Ed.), *Handbook of qualitative research methods for psychology and the social sciences* (pp. 125-140). Malden, USA: BPS Blackwell Publishing.
- Potterton, J., Stewart, A., & Cooper, P. (2007). Parenting stress of caregivers of young children who are HIV positive. *African Journal of Psychiatry*, 10(4), 210-214.
- Preston-Whyte, E. M. (1991). *Teenage pregnancy in selected coloured and black communities*. Pretoria: Human Sciences Research Council.
- Pretorius-Heuchert, J. W., & Ahmed, R. (2001). Community psychology: Past, present, and future. In M. Seedat, N. Duncan, & S. Lazarus (Eds.), *Community Psychology: Theory, method and practice* (pp. 17-36). Cape Town: Oxford University Press.
- Raikes, H. A., & Thompson, R. A. (2006). Family emotional climate, attachment security and young children's emotion knowledge in a high risk sample. *British Journal of Developmental Psychology*, 24, 89-104. doi: 10.1348/026151005X70427
- Ramchandani, P. G., Richter, L. M., Stein, A., & Norris, S. A. (2009). Predictors of postnatal depression in an urban South African cohort. *Journal of Affective Disorders*, 113, 279-284. doi: 10.1016/j.jad.2008.05.007

- Rapmund, V. J. (1999). A story around the role of relationships in the world of a “depressed” woman and the healing process. *Contemporary Family Therapy: An International Journal*, 21(2), 239-263.
- Rapmund, V. J., & Moore, C. (2000). Women’s stories of depression: A constructivist approach. *South African Journal of Psychology*, 30(2), 20-30.
- Rishel, C. W. (2012). Pathways to prevention for children of depressed mothers: A review of the literature and recommendations for practice. *Depression Research and Treatment*, 2012, 1-11. doi: 10.1155/2012/313689
- Rumble, S., Swartz, L., Parry, C., & Zwarenstein, M. (1996). Prevalence of psychiatric morbidity in the adult population of a rural South African villiage. *Psychological Medicine*, 26(5), 997-1007.
- Sadock, B. J., & Sadock, V. A. (2007). *Kaplan and Sadock’s synopsis of psychiatry: Behavioural sciences/clinical psychiatry (10th ed.)*. Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins.
- Shalowitz, M. U., Berry, C. A., Quinn, K. A., & Wolf, R. L. (2001). The relationship of life stressors and maternal depression to pediatric asthma morbidity in a subspecialty practice. *Ambulatory Pediatrics*, 1(4), 185-193.
- Shay, N. L., & Knutson, J. F. (2008). Maternal depression and trait anger as risk factors for escalated physical discipline. *Child Maltreatment*, 13, 39-49.
doi: 10.1177/1077559507310611

- Shefer, T. (2008). Psychology and the regulation of gender. In D. Hook, N. Mkhize, P. Kiguwa, A. Collins, E. Burman, & I. Parker (Eds.), *Critical psychology* (pp. 187-202). Lansdowne: UCT Press.
- Shin, D. W., & Stein, M. A. (2008). Maternal depression predicts maternal use of corporal punishment in children with attention-deficit/hyperactivity disorder. *Yonsei Medical Journal*, *49*, 573-580. doi: 10.3349/ymj.2008.49.4.573
- Siefert, K., Finlayson, T. L., Williams, D. R., Delva, J., & Ismail, A. I. (2007). Modifiable risk and protective factors for depressive symptoms in low-income African American mothers. *American Journal of Orthopsychiatry*, *77*, 113-123.
doi: 10.1037/0002-9432.77.1.113
- Spence, S. H., Najman, J. M., Bor, W., O' Callaghan, M. J., & Williams, G. M. (2002). Maternal anxiety and depression, poverty and marital relationship factors during early childhood as predictors of anxiety and depressive symptoms in adolescence. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *43*(4), 457-469.
- Stein, D. J., Seedat, S., Herman, A., Moomal, H., Heeringa, S. G., Kessler, R. C., & Williams, D. R. (2008). Lifetime prevalence of psychiatric disorders in South Africa. *The British Journal of Psychiatry*, *192*, 112-117. doi: 10.1192/bjp.bp.106.029280
- Stewart, R. C., Bunn, J., Vokhiwa, M., Umar, E., Kauye, F., Fitzgerald, M., . . . Creed, F. (2010). Common mental disorder and associated factors amongst women with young infants in rural Malawi. *Social Psychiatry Epidemiology*, *45*, 551-559.
doi: 10.1007/s00127-009-0094-5

- Stoppard, J. M. (2000). *Understanding depression: Feminist social constructionist approaches*. London: Routledge.
- Taylor, L. (2011). "Mad, bad and sad" – but still coping: An intersubjective psychoanalytic case study of depression in one low-income South African woman (Unpublished master's thesis). Department of Psychology, University of Stellenbosch, South Africa.
- Tenzer, S. A., Murray, D. W., Vaughan, C. A., & Sacco, W. P. (2006). Maternal depressive symptoms, relationship satisfaction, and verbal behaviour: A social-cognitive analysis. *Journal of Social and Personal Relationships*, 23, 131-149.
doi: 10.1177/0265407506060183
- Tomlinson, M., Grimsrud, A. T., Stein, D. J., Williams, D. R., & Myer, L. (2009). The epidemiology of major depression in South Africa: Results from the South African stress and health study. *South African Medical Journal*, 99(5), 368-373.
- Tomlinson, M., Swartz, L., Cooper, P. J., & Molteno, C. (2004). Social factors and postpartum depression in Khayelitsha, Cape Town. *South African Journal of Psychology*, 34(3), 409-420.
- Tomlinson, M., Swartz, L., Kruger, L. M., & Gureje, O. (2007). Manifestations of affective disturbance in sub-Saharan Africa: Key themes. *Journal of Affective Disorders*, 102, 191-198. doi: 10.1016/j.jad.2006.09.029
- Trapolini, T., McMahon, C. A., & Ungerer, J. A. (2007). The effect of maternal depression and marital adjustment on young children's internalizing and externalizing behaviour problems. *Child: Care, Health and Development*, 33, 794-803.
doi: 10.1111/j.1365-2214.2007.00739.x

- Trapolini, T., Ungerer, J. A., & McMahon, C. A. (2008). Maternal depression: Relations with maternal caregiving representations and emotional availability during the preschool years. *Attachment & Human Development, 10*, 73-90.
doi: 10.1080/14616730801900712
- Treutler, C. M., & Epkins, C. C. (2003). Are discrepancies among child, mother, and father reports on children's behaviour related to parents' psychological symptoms and aspects of parent-child relationships?. *Journal of Abnormal Child Psychology, 31*(1), 13-27.
- Turney, K. (2012). Pathways of disadvantage: Explaining the relationship between maternal depression and children's problem behaviors. *Social Science Research, 41*, 1546-1564. doi: 10.1016/j.ssresearch.2012.06.003
- Ussher, J. M. (2010). Are we medicalizing women's misery? A critical review of women's higher rates of reported depression. *Feminism and Psychology, 20*, 9-35.
doi: 10.1177/0959353509350213
- VandenBos, G. R. (Ed.). (2007). *APA dictionary of psychology*. Washington, DC: American Psychological Association.
- Van Doesum, K. T. M., Hosman, C. M. H., Riksen-Walraven, J. M., & Hoefnagels, C. (2007). Correlates of depressed mothers' sensitivity toward their infants: The role of maternal, child, and contextual characteristics. *American Academy of Child and Adolescent Psychiatry, 46*, 747-756. doi: 10.1097/chi.0b013e318040b272
- Vik, K., & Braten, S. (2009). Video interaction guidance inviting transcendence of postpartum depressed mothers' self-centred state and holding behaviour. *Infant Mental Health Journal, 30*, 287-300. doi: 10.1002/imhj.20215

- Watson, K. H., Potts, J., Hardcastle, E., Forehand, R., & Compas, B. E. (2012). Internalizing and externalizing symptoms in sons and daughters of mothers with a history of depression. *Journal of Child & Family Studies, 21*, 657-666.
doi: 10.1007/s10826-011-9518-4
- White, R. (2004). Discourse analysis and social constructionism. *Nurse Researcher, 12*(2), 7-16.
- Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Philadelphia, USA: Open University Press.
- World Health Organization. (2006). *Women's mental health: A public health concern. Regional health forum*. Retrieved from www.searo.who.int/en/Section1243/Section1310/Section1343/Section1344/Section1353_5282.html
- Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 235-251). London: SAGE Publications.

Bylae A

Semi-gestruktureerde Onderhoudskedule

Die onderhoudskedule dui die onderwerpe aan wat gedek sal word tydens die onderhoud en voorsien ook 'n uiteensetting van die algemene styl van onderhoudvoering. Deur die riglyne vir die voer van oop-einde onderhoude te volg (Willig, 2001), sal die onderhoudvoerder so min as moontlik vrae vra, terwyl die onderhoudvoerde steeds daarna sal streef om al die aangeduide onderwerpe (soos hieronder aangedui) te dek. Die volgorde van die vrae kan wissel en al die vrae hoef nie noodwendig gevra te word nie.

1. Huidige simptome en tekens

Hallo x. Ons het al gesels oor waarom ek graag vandag met jou wil praat, dat die suster/dokter gesê het jy sukkel met depressie/het al met depressie gesukkel.

- Ek wil begin deur jou te vra hoe dit vandag met jou gaan?

(Reflekteer antwoorde op empatiese wyse, vra vir meer besonderhede, maar moenie enige leidende vrae vra nie.)

- Sou jy sê jy is op die oomblik depressief?
- *(as antwoorde nee is)*
 - Hoe voel jy gewoonlik as jy depressief is?
 - Wanneer laas was jy depressief?
 - Hoe het jy toe jou depressie vir ander mense verduidelik?
 - Is jy onder enige behandeling? Dink jy dit help?
- *(as antwoord ja is)*
 - Hoe lank is jy nou al depressief?
 - Is jy onder enige behandeling? Dink jy dit help?
 - Hoe verduidelik jy die depressie vir ander mense?

2. Eerste diagnose

Ek wil nou hê jy moet terugdink aan die eerste keer toe jy gediagnoseer is deur iemand anders met depressie – miskien is hierdie selfs jou eerste keer? Ek wil oor die eerste diagnose praat.

- Wie het jou eerste gediagnoseer?
- Wanneer?
- Wat het hierdie diagnose vir jou beteken? Hoe het jy die feit verstaan dat jy met depressie gediagnoseer is? Wat het jy onder die woord depressie verstaan?
- Hoe het jy oor hierdie diagnose gevoel?
- Watter behandelingsplan is vir jou voorgeskryf?
- Hoe het jy oor hierdie behandelingsplan gevoel? Het dit jou gehelp? Watter tipe hulp/ondersteuning/behandeling sou jy verkies het?

3. Redes vir depressie: deelnemer

As ek nou so luister klink dit vir my of jy nog net een keer/meer as een keer al so (*probeer om die deelnemer se eie woorde te gebruik*) gevoel het. Ek wil nou hê ons moet teruggaan na elke keer wat jy hierdie gevoelens gehad het en bietjie praat oor wat jy dink toe in jou lewe aan die gang was en wat hierdie gevoelens veroorsaak het. Waaraan skryf jy hierdie gevoelens toe?/ Wat dink jy het hierdie gevoelens in jou veroorsaak?

*(Probeer die deelnemer se eie teorie oor **elke episode** kry-dit mag dalk net een episode wees. Geen leidende vrae nie, eerder: vertel my meer, sê nog, kan jy bietjie uitbrei?)*

4. Redes vir depressie: gemeenskap

Deur hierdie tye, wie was die belangrike mense in jou lewe? Wat het hulle gedink? Waarom het hulle gedink dit het met jou gebeur/dat jy hierdie gevoelens ontwikkel het? Waaraan het hulle dit toegeskryf?/Wat het hulle gedink is die oorsaak van hierdie gevoelens in jou?

(Probeer 'n lys kry van belangrike persone in die deelnemer se lewe en hul teorieë oor die deelnemer se depressie. Geen leidende vrae nie.)

5. Depressie en verhoudings

- Watter impak dink jy het depressie op die verhoudings met belangrike persone in jou lewe?
- Op watter persone in jou lewe dink jy het depressie die grootste impak?

- Watter impak dink jy het hierdie verhoudings met belangrike persone in jou lewe (*noem die persone waarna sy verwys het*) op jou depressie?

6. Verhouding met kinders

As 'n mens 'n ma is, is dit mos dikwels so dat jou kinders 'n groot of belangrike deel van mens se lewe vorm. Daarom wil ek vir jou vra:

- Hoeveel kinders het jy? Wat is hul name? Hoe oud is hulle?
- Hoe is die verhouding tussen jou en jou kinders?
- Watter impak dink jy het depressie op jou verhouding met jou kind/ers?
- Dink jy dat jou depressie 'n impak het op jou rol as ouer? Op watter maniere?
- Wat dink jy is die impak van jou depressie op jou kind/ers self?
- Watter invloed dink jy het jou verhouding met jou kinders op jou depressie?

7. Behandeling

As mens aan depressie ly begin mens dit so bietjie ken, mens kan amper sê jy is self so bietjie van 'n ekspert daaroor? Daarom wil ek nou vir jou vra:

- Wat dink jy het vir jou gehelp?
- Wat het glad nie gehelp nie of min gehelp?
- Watter hulp sou jy wou gehad het?
- As jy nou vir mense moet raad gee oor wat help of watter soort hulp hulle moet kry. Wat sal jy sê?

8. Afsluiting

Baie dankie. Jy het nou met my oor baie moeilike dinge gepraat. Hoe voel jy nou?

(Afhangende van die deelnemer se huidige geestesgesondheidstoestand, sal jy moontlik 'n deelnemer wil verwys vir verdere behandeling. Gee ook die supervisor se telefoonnommer by die Universiteit, asook die nommer van die Welgevallen Eenheid vir Sielkunde as daar enige verdere vrae is of as die deelnemer voel dat sy later sal hulp nodig hê.)

Appendix A

Semi-structured Interview Schedule

The interview schedule indicates the topics which will be covered by means of the interview and provides an outline of the general style of interviewing. Following the guidelines of conducting open-ended interviews (Willig, 2001), the interviewer will ask as few questions as possible, while also striving to cover all the indicated topics (as indicated below). The order of the questions may vary and all the questions do not necessarily have to be asked.

1. Current symptoms and signs

Hello x. We have already discussed why I would like to speak to you today: that the sister/doctor said that you are struggling with depression/have struggled with depression in the past.

- I would like to start by asking you how you are doing today?

(Reflect answers in an empathic way, ask for more detail, but do not ask any leading questions.)

- Will you say that you are currently depressed?
- *(if answer is no)*
 - How do you normally feel when you are depressed?
 - When was the last time when you were depressed?
 - How did you then explain your depression to other people?
 - Did you receive any treatment? Do you think that it helped?
- *(if answer is yes)*
 - For how long have you been depressed?
 - Do you receive any treatment? Do you think that it helps?
 - How do you explain the depression to other people?

2. First diagnosis

I would like you to think back to the first time you were diagnosed with depression by the sister/doctor – perhaps this is the first time? I would like to speak about the first diagnosis.

- Who diagnosed you with depression initially?
- When?
- What did this diagnosis mean to you? How did you understand the fact that you were diagnosed with depression? What did the word depression mean to you?
- How did you feel about this diagnosis?
- What treatment plan was prescribed for you?
- How did you feel about this treatment plan? Did it help you? What kind of help/support/treatment would you rather have preferred?

3. Reasons for depression: participant

If I listen to you it sounds as if you have only felt like this once/more than once (*try to use the participant's own words*). I would like us to go back to each time that you have experienced these feelings and speak about what you think was happening in your life or what was causing these feelings. What do you think were the reasons for these feelings? / What do you think have caused these feelings?

(Try to get the participant's own theory about each episode – it may only be one episode. No leading questions, rather: tell me more, can you explain more?)

4. Reasons for depression: community

During these difficult times, who were the important people in your life? What did they think? Why did they think you have developed these feelings? What did they think were the reasons for you developing these feelings?

(Try to get a list of important people in the participant's life and their theories about the participant's depression. No leading questions.)

5. Depression and relationships

- What do you think is the impact of depression on your relationships with important people in your life?
- On what people in your life do you think your depression have the greatest impact?
- What do you think is the impact of your relationships with important people in your life (*refer to the people she has identified*) on your depression?

6. Relationship with children

If one is a mother one's children may form a very important part of one's life. That is why I would like to ask you:

- How many children do you have? What are their names? How old are they?
- How is the relationship between you and your children?
- What do you think is the impact of depression on the relationship with your child(ren)?
- Do you think that depression has an impact on your role as a parent? In which ways?
- What do you think is the impact of your depression on your child(ren)?
- How do you think does the relationship with your children impacts on your depression?

7. Treatment

If one suffers from depression, it is almost as if one becomes an expert with regards to the experience thereof? That is why I would like to ask you:

- What do you think was of help to you?
- What did not help at all? Or what helped you a little?
- What kind of help would you have preferred?
- If you have to give advice to others with regards to what helps or what kind of help they should get - what will you say?

8. Closure

Thank you. You have talked to me about very difficult things in your life. How do you feel now?

(Depending on the participant's current mental health state, you would probably want to refer a participant for further treatment. Give the supervisor's telephone number at the University, as well as the contact details of the Welgevallen Unit for Psychology, in case there are any questions or if the participant feels that she will need help during a later stage.)



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY
jou kennisvennoot • your knowledge partner

Bylae B

INGELIGTE TOESTEMMING OM AAN NAVORSING DEEL TE NEEM

(vir Afrikaanse deelnemers)

Die Aard van die Verhouding tussen Moeders met Depressie en hul Kinders en die Effek daarvan op die Ontwikkeling en Ervaring van Materne Depressie:

Perspektiewe van 'n Lae-Inkomste Suid-Afrikaanse Gemeenskap

Jy word gevra om deel te neem aan 'n studie van die Departement Sielkunde aan die Universiteit van Stellenbosch, wat uitgevoer word deur Marleen Lourens (B in Maatskaplike Werk en BA Sielkunde Honneurs). Die bevindinge van die studie sal bydra tot Marleen se MA Sielkunde tesis. Jy is gekies as moontlike deelnemer aan die studie, omdat jy deel vorm van die populasie wat die navorser in belangstel om te ondersoek.

1. DOEL VAN DIE STUDIE

Hierdie studie het ten doel om 'n meer in-diepte begrip van die ervaring van depressie onder lae-inkomste Suid-Afrikaanse vroue te voorsien. Daar sal spesifiek gefokus word op die aard van die verhouding tussen moeder en kind, asook die effek daarvan op die ontwikkeling en ervaring van materne depressie.

2. PROSEDURES

As u besluit om aan die studie deel te neem, sal die volgende van u gevra word:

- Om deel te neem aan een semi-gestruktureerde onderhoud, waartydens die onderhoudvoerder vir u 'n paar vrae sal vra oor hoe dit is om met depressie te lewe, waarop u vrylik en openlik kan antwoord.
- Die onderhoud sal nie langer as 'n uur en 'n half (90 minute) duur nie.
- Die onderhoud sal op band opgeneem word.
- Die onderhoud sal gevoer word waar en wanneer dit u pas en op 'n plek wat privaat is.
- Om die onderhoudvoerder vir die onderhoud te ontmoet op die tyd en by die plek waar jul ooreengekom het.

3. POTENSIËLE RISIKO'S EN ONGEMAK

Ons verstaan dat die onderwerpe wat tydens die onderhoud bespreek sal word, ongemaklike gevoelens by u kan oproep en daarom is 'n verwysingstelsel in plek gestel. Dit beteken dat die onderhoudvoerder u na 'n toepaslike professionele persoon kan verwys, indien u nodig

het om enige probleme of ongemaklike gevoelens verder te bespreek met 'n professionele persoon. As u enige ongemaklikheid tydens die onderhoud ervaar, mag u die onderhoud by enige punt tot 'n einde bring.

4. POTENSIËLE VOORDELE VIR DEELNEMERS EN/OF DIE SAMELEWING

Ons vertrou dat die onderhoud interessant en nuttig sal wees vir elkeen wat aan hierdie studie deelneem. Ons ervaring is dat dit gewoonlik help om oor pynlike gevoelens en moeilike ervarings te praat. Die voordele van hierdie studie is dat u potensieel kan bydra tot 'n beter begrip van hoe Suid-Afrikaanse vrouens met depressie saamleef, asook tot 'n beter verstaan van die aard van die verhouding tussen 'n moeder met depressie en haar kind/ers. Hierdie begrip sal 'n groot bydrae kan lewer tot die ontwikkeling van verbeterde assesserings, behandeling en voorkomende maatstawwe ten opsigte van depressie onder Suid-Afrikaanse vroue.

5. BETALING VIR DEELNAME

Nadat die onderhoud gevoer is, sal u 'n bedrag van R100 ontvang as vergoeding vir die tyd wat u spandeer het om aan die onderhoud deel te neem. As u sou besluit om tydens die onderhoud te onttrek, sal u steeds die volle R100 ontvang, maar as u besluit om glad nie aan die onderhoud deel te neem nie, voordat die onderhoud begin, sal u nie R100 ontvang nie.

6. KONFIDENSIALITEIT

Enige inligting wat ingesamel word in verband met die studie en wat met u geïdentifiseer kan word, sal konfidensieel of vertroulik bly en slegs bekend gemaak word met u toestemming of soos wetlik vereis word. Konfidensialiteit sal verseker word deurdat slegs die navorser toegang sal hê tot die data en dat die data slegs vir navorsingsdoeleindes gebruik sal word. U naam en identiteit sal nie op enige punt tydens die navorsingsproses bekend gemaak word nie. Die onderhoude sal egter op band opgeneem en getranskribeer word, maar u het die reg tot toegang en redigering van die bande, wat op 'n veilige plek bewaar sal word. Sodra die finale navorsingsprojek voltooi is, sal al die data van die bande afgegee word. Die resultate van die studie sal gepubliseer word, maar u naam of enige ander inligting wat u identiteit kan bekend maak, sal nooit genoem word nie.

7. DEELNAME EN ONTTREKKING

U kan kies of u aan die studie wil deelneem of nie. As u sou besluit om vrywillig aan die studie deel te neem, kan u ter enige tyd van die studie onttrek of die onderhoud tot 'n einde bring, sonder enige gevolge. U kan ook weier om enige vraag te beantwoord wat u nie wil beantwoord nie en steeds deel bly van die studie.

8. IDENTIFIKASIE VAN ONDERSOEKERS

As u enige vrae of bekommernisse het rakende die navorsing, kan u gerus enige een van die volgende persone skakel:

Supervisor: Prof. Lou-Marie Kruger- 021-8083460

Navorser: Marleen Lourens - 0728558111

9. REGTE VAN NAVORSINGSDEELNEMERS

U het die reg om u toestemming ter enige tyd te onttrek en om deelname aan die studie te stop, sonder enige straf of nagevolge. U oortree geen wettige eise, regte of regsmittele deur aan hierdie navorsingstudie deel te neem nie. As u enige navrae het oor u regte as 'n navorsingsdeelnemer, kontak Me. Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] by die Afdeling vir Navorsingsontwikkeling.

HANDTEKENING VAN NAVORSINGSDEELNEMER

Die bogenoemde inligting was aan my, die navorsingsdeelnemer, verduidelik deur Marleen Lourens in Afrikaans of Engels en ek (die navorsingsdeelnemer) is by magte van hierdie taal of die inligting was bevredigend aan my vertaal. Ek was die geleentheid gegun om vrae te vra en hierdie vrae was bevredigend aan my beantwoord.

Ek gee hiermee toestemming om vrywillig aan hierdie studie deel te neem.

Ek het 'n afskrif van hierdie vorm ontvang.

Naam van deelnemer

**Naam van regsverteenvoordiger
 (indien van toepassing)**

**Handtekening van Deelnemer of
 Regsverteenvoordiger**

Datum

HANDTEKENING VAN ONDERSOEKER/NAVORSER

Ek verklaar dat ek die inligting soos vervat in hierdie dokument aan _____ verduidelik het. Sy was aangemoedig en voldoende tyd gegee om enige vrae aan my te stel. Hierdie gesprek was gevoer in Afrikaans/Engels.

Handtekening van Ondersoeker/Navorsers

Datum



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY
jou kennisvennoot • your knowledge partner

Appendix B

CONSENT TO PARTICIPATE IN RESEARCH (for English participants)

The Nature of the Relationship between Depressed Mothers and their Children and the Effect thereof on the Development and Experience of Maternal Depression: Perspectives from a Low-Income South African Community

You are asked to participate in a research study of the Department of Psychology at Stellenbosch University, conducted by Marleen Lourens (B in Social Work and BA Honours in Psychology). Findings from this study will contribute to Marleen's MA dissertation in Psychology. You were selected as a possible participant in this study because you form part of the population she is interested in studying.

1. PURPOSE OF THE STUDY

This study aims to provide a more in-depth account of the experience of depression in low-income South African women. The study will specifically focus on the nature of the relationship between mother and child, as well as the effect thereof on the development and experience of maternal depression.

2. PROCEDURES

If you volunteer to participate in this study, the researcher would ask you to do the following things:

To participate in one semi-structured interview.

To answer questions about living with depression, asked by the researcher.

To answer these questions for, at most, an hour and a half.

To meet the researcher at the designated venue and time.

3. POTENTIAL RISKS AND DISCOMFORTS

We understand that speaking about difficult events in your life may bring about certain feelings of discomfort, and because of this, we have put in place a referral system whereby you will be given the opportunity to further discuss any problems with a professional in training. If you feel any discomfort in the course of the interview, you are allowed to terminate the interview at any point.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

The potential benefits of the study are that you may help in contributing to a more comprehensive understanding of how South African women both experience and think about the development of depression.

5. PAYMENT FOR PARTICIPATION

After the interview has been conducted you will receive R100 remuneration. Should you decide to withdraw during the interview you will still receive the full R100, however, if you decide to not take part in the interview before it has begun, you will not receive payment.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of safeguarding the data: your name will not be used in conjunction with the interview, and the interview material will be restricted to the use of the researcher. The interview sessions will be recorded and transcribed, and you have the right to the accessing and editing of such tapes. Once the final research project has been completed, the audio tapes will be erased. The results of the study will be published, however, there will be no mention of your name, or of any details that may indicate your identity.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you do not want to answer and still remain in the study.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact:

Supervisor: Prof. Lou-Marie Kruger

Investigator/Researcher: Marleen Lourens - 0728558111

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

SIGNATURE OF RESEARCH SUBJECT

The information above was described to me, the participant, by Marleen Lourens in Afrikaans / English and I am in command of this language or it was satisfactorily translated to me. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study.
I have been given a copy of this form.

Name of Subject/Participant

Name of Legal Representative (if applicable)

**Signature of Subject/Participant
or Legal Representative**

Date**SIGNATURE OF INVESTIGATOR**

I declare that I explained the information given in this document to _____
She was encouraged and given ample time to ask me any questions. This conversation was
conducted in Afrikaans / English.

Signature of Investigator

Date

Appendix C

Example of Transcribed Interview

9am, 18 April 2013 (Vané)

I=Interviewer

V=Vané

I: °Daarsy°. Goeiemore Vané.

V: (nods, smiles) ↓Goeiemore.

I: Baie dankie dat jy vanoggend gekom het om met ons te gesels.

V: (nods, smiles) ↓Plesier.

I: Ekskies ek het nou vergeet om die ander een aan te sit. Laat ek nou net gou hom aansit. Jammer man...Ek waardeer dit regtig en ek dink jy gaan...soos wat ons gesê het, ons doel is mos om, uhm, te praat oor die ervarings van materne...ja...materne depressie. En hoe 'n ma...haar depressie ervaar. En ons gaan kyk spesifiek na die verhoudings tussen jou en jou kinders.

V: (nods) Ok.

I: En hoe jy dit ervaar...en hoe dit 'n invloed het op jou depressie.

V: (nods, smiles) Ok.

I: En so dit is...ek wil maar net vreeslik dankie sê dat jy hierso is en dat jy weer bereid is om deel te neem.

V: (nods) OK.

I: Want jy het al voorheen aan ons studie deelgeneem en dit is vir my 'n voorreg om weer met jou te kan gesels.

V: (nods, smiles, chuckles) ↓Plesier.

I: Ons het nou klaar die ingeligte toestemmingsvorm voltooi. Maar...uhm...dan gaan ons nog twee ander vorms voltooi...dis 'n vorm oor jou inligting, jou eie inligting.

V: (nods) mmm.

I: En dan ook 'n BDI. Dis maar net 'n vorm wat ons gaan invul, waarmee hulle gewoonlik depressie meet.

V: (nods) Mmm.

I: Maar ek gaan net vir jou 'n paar vragies vra en dan kan jy maar net vir my sê, uhm wat, watse antwoord vir jou die beste pas.

V: (nods, smiles) ↓Ok.

I: Goed. En het jy al aan 'n kodenaam gedink?

V: Vané.

I: (nods) Vané, ok.

V: (nods) Mmm.

I: Ja, want ek het mos vir jou verduidelik, dan sit ons dit sommer op die navorsing en alles, sodat dit wat jy gesê het, nie by ander mense uitkom nie, dan weet niemand dat jy dit gesê het nie.

V: (nods) Ok.

I: Ok. Julle praat Afrikaans in die huis, né?

V: (nods, smiles) Ja.

I: En hoe oud is jy nou?

V: Een-en-veertig.

I: Jy lyk rêrig nie soos een-en-veertig nie! Jy lyk baie jonger! Sho...jy dra jou jare baie goed.

V: (chuckles) Dankie (laughs).

I: Ok. En die samestelling van jou huishouding: wie bly almal saam in die huis?

V: Dis ek en my man... (0.2) en drie kinders.

I: ↓Jou man... ↓en drie kinders... ↓ok. Sê gou vir my: wat is hulle name?

V: Die oudste een is Ashlyn.

I: °Ashlyn, ok°. En hoe oud is hy?

V: [S_yis] sewentien.

I: [°oo, s_y°]

I: Ok. Dit is van haar wat jy my vertel het?

V: Ja.

I: Ok, alright. En nou die tweede een?

V: Lyndsay.

I: Lyndsay, ok. En hy is?

V: E:lf.

I: Elf.

I: (0.5). En dan die laaste een?

V: Lezzane.

I: Ok (writes).

V: Sy's vier.

I: °Vier....ok. (writes). So Ashlyn is jou dogter en Lyndsay is jou seun, né? °

V: °Ja°

I: En wie kyk nou na Lyndsay terwyl jy hier is?

V: Sy pa is by die huis.

I: Is die pa by die huis? Ok, alright. Werk jou man?

V: Nee, nie nou nie.

I: Ok, nie nou nie.

V: (shakes head)

I: Doen hy seisoenwerk, of... [kontrak werk]?

V: [Hy].... het uhm by Pniel Constructions gewerk en hulle het nou klaar gemaak, maar hy het sy CV ingegooi by GForce Securities.

I: (nods) O::k.

V: Toe het hy gegaan laaste week vir 'n toets wat hy geslaag het. Toe bel hulle hom net vir 'n interview; toe gaan hy. Nou...moet hulle kyk of hy 'n kriminele rekord het en al daai goete..., maar gelukkig het hy sekuriteitsondervinding...

I: Ok, so hulle sal hom moontlik aanstel. Want hulle [soek mos maar] mense...

V: [Hulle soek] ja:: [Hulle] soek mense.

I: [Ja]...

V: (0.3). En... (0.2) gisteraand toe bel hulle vir hom dat more-oggend hy moet by hulle kantore wees.

I: Ok, alright. So dis 'n goeie ding.

V: Ja dit is. Dis wat hy gesê het, want hy het mos nou klaar alles gedoen. En more moet hy...sy klere loop haal.

I: Dit klink baie goed. Sho.

V: Ja:: 'n mens moet positief wees.

I: Ja 'n mens moet. Dis al wat help deesdae.

V: Regtig man.

I: Ok...so jy's getroud, né?

V: Ja::, ek is getroud (scratches neck).

I: Ok (0.2). Hoe lank is julle al getroud?

V: Amper twaalf jaar.

I: O:k. Sho, dis al 'n hele tydjie!

V: (giggles) Mmm.

I: Dis 'n lang tyd om met iemand uit te hou! (giggles)

V: (giggles), ja:::

I: °Ok, ons is klaar...met jou kinders... (0.2) goed°. Werk jy self Vané?

V: Nee, ek kyk na Lyndsay.

I: Oo, ok (writes). (0.2) Jy het gesê, um, Lyndsay is gestremd, né?

V: Mm mm (nods).

I: Ok. Watse gestremdheid het hy?

V: Hy is blind... (0.2).

I: °Ok°

V: Wanneer hy was gebore, het hy hydrocephalus...in Afrikaans is dit “waterhofie”.

I: (nods) Ok.

V: Skade op sy brein...Hy's blind. Verkorte arm en regte been...

I: °Sho::°

V: En hy kry die epileptiese aanvalle...

I: °Sho::°

V: Soveel so dat ek vir homself 'n drug gee.

I: °Ok°

V: Om hom onder beheer te kry...

I: °Ok°

V: En dan is hy (0.3) die een-en-dertigste Janua::rie (0..2) me::t nog 'n sindroom gediagnoseer: Prader-Willi sindroom.

I: Mm mm. En wat is dit?

V: Dit is...umV:::. Sy geslagsdele groei nie, sy hande groei nie, sy voete groei nie, sy voorkop groei nie.

I: °Sho::°

V: En um ek moet probeer dit in Afrikaans sê...en hy tel net gewig op (hand gestures forward).

I: Ok.

V: Maar dis niks wat niemand...daar's nie 'n pilletjie of iets nie.. kyk 'n sindroom is iets wat nie reverse kan word nie...

I: Ja, dit gaan net aan...

V: Dit gaan net aan en dan dit gaan net so (.hhhh); gewig optel, gewig optel (hand gestures) tot sy hart dit nou nie meer...en op die huidige oomblik weeg hy vier-en-sestig. Hy het Januarie-maand twee-en-sestig geweeg, hy weeg nou vier-en-sestig.

I: So hy tel letterlik maandeliks [gewig op]?

V: [Ja, ja.] En hy groei; hy word nie lank nie, hy groei net al hoe vetter.

I: Sho, so hy groei in die breedte maar nie in die lengte nie. Dit moet moeilik wees vir jou om na hom te kyk elke dag.

V: ↑Dit is, dit is en en NOU voel ek amper ek wil wegbreek.

I: Mm mm.

V: Ek ek ek ek voel ek moet êrens 'n bietjie loskom want...Lyndsay is amper twaalf en vir twaalf jaar, is ek soos een wat in vier mure vasgedruk is.

I: Mm mm.

V: Ek het nie 'n lewe nie. Ek gaan nie uit nie. Ek bly net hier. Ek gaan net uit as Lyndsay pay hier op Stellenbosch en wanneer hy Tygerberg toe gaan en toe't ek...dis amper van Vrydag af

wat ek voel ek moet werk; ek moet vir my 'n werk kry, net om bietjie ↑WEG TE KOM of tussen mense te kom.

I: (nods) Ja.

V: Ek sê vir my man, jy gaan werk toe...ek is by die huis...Jy gaan werk elke Saterdag...as jy terugkom...ek is by die huis... ek ↑BLY NET BY DIE HUIS.

I: (nods) Mmm.

V: En vanoggend toe praat ons weer daaroor, toe sê ek vir my man, ek kan nie werk nie, want ek moet na Lyndsay omsien.

I: Mm mm.

V: (.hhhh). Toe was ek by 'n juffrou wat by... 'n gestremde skool in die Paarl is.... () Ligstraal.

I: Oo ja, ja.

V: Toe sê sy...maar ongelukkig vat hulle nie blinde kinders nie...

I: Oo.

V: En die naaste skool is in Worcester...

I: Ja.

V: En dis 'n bietjie [ver].

I: [ver]

V: Ja, dit is te ver en ek wil ook nou nie vir hom na amper twaalf jaar, vir hom net laat gaan nie, vir my is...dit nie asof dit reg is nie.

I: (nods)

V: Toe sê my man die rede hoekom ek wil werk, is seker omdat hy nou nie werk nie. Toe sê ek: Nee, jy pay dan nou volgende week, ek voel net, ek voel net...ek sê vir hom... () ↑EK IS EEN-EN-VEERTIG jaar en ek het nie 'n lewe nie. MY lewe draai om Lyndsay en Ashlyn.. maar nie so seer () Ashlyn nie, want sy is maar meestal op haar eie.

I: (nods) Ja.

V: En Lezzane...en Lyndsay. En ↑ek is in die huis of ek moet by die huis wees. En dis wasgoed was en dis kosmaak en dis huis skoonmaak...en op die huidige oomblik ja, voel dit vir my dis te veel...en (shakes her head)...

I: Dis te veel...

V: JA OP DIE OOMBLIK voel dit asof dit te veel is. Dis te veel - êrens moet ek wegbreek.

I: Ja.

V: Dan op... (0.3) DINSdag...

I: Ja?

V: Oggend, toe staan ek op en ek is VERSKRRIKLIK geïrriteerd. Ek sê, ek ek ek moet uitkom uit die huis uit, ek moet loop.

I: (nods)

V: (.hhhhh) En ek sê vir my man, ek sê ek loop net. En ek loop Swartstraat af en ... () daar by die brug, amper by Kylemore se ingang...

I: Ja:::

V: Net dat ek kan WEGkom.

I: Net om uit [te kom].

V: [NET OM] UIT te kom. En toe ek terugkom, toe voel ek verskriklik goed...beter.

I: Jy voel beter.

V: Want my man sê toe vir my...ek het my wasmasjien gegooi...ek was besig om te was...en ek gooi die wasmasjien en hy kyk vir my en hy sê vir my jy is weer vo::l stres.

I: Mm mm.

V: En ek gee hom nie antwoord nie. (Hiccups) Ekskies tog...en ek dink toe, gee net pad – dit is die beste. As ek depressed voel, dan loop ek; om net UIT te kom.

I: Om net uit te kom.

V: REGTIGwaar, om net uit te kom, ek loop, ek loop, ek loop, omdat...ek wil nie rondom mense wees nie – ek wil niemand rondom my hê nie. Ek wil net op my eie wees. Ek loop vir ‘n uur, of ‘n uur-en-‘n-half. Dit doen vir my baie baie goed, want ander tye...ek gee nie om wat ek sê nie, ek gee nie om wat ek doen nie. Ek het al sover gegaan om te sê, “ek maak julle almal vrek, ek maak julle almal vrek”. En ek sê dan kyk die vier-jarige enetjie vir my en ek sê, “maar ek kan nie dit doen nie” en eintlik abuse ek my hele huisgesin...So die beste is loop weg.

I: Mm mm.

V: NIEMAND rondom jou nie, ek hoor niks nie, ek sien niks nie. Ek loop in ‘n wêreld van my eie...

I: Mm mm. Nou jy sê nou abuse, is dit verbal of fisies of watse tipe abuse is dit?

V: EK VLOEK, ek skel. Ek gee nie om wat ek vir hulle sê nie. Ek sal nie sommer...

I: Mm mm.

V: Want ek ken myself en as ek moet slaa:::n, dan...soos Lezzann:::e (0.3). Dit was een Vrydag. Nou sê ek vir Lezzane, “kom nou dat Mammie jou hare kan klaarmaak dat ons kan dorp toe gaan”. Nou SY wil vir my sê hoe ek haar hare moet maak en ek kry haar en ek DRUK haar so (gestures with hands). Nou skree die meisiekind, “mammie nee!” “Mammie sal haar RUG breek” en ONMIDDELIK voel ek toe BAIE baie sleg, en ek verduidelik vir haar en ek sê vir haar, sy’s vier jaar oud. “As ek vir jou sê, ek moet jou hare vleg, moet jou hare gevleg word”.

I: Mm mm.

V: JY kan nie van my sê, “maar mammie ek wil los hare of maak vir my ‘n bolla of ek weet nie WAT soek jy nie”.

I: Mm mm.

V: “Djy moet doen wat ek vir jou sê, want jy is nog ‘n kind”.

I: Ok. Ja::: Nou sê vir my, hoe is jou verhouding met Lyndsay?

V: Ek is BAIE oor hom.

I: Is jy erg oor hom?

V: O, ek is VERSKRIKLIK...Ek sê vir my man wanneer?...Gister...nou sit hy by my. Lyndsay, toe Lyndsay jonger was, toe was hy nie baie oor my nie, maar lyk my soos hy ouer word...word hy meer. Nou roep hy vir my...hy sit op ons bed, nou sê hy ek moet hier kom sit. En nou dra hy sy arm so rondom my nek en nou soen hy my DRIE kere en hy sê vir my...(0.2) uhm... “Lyndsay is BAIE lief vir mammie”. Nou sê ek, “mammie is net so lief vir jou”, sê ek toe.

I: Mm mm.

V: Ek is BAIE oor hom, maar ek weet OOK dat Lyndsay nie vir altyd gaan lewe nie.

I: Ja::

V: Maar om eerlik te wees, is ek al voorberei, so as die Here vir hom weg gaan neem, moet die Here hom wegneem, maar as hy bly by my, hy bly by my.

I: Mm mm.

V: En ek sal nie ‘n skuldige gewete hê as die Here besluit om vir hom weg te vat nie, want ek het ALLES GEDOEN vir HOM wat ek kon.

I: Mm mm.

V: Ek kan vir Suster Coetzee vra by die kliniek...daar’s SOMTYDS wat ek nagklere nog onderaan het, met my gewone klere bo-aan en ek moet kliniek toe hardloop want...of hy kry ‘n aanval. Die laaste een was...laasmaand. Toe ek opstaan, soggens as ek opstaan, voor ek enigiets doen, was ek en...hy dra mos nog kimbie.

I: Ja::

V: Toe ek nou vir hom uittrek, sien ek ma hy het nou PITSWERE. Sy rug...en knoppe op sy been.

I: Ag nee...

V: (.hhhh) En ek sê toe vir die meisiekind, gee net gou vir my klere aan vir hom...NEE trek hom gou aan...ek kan gou vir my aantrek. En ek sê toe ek klaar vir my aangetrek het...toe

gaan ek gou kliniek toe...toe help suster sommer vir hom onmiddellik. Toe sê sy, “Vané, yo”, jy gee nie eers om van enigiets nie”. Iemand sê, “die vrou het nie eers kop gekam nie!”

I: (giggles) Ja::

V: Maar my ding is net Lyndsay is my eerste prioriteit.

I: Ja::

V: Lezzane is quite fine. Sy’s BAIE oulik, sy WAS self en sy maak haar mond skoon.

I: Mm mm.

V: Nou die dag, toe tel my ma:::, nou tel mammie tien panties van Lezzane. Nou vra mammie, “hoekom het Lezzane net tien panties?” Nou sê ek, “ja, mammie, sy’s so klein, sy glo daaraan dat die pantie wat sy vanaa::nd aantrek, moet sy more-oggend uittrek”.

I: Aah.

V: NOU sê my suster, “Vané, hoekom koop jy nie vir haar nog nie?”

Ek sê, “ja, die’s vir haar vyf dae se panties”.

I: Mmm.

V: En die slaapklere. Askies, die wat vanaand in slaap, moet ek nie dink, gaan sy more weer aantrek nie.

I: Ja:::. Sy soek dit skoon.

V: En whooo, en nou weet ek nie of sy eendag vuil of morsig gaan wees as sy groot is nie! (laughs)

I: (laughs). Nee, hopelik is sy net soos wat sy nou is...

V: [Ek kan ek kan] nie dink dat Lezzane...en haar HANDE moet nie vuil wees nie en niks...

I: Mmm, ja.

V: SY moet nie NAT wees nie. Dit lyk Lezzane freak uit oor vuil hande. Sy sê vir my, “↑
KYK HOE LYK MY HANDE! WAS MY HANDE!”

I: Ja::

V: So. REGTIG. Sy's BAIE baie (0.1) baie presies op haarself en sy's baie handig wat Lyndsay betref.

I: Hmm mm?

V: Sy was in die kleuterskool, toe het 'n seuntjie blykbaar vir haar gestoot en toe kap hy haar aan die bokant van haar vaginatjie.

I: Oo, ai.

V: Ja. En ek sê ek dink jy kan pas...daar is twee juffrouens en seker twee-en-tagtig kinders

I: Hmm, ja?

V: Ek gaan nie vir Lezzane laat terug gaan nie. En (0.3) hulle sê, nee ek moet vir haar laat gaan, want dan het ek meet tyd.

I: Hmm.

V: SY, as sy nie wil slaap nie, sê sy vir my, "ek kan mos sien sy gaan nie nou slaap nie."

Nou ek het 'n routine, hulle moet elke dag slaa::p, omdat Lyndsay in die nag sy epileptiese aanvalle...

I: Oo::k.

V: Van twaalf uur af...want daai tyd is my huis alreeds skoon. Dan laat ek Lindsay slaap en ek slaap en ons twee slaap. Maar sy is nou op daai tyd, wat sy nou nie meer in die middag wil slaap nie.

I: Oo::kay.

V: So sy wil nou op haar eie of winkeltjie of skooltjie toe of wat so ever...

I: Sy is op die self-stadium.

V: Ja:::: en toe sê ek vir my man maar ek...Lezzane is baie ongelukkig by die skool...En as Lezzane by die huis kom, is Lezzane quite fine.

I: Mmm.

V: En ek het met my vriendin gepraat...daar's te veel kinders en daar's NET twee onderwysers.

I: Mm mm.

V: Toe is ek die next dag skool toe om uit te vind wie Lezzane omgestoot het, nie EEN van hulle kan vir my sê watter seuntjie het vir Lezzane gestoot nie.

I: O::, aai.

V: En Lezzane wys toe nou self. Toe sê ek Lezzane is ongelukkig en ek gan nie ELKE oggend...dan huil die kind.

I: O::, ja.

V: En op die einde toe sê sy vir my, "mammie kyk na boeta, mammie kan na my ook kyk."

I: Mm mm.

V: (.hhhhh) En die Here is my getuie, as ek soggens vir Lyndsay was, sy gaan haal vir hom 'n kimbie uit. Ons het nie warm water nie, nou sê sy, "mammie moet ek die ketel aansit?" en ek sê, "wag Zanne, kyk eers of daar water in is."

I: Ja::

V: Nou sal sy vir my sê, "ja mammie, daar's water in die ketel". Dan sit sy aan, sy gaan haal die bad vir my buite. Sy sê nou die dag, "mammie moenie boeta se zink so hoog sit nie, want ek kan nie bykom nie."

I: Aah.

V: SY'S VERSKRIKLIK. Maak gou vir my die kombuis skoon, oud soos Lezzane is, droë Lezzane af, sy pak weg, sy vee die kas, sy vee die microwave, sy vee die...

I: Ooo julle, so sy's so hulpVAARDIG.

V: Regtigwaar. Was ek die wasgoed...As ek sien Lezzane, sy hang AL die panties en die sokkies, al die onderklere hang sy op, op haar manier.

I: Mm mm.

V: As ek die wasgoed afhaal, help sy vir my afhaal. SY VOU SO NETJIES wasgoed op. Dis net nie waar nie.

I: Ai julle...

V: Haar pa sê, hy kyk gisteraand, terwyl ek by my ma was. Nou het ek nou die dag gewas, Dinsdag gewas mos nou...toe dink hy hy gaan daai wasgoed gou opvou. Hy sê hy hy verkyk vir hom aan Lezzane. Hy sê hoe goed op so 'n ouderdom. Hy sê vir my, "Vané, sy vra vir my 'dadda, wat gan dada maak as dit my tyd kom om BRA te dra?' " (laughs)

I: Ag, my moeder! (laughs) Sy dink al aan sulke goed.

V: JA! Haar pa sê, "Lezzane maar dis mos nou nog nie jou tyd nie..."

I: Ja.

V: Sy sê, "daddy ek weet dit is nie my tyd nie, maar ek VRA mos nou vir jou, 'wat gaan dada sê as...'

I: Ja::

V: 'as dit nou my tyd is om bra te dra?' " (laughs)

I: Ag, moeder! So hulle het ook 'n goeie verhouding?

V: Baie. (Laughs)

I: Nou sê gou vir my, hoe is jou verhouding met Ashlyn?

V: Baie goed, baie goed. Ons twee het eers vir 'n tyd nie gekliek nie, want sy is amper soos 'n rebel. Sy wil doen en maak wat sy wil.

I: Ja, haar tienerfase?

V: Ja:::. En toe het 'n ander vrou vir my eendag gesê, ek moet haar los, dis 'n fase wat hulle deurgaans en sy was mos uit die skool uit en toe is sy weer terug skool toe, want Northlink College se mense sê toe...

I: O::k

V: Want ek het vir haar gevra laasjaar, ek sê, “Jinne my kind, wat gaan van jou lewe word?” “Jy het dan vir my gesê jy wil ‘n maatskaplike werkster word...nou wat het dan nou van my maatskaplike werkster geword?”

I: Ja, daar is baie van hulle nodig.

V: Ja:: Ek sê vir haar my kind in vandag se lewe kyk, ‘n seunskind wat uit die skool uit gaan, word ‘n GANGSTER en ‘n meisiekind wat uit die skool uitgaan word ‘n PROSTITUUT.

I: Mmm.

V: Ek sê, ek weet nie. “Ek gaan nie vir jou, ek gaan nie vir jou druk om te gaan nie, maar ek wil net vir jou sê, ek weet nie, ek gaan dood, ons almal gaan dood...dan bly dji agter”.

I: Ja::

V: Jy het dan vir my gesê, “eendag as...jy wil werk dat jy vir Lindsay kan sorg of vir Lezzane kan kyk”. O::::: nou, sê ek.

I: Mm mm.

V: En toe Januarie, toe het die klomp wat saam met haar gebore is; so ene Brendon, toe kom hy vir haar sê, want hy was ook daar...”Ashlyn, kom die Kollege se mense sê hulle vat...”

I: Mmm.

V: Want dit was haar derde jaar graad nege...en sy nou. Hy sê toe vir my maar aunt Liezel moet self gaan hoor, toe is ek nou op Kollege toe. Gelukkig trek sy die next dag haar skoolklere aan. Ek het gekom, ek sê toe vir die Kollege meneer...wil u nie vir haar nog ‘n geleentheid gee nie? Die skool wil haar toe nou nie meer aanvaar nie.

I: Mmm.

V: En Ashlyn is toe terug en Ashlyn is so::: gelukkig.

I: Aai.

V: Sy doen nou, al haar standards klaar; sy is in Oktober klaar.

I: Sho:::

V: Dan moet hulle sewe en vyftig persent het vir 'n beurs by Northlink Kollege. Nou sy doen so verskriklik goed. Sy doen nie die heel week klas nie, sy het net drie dae.

I: Aai, want sy het nie nodig om so baie klas toe te gaan nie.

V: Ja nou is sy by die huis, want hulle lêers is Vrydag Johannesburg toe.

I: Sho::

V: En nou nie almal nie, seker nou net wie goed doen se lêer is soontoe. Nou sê ek vir haar, “weet jy, ek voel BAIE trots op jou, want jy is my my heel eeste, my OUDSTE kind, en 'n ma, elke ma wil net die beste hê vir haar kind”. Ek sê vir haar, “jy gaan nie spyt wees nie, want jy doen dit nie vir my nie, jy doen dit vir jouself”.

I: Mm mm.

V: Nou my man is nie haar pa nie.

I: Ok.

V: Maar ek kan vir jou dit met trots sê, sy word nie stief behandel nie.

I: Ja.

V: Gisteraand toe skel ek op haar. Sy tart vir Lezzane. Tart sy en sy tart en sy tart...nou skel Lezzane vir haar.

I: Mmm.

V: Maar nou hoor haar pa Lezzane sê, sy het gesê “voetsek!”. Toe se ek, “nee, hier bly nie honde in ons huis nie”. Toe sê haar pa vir my, “maar ek gaan vir jou slat”. Toe sê ek, “maar djy weet nie wat doen Ashlyn nie!” Ashlyn tart en tart en tart vir Lezzane.

I: Ja.

V: En Lezzane pimp haar, want Lezzane het vir my gesê, “mammie, maar Ashlyn rook”.

I: O::

V: Toe sê ek, o, nou lyk dit, sy het nou vir my een keer gesê, “weet mammie, ek sal vir Lezzane vat en vas teen die kop druk.” Toe sê ek vir haar, “Nee man, Lezzane is baie

streng”. “Lezzane vra vir jou, ‘heeldag weer op mixit né, heeldag! Het jy nie werk om te doen nie?’ ” (Lauhgs) So, maar ek en sy kom baie baie goed oor die weg.

I: Dis goed.

V: Sy dy:::e my hare vir my, sy blo:::w my hare vir my. Sy...wanneer het dit so gereën, toe reën my hare sopnat. Toe sê sy, “haai Vané, ek het jou hare dan so pragtig gemaak?” Ek sê, “nee jy kan mos nou weer die naweek.” (Laughs) Maar ons twee het ‘n baie ope verhouding; praat oor seks, praat oor alles; boyfriends; al die dinge.

I: Dis baie belangrik, veral in die tienerjare.

V: Ja, ja, sy’s nou...sy is nou al vir vier jaar wat daar ‘n outjie agter haar aan is. En ek hou van hom, omdat hy ook nie drink nie.

I: Ja?

V: En nou een week, met December Krismis mos, en Valentines Day, en met haar birthday, koop hy vir haar geskenke. Toe vra ek vir haar, “waar’s Marshall?” want my huis se beleid is, wanneer sy agtien is, dan kan ‘n boyfriend kom by die huis.

I: Mmm.

V: Toe sê sy my, “mammie, hy soek nie vir my deur die dag nie. Nou saans dan wil hy hier kom of hy sien vir mammie of hy sien vir dada en hy vra ‘waar is Ashlyn’? Nou wat wil hy dan saans met my doen wat hy nie met my deur die dag kan doen nie?” En ek gee haar toe nie antwoord nie. Ek sê vir myself, jy het nogal ‘n open mind.

I: Ja.

V: Om nou so:: ver te dink.

I: Ja.

V: Toe sê ek vir haar, “nee, dis ‘n goeie ding wat jy sê”. Sy sê, “Ja mammie, ek het net besluit, as jy nie deur die dag kan kom nie, wat moet ek saans met jou buitekant doen? En wat wil jy in elk geval met my maak in die aand, wat jy nie deur die dag met my kan doen nie?”

I: Mmm.

V: Toe sê ek vir haar, “Weet jy Ashlyn ek is nogal baie trots op jou dat jy so ver dink”.

I: Ja::

V: Sy sê, “nee mammie (ekskies vir die woorde) ek gaan nou nie vir my laat opklim voor my tyd nie”.

I: Natuu::rlik.

V: Nou sê ek vir haar, “Nee dis reg!” Sy sê, “Nee mammie, mammie sê vir my, mammie was 24 toe mammie vir my gekry het” en haar begeerte is, sy sê vir my, sy wil nie ‘n kind hê in haar twintigs nie. Sy kan nie vir haar voorstel met ‘n kind in haar twintigs nie. Toe sê ek vir haar haar twintigerjare moet sy geniet!

I: Ja::

V: Sy wil dit volheid geniet, sy wil werk, sy wil alles in haar vermoë doen. Nou sê ek vir haar. “my kind mammie sê dit altyd, bid vir die Here en die Here wil die begeertes net sien”.

I: Mm, ja::

V: Sy sê, “nee mammie.”

I: Mmm.

V: Nou sien ek weer die ander dag, nou kom hy weer tot daar. Nou is Lezzane ook daar. Toe sê ek, gaan koop julle twee somer vir Lezzane ‘n coke. Nou is hulle twee weg en hulle kom weer terug en hulle is weer in by die huis, maar ek kan net sê, ek het nie probleme met haar nie, van saans buite of so nie.

I: Mmm.

V: Sy sit agter by mammie, op die yard. Sy sit by my ma van twaalf tot twaalf toe, sy is nie op die straat nie. Sy gaan nie een keer uit by die huis nie.

I: Sho::

V: Sy is BAIE BAIE rustig vir ‘n meisiekind van haar ouderdom.

I: Ja, maar dit klink goed so, sy hou by die waardes wat jy haar geleer het.

V: Ja, rêrig. En en en en dit laat vir my baie goed voel, want ek sê vir haar, “ek het groot geraak met ‘n DRONK ma”.

I: Mmm?

V: My ma het nie morele waardes in ons huis nie. En ek sê dit gou by, dit maak nie saak of my ma dronk was of nie en sy kan die () sê...Iewers kom ek by die skool; en sy het vir haar ‘n tatoe laat maak op haar been. Toe kom daar ‘n infeksie in.

I: O::

V: Toe gaan sê ek gou vir die dokter – die derde dag toe is sy skool toe, sy sê, “mammie, o:: dokter kan nie glo dat jy my mammie is nie en weet jy hoe trots voel ek op mammie?”

I: O:: dis baie spesiaal.

V: Ja:: Nou sy sê, sy sê vir haar meneer, “weet meneer hoe oud is my ma? My ma is al een-en-veertig!”

I: (laughs) Hy wil dit nie glo nie!

V: Ja::: Toe kon hy nie glo:: nie...

I: Ja::

V: Toe sê ek, “my kind ‘n mens is hoe jy vir jou hou”. Nou sê ek, “deur AL ons omstandighede, ek gaan nooit nooit nooit ooit laat dinge vir my onderkry nie”.

I: Ja.

V: Soos Saterdag, ek is BAIE lief vir musiek. Nou speel daar ‘n song, en ek sit bietjie harder en ek dans en ek dans! (laughs)

I: Dis goed, dit laat ‘n mens goed voel.

V: Dit laat ‘n mens regtigwaar! En uhm toe sê sy, “mammie, o ja Tietie het gesê...” (dis nou my baby suster)...

I: Ja?

V: “Sy het met mammie gesels dat as ek agtien is, gaan ek en mammie en sy en my oudste suster se dogter, dan gaan ons vier dans tog!” (laughs)

I: (laughs) Ja.

V: Nou sê ek, “ja ons gaan dans tog”. Sy sê, “regtig mammie?”. Ek sê “ja ”. Nou sê my ma maar hy gaan ook saam, nou sê sy, “dada ons gaan nie jol nie”. Ek was laasmaand by ‘n troue.

I: Ja::

V: Dit was vir my en my man...nee gaan, jy moet wegbreek. En oo ek het my HART uitgedans. Dit was vir my so:: lekker! Want ek is sonder man, sonder kinders, is ek daar. Dit was by die (0.2) Stellenbosch brandweer. In daai saal van hulle was dit gewees.

I: Ja?

V: Dit was daar gewees. ‘n Paar mense van Kylemore was genooi.

I: Toe kom jy ‘n bietjie uit?

V: O:: ja::: Dit was verSKRIKlik lekker.

I: Dis goed. Dit laat jou sommer weer goed voel.

V: Regtig waar, regtig waar.

I: Maar Vané, jy het nou-nou verwys na jou dronk ma. Sê gou vir my, hoe was julle verhouding gewees, as kind, toe jy ‘n kind was?

V: Ek het BAIE pakke van my ma kry, verskriklik verskriklik, omdat ek soos ‘n tomboy was.

I: O::k?

V: Ek het die meeste pakke gekry; my neus was al gebreek geslaan.

I: Re::rig?

V: Regtig regtig.

I: Sho!

V: Uhm, ons het ook op die yard gebly by my pa se suster. Toe’s dit nou my niggie se twenty first.

I: Mmm?

V: En as my ma dronk was, het sy sommer altyd spoke gesien.

I: Sho::

V: Tussen five to ten, toe sê sy ek moet huis toe. Dan sê my pa, “alreeds? Die kind is mos net op die jaar”.

I: Mmm.

V: Toe se ek vir my baby suster, “kom ons gaan huis toe.”

I: Mmm.

V: Toe ek inkom, slaan sy my in die FACE.

I: Sho::

V: Die...in die middel van die nag sien ek my face, my mond en my neus staan uit so. En Sondagoggend toe sê my baby suster, “dis was onnodig”. Sê ek, “sy was dronk gewees”.

I: Ja::

V: En my baby suster gaan saam met my hospitaal toe. En beskerm ek, ek het nie gesê dat my ma hit my. Ek sê sommige meisie...

I: Mm mm.

V: Ek sê vir mammie, ek is al groot (mumbles). Sy het my gegooi met ‘n vurk. (Starts to roll up sleeve to show where the scar is.)

I: Sho::: Hoe oud was jy; was jy al ‘n groot meisie of was jy nog klein?

V: Ek was ‘n groot meisie, ek was amper een-en-twintig.

I: Toe bly jy nog in die huis?

V: Toe bly ek nog in die huis.

I: Is daar ‘n merk wat jy kan wys?

V: Ja. Hierso. Toe sy gooi dit wanneer ons het ons kos, toe ek opgestaan het.

I: Sho:: as die merk soos daai lyk, moes sy dit diep gegooi het.

V: BAIE baie.

I: So sy was baie aggressief met jou.

V: Baie baie, en ek a::ltyd gesê, eendag as die Here vir my kinders gee, wil ek NOOIT ooit my kinders so behandel soos my ma vir my...

I: behandel het nie?

V: Ja, my ma, en die omstandighede waarin ons groot geword het nie.

I: Mmm.

V: (.hhhh) ek het al gewerk, ek het al op vyftien-jarige ouderdom gewerk in klere en fabriek en uhm, Vrydag kom ons huis toe; ek het gepay, dit was ek en my oudste suster.

I: Mm mm.

V: Dan gaan drink sy dit uit. Ek was al met 'n aapstert het sy my al geslaan. Daar was destyds 'n outjie agter my. Ons was na 'n dans toe en iemand het seker vir haar gesê, maar die outjie was by my, en toe slaan sy vir my met 'n aapstert...Die maandagoggend toe ek nou werk toe, so dra ek my langarm in, sodat hulle nie moet sien hoe my lyf lyk nie - my arms en bene - my hele hele lyfie. (Rubs down her arms and legs to show where she was hit.)

I: Aah julle, dit moes erg vir jou gewees het as jou eie ma jou so slaan.

V: DIT WAS, DIT WAS.

I: Hoe dit jou laat voel as jou eie ma dit aan jou doen?

V: O::: so ongemaklik ek kan daai vrou doodmaak – regtigwaar.

I: Ja::

V: Hoe kan 'n MA:: haar eie kind so slaan?

I: Mmm.

V: En ek is haar GROOT meisie. En uhm...

I: Maar wou jy haar beskerm by die hospitaal?

V: Ja::

I: Dit was daai dubbele ding van jy is kwaad vir haar omdat sy jou slaan, maar jy wil haar ook beskerm.

V: Ja:: dit is so. Dit was moeilik gewees, dit was verskriklik. En my pa het nie gedrink nie, maar my ma het gedrink.

I: Ok. En sê gou vir my, kan jy met jou ma praat soos jy met Ashlyn praat?

V: Nee, glad nie. Tot vandag nie. Nee.

I: Mmm.

V: Daar is nie, daar is nie dat ek nie van mammie hou nie, maar daar is nie...hoe kan ek sê... tussen ons twee moeder en dogter, daai regtig verhouding nie. En ek dink nie dit sal ooit... ek is nog nou al... (0.2) te groot. En (0.2) ek het kinders van myself gehad en as sy siek is - sy het hartaanvalle - as sy hospitaal toe gaan, is ek altyd die een. Ek sien dat haar huis altyd skoon is en alles, maar... (arms folded across her chest while she talks about this; her body language and tone suggest she is burdened and resentful of all of the work she does for her mother).

I: Sho:: Bly sy ook by Kylemore?

V: Ja sy bly in Kylemore.

I: Ok, so jy sien haar op 'n daaglikse basis?

V: Ja, ek bly agter hulle in die yard.

I: O, ek sien, so julle sien mekaar baie. En jy wil nie jou verhouding met jou ma herhaal in jou verhouding met jou eie kinders nie?

V: Nee, nee, nee (shakes her head).

I: Dit klink nie vir my dat dit gebeur nie; dit klink vir my of jy 'n baie goeie verhouding met hulle het.

V: Baie baie goed.

I: Maar ek moet nie vergeet om hierdie vorms in te vul nie. Kan ons net hulle gou klaarmaak. [Oopsie!] Amper slaan jy agter oor! (laughs as V's chair tilts too far backwards).

V: [Yoooo!] (Chair almost falls over backwards as she moves).

I: Ek hou nie van vorms invul nie, maar ons moet dit ongelukkig nou doen.

V: Ok.

I: Watse werk doen jou man?

V: Hy is mos nou by die huis.

I: Hy is nou by die huis, maar as hy nou werk, jy het gesê dat hy doen aansoek vir sekuriteitswerk?

V: Mm mm. Ja:::

I: Maar op die oomblik is hy werkloos.

V: Ja:::Ek kyk maar tot na more toe.

I: Ja. Nou en... jou eie ouers? Wat het jou ma gedoen, (0.2) toe sy nog kon werk?

V: Mammie (0.1) het in (0.1) die fabriek gewerk al die jare.

I: Ok, en... jou pa?

V: 'n Painter.

I: Ok jou ma het in die fabriek gewerk en jou pa was 'n painter.

V: Ja:::

I: So self, verdien jy nie nou 'n inkomste nie, né?

V: Nee.

I: En jou man; as hy nou werk, wat verdien hy min of meer?

V: Uhm (0.2) hy kry per fortnight, dan kry hy een duisend twee honderd rand.

I: Ok, R1200 vir 'n fortnight...Jy het gesê, wat is die inkomste van julle huishouding dan? Kry Lyndsay 'n ongeskiktheidstoelaag?

V: Lyndsay, Ashlyn en Lezzane se geld saam is R1840.

I: R1840.

V: Ja.

I: Ok so dit is dan nou die toelae.

V: Ja.

I: Ok so Lyndsay kry die ongeskiktheidstoelaag en die ander twee kry die kindertoelaag.

V: Ja.

I: Ok ok. En sê vir my, kan jy gemaklik lees en skryf?

V: Mmm, ja. Ek hou baie van lees.

I: Ok. En tot watter graad het jy by die skool voltooi?

V: Mmm, maar standard drie.

I: Standard drie, dit is graad vyf né?

V: Ja.

I: Ek praat ook nog van die standards! (laughs)

V: (laughs)

I: En sê vir my, van watter Godsdienst is jy?

V: Ou Apostolies.

I: Ou Apostolies, ok. En is jy aktief betrokke by die kerk?

V: Ja.

I: Ok. Gaan julle gereeld Sondag kerk toe?

V: Gereeld Sondag.

I: Ok (writes) (0.4). Alright. En hoeveel jare bly jy al hierso in Kylemore?

V: (Clears throat) Vandat ek gebore was.

I: Vandat jy gebore was?! So jy het hier groot geword? Sho.

V: Ja.

I: So jy sal nie sommer van hier wegtrek nie.

V: Mmm, nee, baie rustige plek hier.

I: En sê vir my, hoeveel vertrekke is in julle huis?

V: Drie.

I: Drie, ok. En die aantal slaapkamers?

V: Drie.

I: En saam met wie deel jy 'n slaapkamer?

V: Ek en my man, en die kleintjie en Lyndsay.

I: En, julle het 'n badkamer in die huis, né?

V: Nee, buitekant van die huis.

I: Ok, buitekant. En elektrisiteit?

V: Ek kry van my ma-hulle.

I: Ok (writes) (0.3). Die laaste vorm wat ons moet invul is net die BDI. Ek gaan net vir jou lees wat hulle hierso sê. Hierdie vorm bestaan uit 21 stellings. Ek gaan vir jou die stellings lees en dan moet jy die een stelling kies in elke groep wat die beste beskryf hoe jy die afgelope TWEE weke, insluitend vandag, gevoel het. So die afgelope twee weke, saam met vandag. En dan gaan ek die syfer omkring wat u gekies het. Indien verskeie stellings tot dieselfde mate op u van toepassing is, omkring dan die hoogste syfer in daardie groep. Maak seker dat u nie meer as een stelling by enige groep kies nie. Ok, so jy moet net ene kies. Ok, ek gaan net gou seker maak of hierdie goed nog aan is. Is dit reg so?

V: Als in die haak.

I: Ek weet nie so lekker hoe dit werk nie, ek hoop maar dis reg. Ok dit lyk vir my hy neem nog op. Ek gaan dalk net netnou 'n ander cd insit, want hy kan net 'n uur opneem.

V: O:::

I: Ek gaan die ander CD insit as jy nie omgee nie.

V: Dis reg.

I: Ok kom ons kyk nou gou. Uhm die eerste een is “Hartseer”. Die eerste een is “Ek voel glad nie hartseer nie” of “ek voel die meeste van die tyd hartseer”, “ek voel altyd hartseer”, “ek voel so hartseer en ongelukkig dat ek dit nie meer kan hou nie”. (0.4) Watse een pas die beste by jou vir die afgelope twee weke? (Shows V the options again.)

V: (0.6). Ek voel die meeste van die tyd hartseer.

I: Ok so ek omkring ek voel die meeste van die tyd hartseer. Daai was nommer een. Uhm “Pessimisme”. Dit is maar, jy is negatief rakende dinge as gevolg van jou omstandighede. Nou die eerste een is, “ek is nie ontmoedig ten opsigte van my toekoms nie”, “ek voel meer ontmoedig ten opsigte van my toekoms as wat ek was”, of, “ek verwag nie dat dinge vir my sal uitwerk nie”, of “ek voel my toekoms is hopeloos en dat dit net slegter kan gaan”.

V: Mm, nommer 1.

I: Nommer 1. Ok “ek voel meer ontmoedig oor my toekoms as wat ek was”.

V: Nee, ek is nie [ontmoedig nie]...

I: [nie ontmoedig teen my toekoms] nie. Ok, dis ‘n goeie ding.

V: Ja::

I: Ok, “Vorige mislukking”. “Ek voel nie soos ‘n mislukking nie”, “ek het meer misluk as wat ek moes”, of, “as ek terugkyk, sien ek ‘n klomp mislukkings”, of, “ek voel as persoon ‘n algehele mislukking”.

V: As ek terugkyk, sien ek ‘n klomp mislukkings...verlede jaar.

I: Ok. “Verlies aan Genot”. “Ek kry net soveel genot uit die dinge wat ek voorheen geniet het”, of “ek geniet dinge nie soveel as vantevore nie”, of, “ek put min genot uit dinge wat ek voorheen geniet het”, of, “ek put geen genot uit dinge wat ek voorheen geniet het nie”?

V: Ek put min genot uit dinge wat ek voorheen geniet het.

I: Ok, alright. Dan “Skuldgevoelens”. “Ek voel nie besonder skuldig nie”, of, “ek voel skuldig oor baie dinge wat ek gedoen het of moes gedoen het”, of, “ek voel die meeste van die tyd skuldig”, of, “ek voel die hele tyd skuldig”?

V: Ek voel (0.3) voel skuldig oor baie dinge wat ek gedoen het of moes gedoen het.

I: Alright, o:k. Hierdie lys vat darem nie so: lank nie. Dis darem die laaste een. Ok “Gevoelens van straf”. “Ek voel nie dat ek gestraf word nie”, of, “ek voel dat ek gestraf kan word”, of, “ek verwag om gestraf te word”, of, “ek voel ek word gestraf”.

V: Ek voel ek word gestraf. Die een.

I: Veral met Lyndsay?

V: Mmm.

I: Ok. Jy voel jy verdien dit nie eintlik nie?

V: Ja.

I: Ok. “Afkeer in self”: “Ek voel nog dieselfde oor myself as voorheen”, of, “ek het vertrou in myself verloor”, of, “ek voel teleurgesteld in myself”, of, “ek hou nie van myself nie”.

V: Ek het vertrou in myself verloor.

I: Ok. Dan “selfkritiek”. “Ek kritiseer of blameer myself nie meer as gewoonlik nie”, “ek is meer krities teenoor myself as wat ek gewoonlik was”, “ek kritiseer myself vir al my foute”, of, “ek blameer myself vir alle slegte dinge wat gebeur”?

V: Ek blameer myself vir alle slegte dinge wat gebeur.

I: Dan “Selfmoordgedagtes of begeertes”. “Ek dink nie daaraan om myself om die lewe te bring nie”, “ek dink soms aan selfmoord, maar sal dit nie uitvoer nie”, “ek sou wou selfmoord pleeg”, of, “sou ek die kans kry, sal ek selfmoord pleeg”?

V: Ek dink soms aan selfmoord, maar sal dit nie kan uitvoer nie.

I: Ok, so jy sien dit partykeer as ‘n uitkoms?

V: Ja:, dit is ja.

I: En wat keer jou dan om dit nie te doen nie?

V: Soos...dis was nou twee:: weke terug. Dink ek (0.2) my meisiekind was in die skool, my man is in die werk, nou is daar niks om te doen in die huis nie, nou wonder ek of die beste nou nie maar is om vir my en Lyndsay en Lezzane dood te maak nie en as hulle nou daar kom...

I: Sho::

V: Maar toe dink ek by myself dis nie die moeite werd nie, miskien survive ek, dan verwyd ek nou myself as Lyndsay en Lezzane miskien nou dood is of ek gaan miskien nou tronk toe.

I: Ok. So jy het gevoel dis 'n oplossing?

V: Ja. Ja.

I: Omdat alles het te veel geraak vir jou?

V: Ja, alles het te veel geraak vir my.

I: Maar jy sien nie jousef dat jy dit kan doen nie?

V: Nee, ek dink nie ek het daai guts nie.

I: Ja, want dan jy beïnvloed nie dan net jousef nie, jy beïnvloed ook jou kinders.

V: Ja, dit is so.

I: Ok. "Huilerigheid". "Ek huil nie meer as gewoonlik nie", "ek huil meer as gewoonlik", "ek huil oor elke klein dingetjie", "ek wil huil, maar ek kan nie".

V: Ja, meer as gewoonlik.

I: Ok. Uhm "Geaggiteerdheid of rusteloosheid". "Ek voel nie meer rusteloos of opgewen as gewoonlik nie", "ek voel meer rusteloos of opgewen as gewoonlik", "ek is so rusteloos of geaggiteer dat ek moet aanhou om te beweeg of iets te doen"...

V: Ek voel meer rusteloos.

I: Of opgewen.. ok. "Verlies aan belangstelling". "Ek het nie belangstelling in ander mense of aktiwiteite verloor nie", "ek is minder geïnteresseerd in ander mense of aktiwiteite as voorheen", "ek het die meeste van my belangstelling in ander mense of aktiwiteite verloor", of, "dis moeilik om in enigiets belang te stel"?

V: Mm, nommer een.

I: Ok. Is dit hierdie “ek is [minder] geïntereseerd”?

V: [Ja]

I: Goed. Dan “Besluiteloosheid”. “Ek neem besluite nog net so maklik soos altyd”, “ek vind dit moeiliker as gewoonlik om besluite te neem”, “ek vind dit baie moeiliker om besluite te neem as voorheen”, of, “ek ervaar probleme om enige besluite te neem”.

V: Nommer twee.

I: Nommer twee.

V: Mmm.

I: “Ek vind dit moeiliker om besluite te neem.” Ok. “Waardeloosheid”, “Ek voel nie dat ek waardeloos is nie”, of, “ek beskou myself nie as so waardevol en van nut soos voorheen nie”, of, “in vergelyking met ander mense, voel ek meer waardeloos”, of, “ek voel uiters waardeloos”?

V: Beskou myself nie meer so waardevol nie.

I: Ok en van nut as voorheen nie? Ok. “Verlies aan energie”. “Ek het net soveel energie as voorheen”, “ek het minder energie as gewoonlik”, of, “ek het nie genoeg energie om baie te doen nie”, of, “ek het nie genoeg energie om enigiets te doen nie”.

V: Ek het minder energie.

I: As gewoonlik?

V: As gewoonlik.

I: Ok. Dan “Verandering in Slaappatroon”. “Ek ervaar geen verandering in my slaappatroon nie”, “ek slaap ietwat meer as gewoonlik”, of, “ek slaap ietwat minder as gewoonlik”, of, “ek slaap baie meer as gewoonlik”, of, “ek slaap baie minder as gewoonlik”, of, “ek slaap die grootste deel van die dag”, of, “ek skrik een tot twee ure te vroeg wakker en kan nie weer aan die slaap raak nie”?

V: Ek slaap baie minder as gewoonlik.

I: Ok. Slaap baie minder...

V: Ja.

I: Dan “Irriteerbaarheid”. “Ek is nie meer geïrriteerd as gewoonlik nie”, “ek is minder geïrriteerd as gewoonlik”, “ek is baie meer geïrriteerd as gewoonlik”, of, “ek is die heeltyd geïrriteerd”?

V: Ek is meer geïrriteerd as gewoonlik.

I: Ok. En sê vir my, as jy geïrriteerd is, wat doen jy met daai geïrriteerdheid?

V: Oo:::: (laughs). Soos ek nou (throws hands up in air, makes fists and makes a frustrated sound) L::::

I: Jy net skree!

V: Ja, regtig. So ek sê net: “L::::” en as ek by Ashlyn kom, sy sê, “nee mammie, mammie nee.”

I: Ok dan, haal jy dit op jou kinders uit of hou jy dit by jouself?

V: Nee, ek doen, ek skree net so: “L::::”

I: Jy skree net, ja.

V: Dan loop ek net uit.

I: Dan jy moet, ja. Vat jy die pad en dan kom jy weer na ‘n ruk terug?

V: Ja. En ek steek ‘n sigaret brand.

I: Ok en in daai tyd, kyk Ashlyn na Lyndsay?

V: Ja, sy’s baie oor hom. Sy is nie oor Lezzane nie. Sy is baie oor hom.

I: So Ashlyn en Lezanne gee ook baie om vir Lyndsay? Hulle kyk na hom?

V: Ja. Veral Lezzane.

I: Ok, soos wat jy nou-nou verduidelik het.

V: Ja.

I: Dan “Verandering in Eetlus”. “Ek ervaar geen verandering in my eetlus nie”, “my eetlus is ietwat minder as gewoonlik”, of, “my eetlus is ietwat meer as gewoonlik”, of, “ek het geen eetlus nie”, of, “ek is gedurig lus vir kos”.

V: My eetlus is baie minder as gewoonlik.

I: Baie minder as gewoonlik.

V: Net een keer per dag.

I:Sho::: Jy kan lank uithou (giggles).

V: Ja.

I: Dan “Konsentrasieprobleme”. “Ek konsentreer nog net so goed soos gewoonlik”, of, “ek kan nie so goed soos gewoonlik konsentreer nie”, of, “ek vind dit moeilik om vir baie lank op enigiets te konsentreer”, of, “ek vind dat ek op niks kan konsentreer nie”.

V: Ek kan nie so goed soos gewoonlik konsentreer nie.

I: Ok. Dan “Moegheid of Uitputting”. “Ek voel nie moeër of meer uitgeput as gewoonlik nie”, “ek raak maklik moeër of meer uitgeput as gewoonlik”, “ek is te moeg of uitgeput om baie dinge wat ek voorheen gedoen het, te doen”, of, “ek is te moeg of uitgeput om die meeste van die dinge te doen wat ek voorheen gedoen het”?

V: Ek raak maklik moeër of meer uitgeput as gewoonlik.

I: Ok en “Verlies aan Belangstelling in Seks”. “Ek het geen onlangse verandering in my belangstelling in seks opgemerk nie”, “ek stel minder belang in seks as voorheen”, “ek stel nou baie minder belang in seks”, of, “ek het my belangstelling in seks heeltemaal verloor”?

V: Ek stel minder belang in seks as voorheen.

I: Ok. Goed, dan is ons darem klaar met die BDI. Ok, alright. Dan wil ek net gou seker maak van daai ding, of hy nog nie afgegaan het nie, en dan gaan ek jou nog net so ‘n paar vragies vra. Ok hy record darem nog. Ok ek sien hy het nog so 15 minute oor...

V: (laughs)

I: Ok, so ons het nou klaar begin met die onderhoud, maar dit gaan goed vandag met jou né?

V: Ja, ja.

I: Ok ek wil net seker maak, want dit lyk of dit goed gaan of beter gaan as wat ek die vorige keer met jou gesels het.

V: Mm ja.

I: Ok. Goed. En sou jy sê jy is op die oomblik depressief?

V: Nee. Nie nou op die huidige oomblik nie.

I: Nie op die huidige oomblik nie, maar in die afgelope twee weke?

V: Ja.

I: Ok.

V: Baie.

I: Het jy baie depressief gevoel? En sê vir my, wat het jou so depressief laat voel?

V: Dit lyk amper (0.2) my man is nie gepla nie, omdat hy nie nou werk nie. En almal kerm om my.

I: Mm mm.

V: Of Lyndsay kerm, hy wil kos hê. Lezzane kerm, sy wil kos hé. Ashlyn kerm, sy wil kos hê. “Mammie ek is honger.” En dit lyk hy is as aan. En almal kom na my toe, almal vra vir my. Hulle kerm na my toe (). Nou sê mammie, “die feit van die saak is, ek vra nie vir julle ‘n stukkie brood nie. Ek vra vir julle niks nie. Ek gaan na Sienna toe, of ek bel my vriendin. Dan gaan ek soontoe, ek vra vir julle niks nie”.

I: Ja.

V: Dan seker, alles word te veel vir my, want almal kerm op my.

I: Ja.

V: My ma wil kerm. Ashlyn sê sy’s honger. Nou vra Lezzane vir my, binne-in my oë kyk sy vir my, “mammie wat kan ek nou weer eet?” Want sy eet die HEEL dag. En die sindroom wat Lyndsay het, ek het vergeet om dit te noem, hy vra heeldag kos.

I: O, ek sien.

V: Dit is 'n body and mind thing.

I: Ja:: So hy wil die heelyd eet.

V: Ja::: Maar ek gee nie vir hom nie.

I: Ok en jy kan ook nie ()?

V: Ja::, dit is so ja.

I: Ok, en is dit nie spanningsvol vir jou, omdat as jy 'n lae-inkomste het, om vir hom genoeg kos te voorsien nie?

V: Ja, dit is. Want ek sê, ek sê gister vir my man, my begeerte is net ek moet genoeg kos in die huis hê. Dis, as my kinders vra, daar moet wees vir hulle. Ek moenie vir hulle sê, "Lezzane maar mammie moet nou eers kyk waar mammie 'n brood se geld kry nie". Of wat vir my BAIE baie uitstres - Ashlyn gaan skool toe sonder brood en as sy uit die skool uitkom...ek glo daaraan dat daar MOET vir haar 'n stukkie brood wees, omdat op die uiteinde breek dit vir haar af, want sy gaan skool toe sonder brood en as sy uit die skool uitkom, is daar vir haar niks om te eet nie...vir my is dit nie...dis nie reg nie.

I: Nou hoe laat dit vir jou voel as jy nie [genoeg kos het nie]?

V: Dit laat my so NUTTELOOS voel. Ek is nie die woord "ma" werd nie, ek kan nie provide vir hulle nie.

I: Mm mm

V: Issie, is nie reg nie. Want ek het in 'n dronknes grootgeword, maar my ma het vir ons gesorg. Sy het vir ons gesorg elke dag.

I: Sê vir my, as jy nou nie vir hulle kan voorsien nie, dink jy dit dra by tot jou depressie of jou gevoelens van depressie?

V: Ja, dit raak baie baie.

I: Nou hoe dink jy dra dit by?

V: Uhm (0.2) Hoe bedoel jy nou?

I: Laat dit jou skuldig voel?

V: Ja, dit laat vir my baie baie skuldig voel.

I: So, dit lei tot skuldgevoelens by jou?

V: Ja, ja::: dit laat my baie skuldig voel, dis hoekom ek voel ek moet werk dat ek kan sorg vir hulle. Ashlyn is... 'n jong meisie. Sy wil aantrek en alles. En ek, ek kan dit nie bekostig nie.

I: So jy is half in 'n catch 22, want jy wil werk, maar jy moet ook na Lyndsay omsien, want hy moet eintlik 24 uur na gekyk word?

V: Ja.

I: Anders moet jy weer vir iemand anders betaal om na hom te kyk?

V: Dit is so, ja.

I: So jy's amper 'n bietjie vasgevang?

V: Ja:: HEELTEMAL vasgevang.

I: Nie net 'n bietjie nie. Sommer heeltemal.

V: Ja.

I: Ja, ok. Dan wil ek gou hoor: jou eerste diagnose, die eerste keer toe jy gediagnoseer is met depressie: wie het jou gediagnoseer? Kan jy onthou?

V: Ek dink dit was by Helen...Nee voor dit het ek baie met Suster Coetzee gepraat, [by die Kliniek].

I: [By die Kliniek].

V: Ja. Ons twee het 'n baie baie goeie verhouding.

I: Ok.

V: Gaan praat ek by haar, toe reël sy dat ek iemand by...Cloeteville Kliniek moet sien.

I: O::k.

V: En sy het gebel en toe sê sy, uhm, ek wil nooit ge-admit het dat ek depressie het nie en toe na daai dag, toe erken ek dit. Toe reël sy weer iemand moet my kom sien, soos nou (0.2) die next dag.

I: Mm mm.

V: En toe gebeur dit toe nou so dat Lyndsay daai nag siek word; 'n epileptiese aanval, die ambulans het hom kom haal, toe ongelukkig toe kon ek toe nie daar uitkom nie.

I: Mm mm.

V: Toe het ek nie weer geworry nie, en toe het ek dinge so op my eie gehanteer...

I: Mmm?

V: As dinge te veel raak, dan gaan ek na haar toe. Toe (0.2) daai dag wat ek vir jou by die kliniek kry?

I: Ja, ek onthou daai dag.

V: Ja, toe voel ek ek moet met iemand...want dinge raak te veel vir my.

I: Mm mm. Ek kon sien jy was daai dag baie ontsteld. Sho::

V: Mm, ja, ja.

I: En toe, het die suster of die dokter by Cloeteville Kliniek vir jou gediagnoseer?

V: Nee, niemand het nog vir my gediagnoseer nie.

I: Maar het Suster Coetzee vir jou gesê dat jy depressie het?

V: Ja::

I: Sy het dit vir jou gesê.

V: Ja::, sy het dit vir my gesê. Ja.

I: Ok, alright, goed. Dan wil ek gou gou hoor: wat dink jy is die redes vir jou depressie?

Wat dink jy dra by tot jou depressie? Wat is die grootste redes?

V: Die grootste redes is my omstandighede waarin (0.2) ons lewe, waarin ek my kinders moet grootmaak.

I: Mmm.

V: En die omstandighede waarin ek is; ek het nie 'n LEWE nie. Ek is caught up, ek is stuck up 24/7.

I: Mmm, ok. (nods)

V: Uhm en dis dinge wat vir my baie moeilik maak. Want, want as ek kyk jong getroude vroue wat hulle manne help werk, hulle gaan vorentoe in die lewe. Vir my is dit amper so, ek is amper 12 jaar getroud, ek is NET daar. Want ek is nie vorentoe nie, ook nie agtertoe nie, ek bly net daar waar ek is.

I: Ok. So dit dra baie by tot jou depressie?

V: Ja, ja::.

I: Ok, goed. Dan wil ek gou hoor: depressie en verhoudings, né? Dit is so as 'n mens depressief is, soos wat jy ook nou-nou gesê het, jy wil net alleen wees.

V: Ja.

I: So dit het ook 'n invloed op jou verhoudings; hoe jy voel het 'n invloed op jou verhoudings met ander mense in jou lewe. Nou, op wie dink jy het jou depressie die grootste invloed?

V: My huisgesin.

I: Op jou huisgesin?

V: Ja.

I: Op watter manier het dit 'n invloed op jou huisgesin?

V: As ek somtyds uitfreak, dan skel en vloek ek in die huis en dan en dan, lyk dit – almal is geskok, niemand sê niks nie, dan lyk dit so almal is bang vir my.

I: Ja?

V: En dis hoekom ek gevoel het die beste is, om dit te vermy, dan loop ek uit die huis op my eie, as wat ek dinge kwynt raak waarvoor ek spyt gaan wees of iets doen waarvoor ek more, oormore spyt gaan wees.

I: So dit klink vir my dat as jy depressief voel, dan skel jy en jy wil daai gevoelens by jou mond laat uitkom?

V: Ja::, ja.

I: Om net ontslae te raak, om dit uit te kry?

V: Ja, ja, van (laughs as chair leans back and she gets a fright)...

I: Die stoel is nie baie, is nie baie ()...

V: As ek dit doen, gaan dit ()...

I: Ok, alright. So op watter persone dink jy het jou depressie die grootste invloed?

V: Lezzane.

I: Op Lezzane. Dis nou jou jongste dogtertjie?

V: Ja:::

I: Ok en nou hoekom sê jy so?

V: Want ek slaan haar sommer.

I: Ok.

V: Daar is sommer tye wat ek vir haar onnodig (.) of ek skree vir haar: “EK SÊ VIR JOU BLÊRRIEWIL EK HET NIE!” of whatsoever.

I: Ok.

V: Of “HOOR JY NIE MEER NIE?” of iets. () Sy die meeste ()...

I: Ok. Wat wat sy doen né, laat jou so voel of jy vir haar wil slaan? Is daar iets wat sy doen wat jou tot by daai punt dryf om vir haar te slaan?

V: Sy het daai hardkoppige manier.

I: Ok?

V: Sy's presies soos ek is. (laughs)

I: Mmm.

V: Sy het daai hardkoppige manier en as sy sê vir jou, "die ding is blou", en sy glo dis blou, gaan jy vir haar nie wegkry van daai redenasiepunt "maar dit is blou", nou daai, dan lyk dit ek kan regtigwaar nou...(shakes her fists)

I: Mmm.

V: As sy sê so, dan is dit so en niemand en niks gaan dit verander nie.

I: Ok nou sou jy sê, julle is baie dieselfde?

V: Ja:: BAIE sê so, my ma sê ook so. Maar as ek vir haar kyk, daai hardegat manier, ek is presies so, ek was so, ek is nou nog so.

I: Ja::

V: Ja.

I: En nou dink jy dis miskien die rede omdat julle twee bots?

V: [hoekom ons op die bots is] Ja, ja.

I: Omdat julle so dieselfde is. Dit is baie keer so; die mense wat dieselfde is, sit vas op dieselfde punte.

V: My pa sê ook gister, nou sê my pa, "Lezzane is presies soos jy is", want dit gaan toe nou oor die hare, ek hou ook nie van hare was nie. Nou sê ek vir haar, "jy's 'n meisie, jy moet vir jou netjies hou". Nou sê my ma en my pa, "jy loop al hoe lank sonder om hare te was". Nou sê ek, "presies, MAAR SY KAN NIE SO WEES SOOS EK NIE! SY'S TE KLEIN!"

I: Nou sê gou vir my, wat dink jy as jy so optree, hoe laat dit jou kinders voel?

V: Sy's, 'n mens kan sommer sien, dit upset vir haar heeltemal, want sê byvoorbeeld sy het iets gedoen en ek raak so, en dan kom sy huil na my toe en sy sê vir my, "sorry mammie, sorry mammie" en sy huil of sê sorry tot, tot ek sê, "dis alright". Sy sê so tot ek iets sê, "mammie is ook jammer". En sy huis tot...en sy sê sorry tot ek vir haar sê, "sorry Lezzane".

I: Ja. So dan voel sy skuldig.

V: Ja, dan voel sy skuldig.

I: Ok, en op Ashlyn, watter invloed het jou depressie op Ashlyn?

V: Ashlyn sit vir my gou op my plek. As ek begin skel, dan Ashlyn sê sommer, “mammie nee nee nee.”

I: Mmm.

V: “Ons drink niemand in die huis nie, niemand in die huis gebruik drugs nie, want ons breins moenie beïnvloed nie. MOENIE SO REAGEER NIE, want dis nie mooi nie. Ek hou nie daarvan mammie moet so vloek nie of ek hou nie daarvan mammie moet so aangaan nie.”

I: Nou as jy so vasgedruk voel né, en jy voel jy wil net uitkom, hoe hanteer Lyndsay dit?

V: Ek sê vir hom, “boeta, mammie gaan nou uit”, dan sê hy vir my, “moenie lank maak nie”. Ek sê vir hom, “nee boeta, mammie gaan nie lank maak nie” of daar is sommige dae wat ek net aan die huil raak, dan sit ek en ek huil en ek huil. En dan upset dit vir hom, want dan vryf hy vir my of hy roep, “Mammie mammie mammie”. En hy lê met sy kop so teen my en dan sal hy vir my sê, “Mammie, Lyndsaytjie is lief vir mammie”.

I: Aah.

V: “Eks lief vir jou self”, sê ek. Dan probeer ek kalmeer of ophou huil, want dit upset vir hom. Of op die uiteinde raak hy ook sommer aan die huil.

I: So hy probeer jou troos?

V: Ja, ja.

I: Hy is, hy is baie beskermend teenoor jou.

V: Hy is, hy is baie beskermend.

I: En dit klink asof hy baie lief is vir jou ook.

V: Ja, regtig man.

I: Dit maak dit darem (.) ja, dit maak dit spesiaal. Al voel mens partykeer moedeloos, sulke tye [dis jou kinders wat vir jou help].

V: [Dis jou kinders wat vir jou help, ja].

I: En in sulke tye, is dit jou kinders wat jou dra of wie dra jou as jy so depressief voel?

V: Dit is hulle.

I: Is dit hulle wat jou dra?

V: Ja.

I: Ok, nou, sê gou vir my: dink jy hulle het 'n invloed op jou depressie? Dink jy dat hulle dra partykeer by tot jou depressiewe gevoelens?

V: Somtyds.

I: Ok, en op watter maniere?

V: Soos as hulle kerm oor goed wat ek nie het nie, of wat ek nie vir hulle kan gee nie, dan, dan...

I: Ja. Dis dan dat jy depressiewe gevoelens het, en dis dan wanneer hulle bydra tot jou depressie?

V: Ja.

I: Ok, nou dink jy jou depressie het 'n invloed op hulle?

V: Ek dink so, dit upset vir hulle.

I: Ok, so dit ontstel vir hulle?

V: Ja. Vir Ashlyn, sy's mos nou al groot, vir haar dit upset vir haar totally, dan sê sy vir my, "mammie dis nie hoe mammie moet praat nie, dis nie hoe mammie wat..."

I: Ok.

V: En dan hou ek my mond, wat sy nou sê en dan na 'n tyd sal ek vir haar verduidelik, maar dis die rede hoekom ek so geskel het of dis die rede hoekom ek so uitgefreak het.

I: Ok. Nou sê gou vir my, dink jy die ontsteldheid is die enigste invloed wat dit op hulle het, of is daar iets anders ook, hoe hulle optree dalk?

V: Nee, [glad nie].

I: Ok, dit lyk vir my ons is klaar daar. Ok nou kom ons sit gou gou 'n ander CD in. Maar ek dink hierdie voice recorder, hy neem nog op. So ons kan sommer net aangaan, dis ok met daai.

V: Ok.

I: Goed. Dan kan ek gou gou hoor: jou verhouding met jou ma, jy sê sy lewe nog?

V: Ja.

I: Jy bly agter haar?

V: Ja::

I: Goed, so jy sien haar elke dag?

V: Mmm.

I: En oor die algemeen, julle kom oor die weg, maar daar is nie 'n oop verhouding tussen julle soos tussen jou en jou kinders nie?

V: Ja, seker byvoorbeeld ek wil, ek sal nou sê, ek wil PRAAT met haar, ek het nooit die vryheid om met haar te praat nie. Dis amper so (0.2). Ek weet nie of ek verby mammi lewe of wat nie.

I: Mmm.

V: Maar ons het nie 'n ma en dogter verhouding nie.

I: Ja?

V: Sê byvoorbeeld daar's 'n probleem, dan kan ek nie na haar gaan nie.

I: Mmm.

V: Het nie daai...met haar.

I: Daai vrymoedigheid om dit te doen nie?

V: Ja...

I: Nou dink jy die skade wat in die verlede gebeur het, waar sy jou so geslaan het, het 'n invloed op jou?

V: Ja, ja.

I: Dat jy nie so, nie so openlik met haar kan praat nie?

V: Ja. Maar dan kla sy weer baie by my, maar ek kan nie.

I: Ok so dis half 'n eenrigting verhouding?

V: Ja.

I: Sy kan met jou praat, maar jy kan nie met haar praat nie?

V: Ja.

I: Sê gou vir my, in die verlede, het jy amper ook mos vir haar beskerm en vir haar moes regsien?

V: Ja.

I: So jy het amper die MA rol gespeel, omdat sy nie self die rol gespeel het nie. Is dit so?

V: Ja, dit is so en soos my twee broers altwee in die tik bedryf.

I: Mmm.

V: Dan sal sy na my toe kom en vir my sê, “Ai, dis nou weer die, dis nou weer daai” of “wat dink jy?” of “wat moet ek maak?” en so aan. En ek sal vir haar raad gee.

I: Mmm.

V: Maar sy's nie een wat sommer vir my...dis hoekom ek nie...

I: Mmm.

V: Ek is gewoon, hoe kan ek sê, my eie battle fight. Ek worry nie nog om...met haar...ek maak dit nie haar besigheid nie.

I: Mmm.

V: Of ek sê somtyds vir myself, “sy het genoeg dinge van haar eie”.

I: Ja.

V: Ek is 'n grootmens op my eie. Ek is hier om my eie battle te fight. So ek voel ek is getroud, ek moet van niks afhanklik wees nie, van my ouers nie.

I: Jy voel jy moet onafhanklik wees van hulle.

V: Ja.

I: Ok, en sê gou vir my, jy het nou verwys dat jy nie 'n ma-dogter verhouding het met jou ma nie, maar volgens jou, het jy 'n ma-dogter verhouding met al drie jou kinders?

V: Ja::

I: Is dit met al drie jou kinders of net met...

V: Met al drie.

I: Met al drie.

V: Met al drie.

I: Ok, en [elke]...

V: [Ek is] te streng, maar ek gesels met hulle, ek lê by hom, hy sê, "ek soek 'n meisie". Ek sê vir hom, "meisies is probleme"... (Smiles)

I: (laughs)

V: Nou sê hy, "mammie, Lyndsay soek 'n vrou soos mammie". Toe sê ek, "oo moet jy 'n meisie het wat soos mammie is?" Nou sê hy, "ja!" Nou sê ek, "boeta, ek dink nie mens kry meer mammie se soort nie. Mammie se soort is skaars..."

I: (laughs)

V: Maar hy's mos nou nie heeltemal normaal nie, sy brein is mos nou maar 'n bietjie stadig, maar hy verstaan alles wat ek voel.

I: Ja::

V: En hy luister vir my.

I: En sal jy sê, sal ander mense hom verstaan of (0.2)...Kan hy normaal praat of verstaan jy net, omdat jy nou al so lank by hom is?

V: Ek dink, omdat hy blind is né, uhm, praat hy miskien so...Sê byvoorbeeld ek praat oor seks en bla bla bla bla bla...

I: Mmm.

V: Nou sal hy nou sommer na 'n lang tyd, sommer paar dae daarna nou vra, "mammie het jy seks gehad?" of "kom sit by my" en dan praat hy van Kobus wat tik en Riaan wat tik.

I: Mmm.

V: Nou hoor hy al die dinge, nou omdat hy nie kan sien nie...

I: Ja?

V: Memorize hulle mos. Nou het ons al vergeet ons praat daarvan, nou sê byvoorbeeld, jy kom na my toe en dan sal hy vir jou vra, "drink jy?" of "maak jy so?" Nou waar ander mense nie verstaan hoekom hy so sê nie, sal ander mense nou dink, die man en die vrou drink of tik seker, want hy vra nou so 'n vraag, veral as ek nou vir hom skel. Dan vra hy vir my, "is jy dronk?"

I: Shame.

V: Want vir hom is dit amper soos dronk mense wat skel.

I: Mm, ja.

V: Nugter mense moenie skel nie. So ander mense wil nie, sal nie vir hom verstaan nie.

I: Soos wat jy hom verstaan nie, want jy het nou oor die jare geleer om hom te verstaan?

V: Dit is so, ja.

I: Dan wil ek gou hoor: behandeling. Wat dink jy in die verlede het jou gehelp met jou depressie?

V: Ek het niks gekry nie.

I: Ok so jy het nog nooit medikasie gekry nie?

V: Mm mm (shakes head).

I: Geen pilletjies gedrink of enigiets nie?

V: Mm mm.

I: Maar wat help jou nou om jou gevoelens te verwerk om jou beter te laat voel?

V: Om musiek na te luister en te sing en te sing...

I: So dis wat vir jou die meeste help?

V: Ja::

I: En wat help glad nie vir jou nie?

V: (0.3) Hoe sê ek nou? (0.2)

I: Ok ons sal weer terugkom na hom toe, dit raak nou al lank, ons het nou al lank gepraat! Ok, nou as jy nou vir mense moet raad gee oor wat help om hulle depressiewe gevoelens te hanteer, né, wat dink jy, watse raad sal jy vir hulle gee? Want as mens nou so lank al depressie het, dan begin mens sommer 'n ekspert raak!

V: Ja::, ja:: Die beste is om om, soos ek loop, met niks niemand rondom my nie...

I: Mmm.

V: Sodat jy, jou mind, dit wat ek gesê het, dit wat ek wil gedoen het of wil gesê het. Die beste is loop en so raak jy ontslae van jou gevoelens. Praat met niemand nie. 'n Ander vrou sê nou die dag vir my, "jy kom nou in gedagte hier aan", nou dink ek ek het nou nie lus vir praat nie. Nou groet ek net, nou loop ek aan. Want ek wil niks en niemand rondom my hê nie. So die beste is loop en so raak jy ontslae van daai...kyk depressie maak dat jy somtyds aggressief raak. Jy wil dinge doen wat jy NIE moet doen nie. So, die beste is loop...As jy in die Here glo, dan praat met die Here. Ek sê, "Here ek wil nie, ek wil nie!" My kinders kan nie skade ly deur die ding nie...Die beste is praat net met die Here, loop net, loop net. Jy beter voel, mens voel beter as jy op jou eie is en jy in 'n rigting loop en jy kom terug en ek het soos 'n nuwe mens gevoel.

I: So dit help om jou kop oop te maak en vars lug te kry?

V: Ja. En dit was koud gewees, maar ek het nie eers koud gekry nie. Ek het die koue eers nie besef nie.

I: Mmm.

V: As ek by die huis kom, sê almal dit is koud, maar ek kry nou warm. Ek en my suster maak tracksuit broeke, die quantex. Nou het ek die broek aan, maar hy het nie die lining in nie. Nou dink ek by myself, maar ek het mos nou net die dun broek aan...

I: Mmm.

V: En ek sê vir myself ek was seker 'n uur en 'n half weg van die huis af en ek het nie besef ek kry so koud nie. Toe ek by die huis kom, sal ek nou...(Laughs)

I: Besef maar dis eintlik koud!

V: Ja, dit is so!

I: Maar V, ek is nou eers klaar met al daai baie vrae! Ek wil rêrig baie dankie sê vir jou tyd.

V: (laughs)

I: Dit was rêrig goed om met jou te gesels, maar ek moet nog seker maak: hoe voel jy nou?

V: Baie goed.

I: Ok, voel jy beter?

V: Baie beter.

I: Dit help om te praat oor die dinge?

V: Dit is so.

I: Maar baie dankie!

Transcription conventions according to Jefferson (1985)

- [] Square brackets mark the start and end of overlapping speech. Position them in alignment where the overlap occurs.
- ↑↓ Vertical arrows precede marked pitch movement, over and above normal rhythms of speech. They are for marked, hearably significant shifts – and even then, the other symbols (full stops, commas, question marks) mop up most of that. Like with all these symbols, the aim is to capture interactionally significant features, hearable as such to an ordinary listener – especially deviations from a common sense notion of ‘neutral’, which admittedly has not been well defined.
- Side arrows are not transcription features, but draw analytic attention to particular lines of text. Usually positioned to the left of the line.
- Underlining Underlining signals vocal emphasis; the extent of underlining within individual words locates emphasis, but also indicates how heavy it is.
- CAPITALS Capitals mark speech that is obviously louder than surrounding speech (often occurs when speakers are hearably competing for the floor, raised volume rather than doing contrastive emphasis).
- °↑I know it,° ‘Degree’ signs enclose obviously quieter speech (i.e., hearably produced as quieter, not just someone distant).
- that’s r*ight. Asterisks precede a ‘squeaky’ vocal delivery.
- (0.4) Numbers in round brackets measure pauses in seconds (in this case, 4 tenths of a second). Place on new line if not assigned to a speaker.
- (.) A micropause, hearable but too short to measure.
- ((text)) Additional comments from the transcriber, e.g. context or intonation.
- she wa::nted Colons show degrees of elongation of the prior sound; the more colons, the

more elongation.

hhh	Aspiration (out-breaths); proportionally as for colons.
.hhh	Inspiration (in-breaths); proportionally as for colons.
Yeh,	‘Continuation’ marker, speaker has not finished; marked by fall-rise or weak rising intonation, as when enunciating lists.
y’know?	Question marks signal stronger, ‘questioning’ intonation, irrespective of grammar.
Yeh.	Periods (full stops) mark falling, stopping intonation (‘final contour’), irrespective of grammar and not necessarily followed by a pause.
bu-u-	Hyphens mark a cut-off of the preceding sound.
>he said<	‘Greater than’ and ‘lesser than’ signs enclose speeded-up talk. Sometimes used the other way round for slower talk.
solid.=	‘Equals’ signs mark the immediate ‘latching’ of
=We had	Successive talk, whether of one or more speakers, with no interval. Also used as below (lines 3–5), where an unbroken turn has been split between two lines to accommodate another speaker on the transcript page.
heh heh	Voiced laughter. Can have other symbols added, such as underlinings, pitch movement, extra aspiration, etc.
sto(h)p i(h)t	Laughter within speech is signalled by ‘h’s in round brackets.