Dissociation as a defensive strategy in pregnant low-income women: A review of the literature

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DECLARATION

I, the undersigned, hereby declare that the work contained in this assignment is my original work and that I have not previously, in its entirety or in part, submitted it at any university for a degree.

ABSTRACT

This paper is an attempt to explore the appropriateness of the use of the specific psychological paradigm of dissociation as a possible response to pregnancy in low-income women. Low-income women who fail to acknowledge their pregnancies may do so in an attempt to defend against feelings of fear, anxiety and helplessness engendered by the crisis of pregnancy. A dissociative response may serve to protect the expectant mother from conscious awareness of the full impact of what is happening, in other words, to provide psychological escape when physical escape is not possible. Such a response may initially be adaptive in that it provides these women with a means of coping. Dissociative processes allow, in the context of an inescapable crisis, the economizing of already limited physical and psychological resources. However, the prolonged use of dissociative strategies during pregnancy may have far-reaching implications, and, as such, be a hindrance to adaptive functioning.

OPSOMMING

Hierdie studie poog om ondersoek in te stel na die geskiktheid van die gebruik van die spesifieke psigiese meganisme van dissosiasie as 'n moontlike reaksie tot swangerskap in lae-inkomste vroue. Lae-inkomste vroue mag hul swangerskappe ontken in 'n poging om verweer te bied teen gevoelens van vrees, angs en hulpeloosheid wat deur swangerskap teweegebring word. 'n Dissosiatiewe respons mag dien om die verwagtende moeder te beskerm teen die volle impak van die gebeurtenis, met ander woorde, om psigiese ontvlugting te bied waar fisiese ontvlugting onmoontlik is. Welke respons mag aanvanklik adaptief wees in dat dit 'n manier van streshantering is. Dissosiatiewe meganismes bevorder, in die konteks van 'n onvermydelike krisis, die besparing van reeds beperkte fisiese en psigiese bronne. Die langtermyn gebruik van dissosiatiewe strategieë gedurende swangerskap mag egter verreikende gevolge inhou, en as sulks adaptiewe funksionering strem.

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To my supervisor, my sincere appreciation for her guidance and inspiration throughout. To the women who made this study possible, especially Maggie and Elize, thank you for lending me your voices.

CONTENTS

1. INTRODUCTION

This paper is an attempt to explore the appropriateness of the use of the specific psychological paradigm of dissociation as a possible response to pregnancy in low-income women. The investigation was motivated by the stories of two young Coloured women, Maggie and Elize[1], both farm workers, who dealt with their experiences of being pregnant by not acknowledging, until late into their pregnancies, that they were in fact pregnant. Maggie and Elize obscured the fact of their pregnancies, not only from their interviewers, but also from each other, from the other farm workers, from the farmer and from health care workers at the local clinic. For example, Maggie only told the farmer that she was pregnant in the eighth month of her pregnancy, about two weeks before she gave birth, and then she said that she was only 7 ½ weeks pregnant. It should also be noted here that in this region there has been lots of anecdotal evidence of women of this population group obscuring "facts" about their personal functioning. For instance, health care workers working with low-income Coloured communities often mention their patients' failures to disclose important health-related information (i.e. that they are HIV-positive, that they are sexually active and that they are pregnant) as one of the major problems they have to deal with (De Villiers, personal communication). The failure to disclose pregnancy is so common that there is a saying in the Coloured community: "langs die pad kraam" – this literally means "giving birth next to the road" – indicating that a woman gave birth unexpectedly without anyone knowing that she was in labour.

Maggie and Elize work and live on a wine and fruit farm in the Winelands region of South Africa. They work in a team of eight women whose main function on the farm is the bottling of spring water. Their supervisor is the farmer, also a woman. They were first interviewed during August/September 1999, together with the rest of the women in their team, as participants in a large qualitative research project concerned with the psychological distress and resilience of female farm workers

[1] Pseudonyms

of colour in South Africa (see Kruger, 1998; Kruger, Campbell, De Villiers & Van Mens-Verhulst, 1999). All participants in this study were seen for five sessions of two hours each. During the in-depth interviews conducted during those sessions open-ended questions about the important psychological issues and moments in women's lives were asked. Questions were asked about psychological distress and well-being, coping and resilience, about family and personal history, physical health, relationships, reproductive issues (specifically pregnancy and motherhood), sexuality and body, eating and dressing, and substance use and abuse. Participants were also extensively asked about how the different contexts within which they function (that is, relationships, the household, the workers group, the farm, the community etc.) impact on their functioning.

Both participants were interviewed by experienced clinical psychologists, one of whom is the project leader of the study. Approximately five weeks after the five-session interviews, the farmer called the project leader to let her know that Maggie gave birth to a full-term baby and that Elize was six months pregnant. This came as a complete surprise to the interviewers. Neither of the participants had disclosed that they were pregnant during the interviews, despite being asked in-depth questions about pregnancy. In fact, when asked during one of her interviews when last she had sex, Maggie replied that is was before the birth of her first son in 1997. Elize, seemingly very embarrassed, said she had never had sex before. When asked whether she had ever been pregnant, she said no. The research team was thus confronted by the possibility that at least two of the participants "lied" about very important issues. However, there was nothing in the interview material that suggested that either Maggie or Elize were hostile or suspicious about the interviews: both interviewers remarked in their journals that they felt very connected to these interviewees and the interviewees did share very emotional material with their interviewers.

Given Maggie and Elize's persistent failure to acknowledge their pregnancies and the context within which it happened, it was decided that they should be

interviewed again. During the second interviews they were only asked to tell their stories around their experiences of falling and being pregnant and giving birth. These interviews were conducted at the end of May 2000. Both the first and second set of interviews were analyzed to try to understand the withholding of the information about the pregnancies.

In order for the reader to gain a better understanding of the phenomenon we observed, some of the interview data is presented below:

> Elize says: When I was pregnant...I didn't really know that I was pregnant. Most of the time my grandmother looked at me. She always asked me: Elize, why are you getting so fat? I say: No, it is probably from the food that I eat! Then she told me: No, you should go and see the doctor. Then I asked her why. Then she said: Yes, it is unhealthy to get fat so quickly.

Elize describes how she tries to deny her pregnant body, she literally describes trying to "normalize" her body:

> I often...I often thought when I was at home: I am not pregnant, I am just normal, I am just that person...I am up...I just want to do everything. Then I grab anything...I sometimes even lifted up the television couches. Then they say: Hey, the woman is pregnant, look what she is doing, she probably wants to lose her baby. Then I say: No, it isn't like that. Then I lift heavy things... then I work in our house...I dust everything from top to bottom...I clean where ever I want...When I'm done cleaning the house like that, then I say: Hey, it's probably me that did this, it's probably me, right? {laughs}

The data suggests more than a mere cognitive "denial", more than a "not acknowledging" of being pregnant to self and others. There also seems to be a sense of "disconnection" from the physical, pregnant body, and, as such, from an integral part of these women's experience of self.

Elize says: Sometimes I think: This is not my body posture ("liggaamshouding") that I have...or this is not my bulk ("massa")...I look at myself...this is not my body, this. I feel: This is not me.

Interviewer: Did you sometimes feel like this when you were pregnant?

Elize: Yes, when I was pregnant...I looked at myself a lot in the mirror when I was pregnant. Then I looked at my stomach...

Interviewer: Then it didn't feel like you...

Elize: Then it didn't feel like me. Then I touched my stomach: "But I didn't have a stomach like this...I had a flat stomach..."

In Maggie's remarkable birth narrative she also describes her body as something curious and alien, as if it has a life separate from her. She says:

Then I was six months (pregnant)...you can say I started my seventh month [ ], but I didn't feel anything strange or so! [ ] So then I started thinking: Boy, but I am sitting uncomfortable, I can't sit so hunched, I am very uncomfortable, I have to sit back. ...and later with my breasts...I feel that my breasts are sore because the milk glands are developing, you know. So later I started feeling that something was wrong. {laughs} [ ] I had to climb up to the loft and everything...and then I had to pack the pallets...had to pack boxes too. That's tiring work, you know! Eventually I said to Elize: But my back. Then she said: It's probably from packing pallets or climbing the loft. I said: That could also be true. But that evening...[ ] Elize came and sat with me that evening. I said to her: Oh, but my back is aching. I am sitting outside. She says: It's those pallets, it's those pallets, I knew those pallets...I said: Yes, it's those pallets. And then as it happened...I have my own room...[ ] And then I had a bath and went to bed...to lie down. ...But later I felt a pressure on my bladder, it's almost like...you have to go to the toilet NOW. You have a great need to go to the toilet. And I went and I peed. Came back again. No, but something is wrong. {laughs} Now I'm lying on the bed...now

as I extend my legs, the pain comes. Then I decided: No, I'm going to sit upright...upright and sleep. That doesn't work either. The pain still comes like...how shall I say?...in stops and starts the pain comes. Not long, then I decided: Wait, wait, wait...I'm not going to lie like this any longer, and I took the double bed...the mattress off...I put it down on the floor {laughs}. I'm thinking: No, wait, this is going to be very comfortable for me. I put it down on the carpet. I put pillows there. {illustrates} No, but the pain is still coming. Eventually I stack pillows here below {illustrates}, then the head lies downwards and thís {points to her bottom} lies upwards! But it doesn't help – the pain comes. But eventually I can't stand it any longer. I get to the door, I say: Dad! Aunt K!...is all that I said. "Come, come, come, come!" And there I grab Aunt K. She says: What is it? I say: Just come, come, come, come! I had just lain down on the bed again. She asks: Now, what is the matter? I had just said: "I don't know", when I screamed! As I screamed the child came! {laughs} It's almost like...it's a relief...that pain...you don't feel that pain anymore. Then I just said: "Oh, thank you God"...is all that I said. Then I heard the child scream: Wa! Wa! Wa! Wa! {laughs}

At the very least the women were consciously withholding certain emotional and physical events or experiences from others. However, it can also be asserted that the failure to acknowledge experiences or events was sometimes more unconscious. It seems reasonable to say that the experience or event was not acknowledged to others, but also not to the self.

Luisa Passerini says: "When talking about their lives, people lie sometimes, forget a lot, exaggerate, become confused and get things wrong. Yet they are revealing truths...All autobiographic memory is true. It is up to the interpreter to discover in which sense, where, for which purpose." (Personal Narratives Group, 1989, p. 261). In wondering why and how these two women obscured such an integral part of their experience of self from the initial interviewers, different possibilities were considered. Was it a simple matter of lying? Was it "forgetting"?

Or were psychological defensive processes such as denial, repression or dissociation possibly at play? The interview data seemed to suggest *more* than a mere "cognitive" non-acknowledgement of pregnancy. Both women seemed to attempt to distance themselves from the bodily experience of being pregnant, and as such from an integral part of their experience of self. The possibility of whether this phenomenon could be understood in terms of a dissociative paradigm was raised by the project leader of the study, and became the subject of investigation for this paper. It should be stressed, however, that Maggie and Elize's psychological processes *per se* are not the main focus of this paper. This paper is more concerned with the appropriateness, from a theoretical perspective, of the use of the specific psychological paradigm of dissociation as a possible response to pregnancy in low-income women generally. Furthermore, this link between bodily experiences (such as pregnancy) and dissociation is not only important with regards to reproductive health; it is well-known that other bodily experiences are often "forgotten" in a similar way, for example, in the case of being HIV positive (S. de Villiers, personal communication, 2001).

In exploring a possible theoretical link between pregnancy and dissociation, three bodies of literature are relevant: that on women's - and especially low-income women's – experience of pregnancy as a stressful event, that on dissociation, and that on trauma and stress in as far as it is associated with dissociative phenomena. The idea is not to suggest that pregnancy is traumatic or stressful *per se* or that all women dissociate in response to their pregnancies. In definitions of both stress and trauma an emphasis is placed on the individual's appraisal of the event in determining its stressful/traumatic nature. It may therefore be argued that, for some women at least, pregnancy may be perceived and experienced as stressful or traumatic. With a well-recognized link between stress/trauma and dissociative phenomena, one can then speculate as to whether Maggie & Elize's responses to their pregnancies, and those of other low-income women who deal with their pregnancies in a similar manner, are dissociative in nature.

2. PREGNANCY, STRESS AND TRAUMA

Although pregnancy and the birth of a child are often joyful, they are also typically stressful experiences (Lederman, 1984; Reading, 1983). Bourne (2000), in a survey of stressful life events, rates pregnancy 12th most stressful life event, with an average stress score of 40/100. Before examining more closely why and how pregnancy might be considered a stressful experience, it is useful to review the definitions of stress as put forth by the literature. Definitions of trauma are also considered, as most contemporary conceptualizations of stress and trauma have brought these terms closer together in meaning by emphasizing similar aspects in both. Furthermore, it would seem that these concepts exist on a continuum of (perceived) extremity of experience, with stressful experiences at the bottom half, and traumatic experiences at the top half of the spectrum.

2.1 The conceptualization of stress and trauma

2.1.1 Stress:

Traditional theories have defined stress in terms of environmental demand for adaptation (Bee, 1996) and stressful situations as those that exceed an individual's adaptational capacity or ability to cope (Cohen, Evans, Stokols & Krantz, 1986; Evans, 1982). More recently, however, consideration of the personal evaluation of potential stressors has entered this definition (Evans & Cohen, 1987; Fleming, Baum & Singer, 1984), so that stress reactions are now said to arise when an individual makes an appraisal that his or her coping abilities are threatened (Graig, 1993). In other words, psychological stress is based upon the perception and interpretation of an event and an evaluation of one's ability to cope with it (Graig, 1993).

Mgrath (1970) define stress as "a (perceived) imbalance between demand and response capability, under conditions where failure to meet demand has important (perceived) consequences (p. 20). Similarly, Lazarus and Folkman

(1984) view stress as "a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (p. 19).

2.1.2 Trauma:

Spiegel (1993) defines trauma as a sudden extreme discontinuity in a person's experience, the essence thereof being physical helplessness, the loss of control over one's body and the environment at a time when pain and damage are being threatened or inflicted. Similarly, Spiegel, Hunt & Dondershine (1999) contend that trauma can be understood as the experience of being made into an object, a thing: the victim of someone else's rage, of nature's indifference, of one's own physical or psychological limitations.

In the DSM-III-R (American Psychiatric Association, 1987), trauma was defined as something "outside the range of usual human experience" that should "evoke significant levels of distress in most people" (p. 250). However, this definition was deemed by many as unsatisfactory, resulting in critical discussions and suggestions for change (Davidson & Foa, 1991; Kilpatrick & Resnick, 1993; March, 1993). The phase, "outside the range of usual human experience", came under particular scrutiny (Gershuny & Thayer, 1999). As Herman (1997) pointed out, "[t]raumatic events are extraordinary, not because they occur rarely, but because they overwhelm the ordinary human adaptations to life" (p.33).

In a similar vein, Tillman, Nash and Lerner (1994) argued that the definition of trauma was unsatisfactory because events that the public eye views as unusually appalling, tragic, victimizing, or brutal, are accepted as traumatic in nature, whereas events that do not seem out of the ordinary, are not viewed as traumatic. The authors suggested that more emphasis be placed on the *individual's* construction of the event in determining what renders such event pathogenic. They argued that, without recourse to the individual's construction of the event and the social/environmental context in which the event is embodied,

errors could be made in both directions: that is, an event might be defined as traumatic when it is not, and not defined as traumatic when it in fact is.

The conceptualization of trauma was changed somewhat in the DSM-IV (American Psychiatric Association, 1994). Trauma became defined as when a person "experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others," and "the person's response involved intense fear, helplessness, or horror" (pp. 427 – 428). This definition is more closely aligned with ideas put forth by a variety of researchers and theorists (for example Classen, Koopman & Spiegel, 1993; Herman, 1997; Kilpatrick & Resnick, 1993; March, 1993; Spiegel & Cardeña, 1991; Tillman et al., 1994) because it is more detailed in operation, more inclusive in experience, and less constrained by the notion of uncommonness (Gershuny & Thayer, 1999). In line with the suggestion made by Tillman and colleagues (1994), the definition put forth in the DSM-IV includes the individual's reaction to the event. Thereby, recognition is given to the fact that a traumatic event is a highly subjective experience: two people may experience the same event, but for one it may be deemed traumatic while for the other it may not (Gershuny & Thayer, 1999). Such an inclusion in the conceptualization of trauma allows the person's subjective experience to be taken into account and potentially allows certain events to be labeled as traumatic even if they are not distressing to most other people (Gershuny & Thayer, 1999). Indeed, findings in a study conducted by Bremner and Brett (1997), which examined dissociative responses to traumatic events and long-term psychopathology in Vietnam combat veterans, suggest that the individual's appraisal and response to the event is a more important determinant of degree of psychopathology following the event than the objectively determined severity of the stressor.

2.1.3 A working definition of stress and trauma:

Given the current move in the literature towards an understanding of trauma which is more inclusive in experience, less constrained by the notion of uncommonness, and which places an emphasis on the individual's subjective experience, the concept of trauma has become closely aligned to that of stress. Furthermore, as Herman (1997) pointed out, traumatic events are considered such "because they overwhelm the ordinary human adaptations to life" (p. 33). Most contemporary definitions of stressful situations similarly refer to those that exceed the individual's (perceived) adaptational capacity or ability to cope. It would seem, then, that the concepts "stress" and "trauma" exist on a continuum, reflecting the degree to which an individual perceives his/her natural coping abilities as being threatened, with stressful experiences at the bottom half, and traumatic experiences at the top half of the spectrum. For the purposes of this paper, the terms "stress" and "trauma" are used in the sense that recognizes (1) their existence on such a continuum, and (2) the dual emphasis on subjective appraisal in determining the stressful/traumatic nature of the experience.

2.2 Pregnancy as a stressful experience demanding adjustment

Pregnancy, like puberty and menopause, is a period of crisis involving profound psychological as well as physical changes (Bibring, 1959; Lederman, 1984; Reading, 1983). As a crisis, pregnancy represents a turning point in the life of the woman, leading to acute disequilibria, which, under favourable conditions result in specific maturational steps toward new functions. (Bibring, 1959; Bibring, Dwyer, Huntington & Valenstein, 1961). Stress is inherent in all areas: in the endocrinological changes, in the activation of unconscious psychological conflicts pertaining to the factors involved in pregnancy, and in the intra-psychic reorganization of becoming a mother (Bibring, 1959). Moreover, the crisis of pregnancy affects all expectant mothers, no matter what their state of psychic health (Bibring, 1959). It is a point of no return, whether a baby is born at the end of term or the pregnancy ends in abortion of miscarriage (Pines, 1993).

Brockington (1996) argues that the psychopathology of pregnancy needs to be understood in terms of the adjustment which all women make when they conceive. "It is important to regard pregnancy not only as a biological event, but also as an adaptive process" (Cohen cited in Brockington, 1996, p. 63), both during and after pregnancy.

Adjustment during pregnancy includes adjusting to physical symptoms such as nausea, vomiting and fatigue, as well as changes in physical appearance and shape. In addition, the pregnant woman must carry the baby through safely, develop an attachment to the baby within, and prepare for the birth (Brockington, 1996).

The adaptive process also continues after pregnancy and childbirth. Pregnancy marks the transition to parenthood, and, as such, represents the end of the woman as an independent single unit and the beginning of an unalterable and irrevocable mother-child relationship (Pines, 1993). Moreover, motherhood is rarely associated with psychological well-being and often associated with psychological distress (Barnett, 1993). Indeed, some studies suggest that the role of mother may be a women's primary source of stress (Barnett & Baruch, 1985; Veroff, Douvan & Kulka, 1981). According to Brockington (1996), the transition to motherhood requires the woman, not only to square up to the sacrifices that motherhood demands in relation to caring for the child, but also to ensure the acceptance of the child by the family, and develop a somewhat different relationship with the father of the child.

In addition, Oakley (1980) argues that pregnancy represents overwhelming loss of identity and reduced status for women, as they undergo major changes such as becoming a patient, retiring form paid work, becoming a housewife, and being pregnant and becoming a mother. The critical factor, she argues, is that these changes are socially constructed as incurring lower status. It would seem then, that women not only face the challenge of dealing with the many physical,

psychological, interpersonal and social adaptations that pregnancy and motherhood demand, but that even *successful* adjustment to these demands, in other words, successful resolution of this period of crisis, carry a cost.

2.3 Factors affecting adjustment to pregnancy

Notwithstanding the fairly universal challenges that expectant mothers face, women vary in their ability cope with these demands. So, for example, it is well recognized that pregnancy varies individually from woman to woman according to her personality structure and her special kind and degree of adjustment and conflict solution with which she enters pregnancy (Bibring et al., 1961). Women also vary in their appraisal of the challenges that pregnancy presents, as well as their appraisal of their ability to cope with these challenges. Personal evaluation then becomes a crucial factor in determining the degree to which the expectant mother regards her pregnancy as stressful.

Other factors recognized in the literature as affecting adjustment to pregnancy relate to the particular life setting and family constellation in which this event takes place (Bibring et al., 1961) - although, even here, the influence of subjective appraisal cannot be denied. One such a factor, for example, is the pregnant woman's relationship with the child's father. In a study of most stressful events, being pregnant out-of-wedlock and receiving no help from the father, or the husband not wanting the baby, were high on the list, only exceeded by having a mentally retarded or damaged child (Helper, Cohen, Beitenman & Eaton, 1968). Whether the pregnancy is planned or unplanned also has an influence on the adjustment process. Unplanned pregnancies are often not welcomed initially. Many women react to unplanned conception with sadness, grief and anger, as they face the prospect of hardship and frustrated ambition (Brockington, 1996). In addition, they may have a difficult relationship with the child's father (Brockington, 1996).

A widely recognized factor that affects prenatal adaptation is a woman's socio-cultural milieu (Aneshensel, 1992; Hobel, 1996; Hughes & Simpson, 1995; Kramer, 1987; Pearlin, 1989; Taylor & Aspinwall, 1996; Taylor, Repetti & Seeman, 1997). Variables such as ethnic background and culture can influence the occurrence of events and activities in one's life; the way in which events are interpreted and coped with; access to social and personal resources; and the unique constellation of norms, demands, and opportunities in the immediate social environment (Revenson, 1990; Szapocznick & Kurtines, 1993; Taylor et al., 1997). Not only can ethnicity influence pregnancy through cultural norms and values, it may also exert an influence through its association with socioeconomic status (SES), especially income and education (Rini, Dunkel-Schetter, Wadhwa & Sandman, 1999). Research has shown that lower SES groups experience a greater number of stressors and higher levels of psychological distress (Seguin, Potvin, St. Denis & Loiselle, 1995). They are more likely to engage in adverse health-related behaviours (Adler et al., 1994), to live and work in riskier environments (Anderson & Armstead, 1995; Taylor et al., 1997), and to have fewer of the social resources that buffer stress during pregnancy (Seguin et al., 1995).

The role of social resources/support as a buffer to stress during pregnancy needs qualification, however, especially when socio-cultural context is taken into account. Social support is generally thought to be stress moderating (Antonovsky, 1979; Cohen & McKay, 1984; Oakley, 1985; Bee, 1996). Supportive relationships may enhance feelings of well-being, personal control, and positive affect, thereby helping women to perceive pregnancy-related changes as less stressful (Norbeck & Anderson, 1989; Tietjen & Bradley, 1985). However, social support might not always be helpful for women (Cameron, Wells & Hobfoll, 1996). One reason has to do with the burdens that accompany social support, that is, the obligation incurred as a member of a support network to provide as well as receive support and the tendency for stressful events occurring to one member of a network to impact other network members

(Cameron et al., 1996). These concerns relate especially to women, because women tend to cultivate broad social-support networks, resulting in their exposure to a greater number of stressors. Because their network ties are generally more intimate than those of men, women also expose themselves to a greater intensity of the stress, burden and strain that come with social networks (Belle, 1987; Kessler, McLeod & Wethington, 1985; Riley & Eckenrode, 1986). More so, there are reasons to question the generalizability of most research on social support to poor and minority women in particular. Although poor women have been found to be quite resourceful in establishing networks of mutual support, this can also increase the risk of stress contagion (Coyne & DeLongis, 1986). Because members of these networks are likely to be poor as well, the risk of stress contagion associated with poor women's social support networks is higher than that associated with the networks of more affluent women (Cameron et al., 1996). In addition, these networks provide more than emotional support: they are essential to coping with practical, everyday needs such as child care and are thus not expendable, even if the costs they entail outweigh the benefits they provide (Belle, 1990; Collins, Dunkel-Schetter, Lobel & Scrimshaw, 1993).

2.4 Low-income women of colour in South Africa, stress and pregnancy

Pregnancy represents an especially stressful period of crisis for low-income women of colour in South Africa as they experience the life adjustments and increased demands on physical and emotional resources, time and finances which pregnancy entails, in the context of reduced resources and high levels of environmental stress (Cameron et al., 1996).

In terms of poverty, female farm workers can be identified as one of the most vulnerable, marginalized and disadvantaged groups in South Africa (Moeller, 1998; Salgado, 1994). In South Africa, farm work has been characterized historically by extremely poor living conditions, including poor wages, inadequate housing, poor sanitation, inadequate water supplies and paternalistic and coersive labour relations (Du Toit, 1992; Farmworkers Research and Resource

Project, 1997; Segal, 1991; Whittaker, 1987). In a survey done by Te Water Naude, London, Pitt and Mohamed (1998) on farms in the Winelands Region of the Western Cape, South Africa, it was found that, in comparison to the men's wages (which were very low already), women were paid significantly less than men.

It is against this background of poverty, discrimination and exploitation that female South African farm workers of colour must deal with the added crisis of falling and being pregnant and becoming a mother. In addition, pregnancies are often unplanned and out-of-wedlock in these communities. As a result, young mothers receive little or no support from the father of the child. This, together with a moral climate antagonistic to extramarital sexual relations, makes adjustment to being pregnant and becoming a mother particularly difficult.

At this stage it may be valuable to consider some of the data from Maggie and Elize's second interviews in order to get a first hand account of how they regarded their pregnancies. The interview data suggests that both Maggie and Elize obviously experienced pregnancy as a stressful time. They both clearly articulated that they experienced pregnancy as a "burden" and a "problem":

> Maggie says: ...Then all that I say {to friends / co-workers} is: It's not your problem, it's my problem. I mean, I have to see for myself what is going on or how I must go further from here...All that I say (to them) is: It's not your problem, it's my problem.
>
> And, ...But on the other hand one thinks: That's my own hardship, I must now carry my own burden.

Upon being asked by the interviewer what her father's reaction to being told that she was pregnant, was, Maggie replies:

> He wasn't angry. All that he said was: That is your problem. You are grown up. I can't tell you any longer what is right and what is wrong. You must carry your own suffering.

When asked what Maggie said when she found out that Elize was pregnant, Elize replies:

> She said: Oh, Elize, it is a very difficult road to walk. She made me feel afraid.

The fact that pregnancy was experienced as burdensome and problematic was much related to the financial implications of having a child. Upon being asked by the interviewer whether she would like more children, Maggie replies:

> No, one will be enough but not more than one. Not now. [ ] When one is married, but not now. Because life is too expensive to...I mean, look how much it costs to put a child in school. I mean, that's only for the crèche. How much is it not already. Now, say you want another one, then it is perhaps two, three or four years from now. Clothes, books and all that stuff. And nappies and stuff, all that. That's the thing, I don't want another now.

The participants talked about being afraid of the pregnancy, of birth and of motherhood, but their biggest fear was about the reaction of others:

> Interviewer: And your girlfriends, how did it feel to tell them (about your pregnancy)?
> Elize: No, I didn't really want to tell them. I was really...afraid to tell them.

And, in relation to her mother and grandmother, Elize says:

> ...I was actually frightened...I thought: My mother is going to kill me.
>
> ...Then I told my grandmother...she was starting to get ill. I was afraid that she would take it in a big way and that it would cause her to die or something. Then my mother told her when I gave birth with E {her son}. I didn't really want to tell her myself. I was afraid. I didn't want to tell her myself.

Maggie talks of her fear of disclosing her pregnancy to the farmer (a woman):

> And then I decided, man, I am going to...I first...how can I say...made up my mind: L {the farmer} is probably going to yell at me or something like that. Because, I mean, if you don't tell her she gets very angry. She stays angry for a month...I mean for a month she will keep you at a distance. Then afterwards she will get used to you being like that (pregnant), she can do nothing about it.

And, in talking about the possible reaction of the father of her child, Maggie says:

> And afterwards you sit with the mess. I mean, you must sit with the child. Perhaps he promises you this and that...Then it is perhaps only for a few months that he stays with you, then he drops you just like that, child and all. Then he gets someone else that he perhaps does the same with.

These fears about the reaction of others have to do with the fact that pregnancy was not regarded as an experience that a young woman wanted. Pregnancy was seen as something to feel guilty and ashamed about:

> Elize says: It also gives other people a bad impression if you have a child with the man and are not married to him. Then the women say...how do

> they say? "You're a whore"...something like that, they'll say. It's a bad impression...

When asked by the interviewer about how she felt when the doctor told her that she was pregnant, Elize replies:

> I felt happy, but I also felt a bit guilty...

Maggie talks about the feared reaction of her friends:

> No, I mean, then one of them may say: Gee, but that other child of yours is only four now and here you are pregnant again and everything...

To summarize then, both of the participants in retrospect say that being pregnant was a problem and a burden, a scary experience that elicited feelings of guilt and shame. It must be emphasized, however, that these extracts are not cited with the aim of suggesting that Maggie and Elize's experiences of their pregnancies represent the experiences of all low-income women. It simply serves as an example of how and why pregnancy may be experienced as stressful to *some* women in similar contexts.

Before speculating as to how some low-income women may attempt to deal with these feelings of fear, guilt and shame in relation to their pregnancies, it is useful to consider how they deal with stress generally. In a cross cultural study determining the coping mechanisms employed by low-income female farm workers in the Western Cape of South Africa (see Spies, 2001), eight participants were asked to respond to an open-ended question on how they cope with life's difficulties. Two important trends were identified: (1) a significantly prevalent use of emotion-focused (vs. problem-focused) strategies was found to be employed by the participants (out of the 28 identified coping mechanisms, 20 were categorized as emotion-focused coping), and (2) it was found that the emotion-

focused coping mechanisms employed by the participants often involved an avoidance of emotion (Spies, 2001).

Whereas problem-focused coping is defined as the cognitive problem-solving efforts and behavioural strategies for altering or managing the source of the problem (Folkman & Lazarus, 1980), such as, taking action, confrontation, seeking advice, thinking about the situation, and planning, emotion-focused coping are efforts aimed at reducing the negative feelings that arise in response to the threat (Carver & Scheier, 1994). As such, emotion-focused coping often involves the diversion of attention from a stressor, for example, the avoidance of thoughts concerning the stressor (Lazarus, 1993). The types of emotion-focused coping mechanisms identified from the interview data in Spies' study include denial-like strategies such as "getting away" or "escape/avoidance" (i.e. engaging in behaviour that involves physically leaving the environment in which the stressful situation occurs), distraction or "forgetting" (i.e. engaging in any activity that serves to divert attention away from thinking about the problem), distancing (i.e. not allowing oneself to get emotionally "caught up" in the stressor), and, keeping feelings to self (i.e. deciding not to share one's feelings with other individuals).

It is valuable to consider the possible explanations for the prevalent use of emotion-focused coping mechanisms among participants of the study, in that they relate closely to the disadvantaged social milieu of these women. According to Dill, Feld, Martin, Beukema and Belle (1980), "options for coping effectively with some problems may simply not be available to a woman already hampered by inadequate financial resources and lacking the power, status, language, information, or appropriate advocates to move institutions in her favour" (p. 507). Fondacaro and Moos (cited in Barnyard & Graham-Bermann, 1988) also hypothesized that continuous stressors may eventually result in a diminished repertoire of coping resources. It is thus vital for researchers to consider a potentially limiting environment, and thus the possibility that a chosen coping

strategy may be reflective neither of a woman's ability, or of what she truly wanted (Dill et al., 1980). Therefore, and especially in the light of the fact that problem-focused coping is often viewed by researchers as the more useful coping strategy (Lazarus, 1999), it is important to consider that "what may seem like poor coping strategies are often the result of severely limited options (Dill et al., 1980, p. 508).

Moreover, in light of the research on stress contagion and the burdens that accompany social support, especially among poor and disadvantaged women, it is perhaps not surprising that these women primarily resort to coping mechanisms that reflect escape, avoidance or distancing strategies. Such strategies may be a desperate attempt to preserve communal resources. As such, each woman may be trying to minimize the burden and strain that come with the obligation to, not only receive, but also provide, support. In other words, keeping one's feelings to oneself, for example, may reflect an attempt to minimize the number of stressors, as well as the intensity of the stress, that oneself and other members of the network are exposed to.

In considering the use of a dissociative strategy as a possible response on the part of some low-income women to the crisis of pregnancy, one might argue that such a response, although more extreme than the ones observed in Spies' study, plausibly falls under the umbrella of emotion-focused coping. And, as such, it should be seen in the context of exposure to continuous stressors, a diminished repertoire of coping resources, and an attempt to minimize the risk of stress contagion among members of the same social support network. It is arguable that, given their limiting environment, some low-income women experience the crisis of falling and being pregnant as stressful to such an extent that the only way they perceive themselves as able to cope with it, is to distance themselves from the pregnancy experience, and, as such, from an integral part of their experience of self. Before exploring the usefulness of thinking about this phenomenon in terms of a dissociative paradigm, it is valuable to consider the

literature that indeed acknowledges such a link between pregnancy and dissociation.

2.5 Failure to adjust: responding to pregnancy with dissociation and denial

Brockington (1996) notes that "the fact the pregnancy can be concealed, even from the mother herself, is well-known" (p. 438). Failure to recognize pregnancy is common in the early stages, especially in those pregnant accidentally for the first time; in a few, this state of affairs continues until the end of pregnancy (Brockington, 1996). Brockington (1996) notes that must distinguish mothers who simply do not notice the pregnancy, from those who conceal it, and women who, against all the evidence, remain obstinately unaware of it. Under the name of "unconscious pregnancy" the latter was recognized by Gould and Pyle (cited in Brockington, 1996), who collected 12 cases from the literature for their miscellany *Anomalies and Curiosities of Medicine*. These patients may present in late pregnancy with abdominal swelling, which may be interpreted as a tumour. At the onset of labour, they may complain of pain in the abdomen and back. There are few systematic studies. Wessel (cited in Brockington, 1996) who described four cases, saw one case in 366 births. Brezinka, Huter, Biebl and Kinzl (1994) collected twenty-seven instances at Innsbruck between 1987 and 1990 – about 1:400 births. In seven, denial lasted 21 – 26 weeks, and in nine it lasted 36 weeks; eleven continued their denial until the onset of contractions and rupture of membranes.

According to Brockington (1996) there are a number of physical, psychosocial and psychological factors that account for the failure to recognize pregnancy. Cessation of menses, the first sign of conception for most women, may occasionally be absent or less obvious in certain mothers, for example, those who are breastfeeding, those with a history of scanty or irregular menstruation, or those with amenorrhoea due to anorexia nervosa or the menopause. Other physical symptoms of pregnancy, for example, nausea or cravings, may be absent or less marked. Weight gain may be minor and there may be little change

in physical appearance. Social factors which may account for a failure to recognize pregnancy include isolation (in that there are no close friends or relatives to notice and comment on the change in appearance), and a moral climate antagonistic to extramarital sexual relations, with its fear of disclosure. Finally, psychological factors that may play a role in the failure to recognize pregnancy include low intelligence and delusional psychosis (Brockington, 1996).

According to Brockington (1996), the psychological mechanisms which enable pregnancy to remain unacknowledged include denial and dissociation. Denial is a widely used defense against unpalatable facts (e.g. psychosis or cancer), unpleasant emotions (e.g. anger and envy) or mental conflict (Brockington, 1996). Similarly, for Brockington (1996), "dissociation" is the shutting out of an idea or perception from consciousness through selective attention. He gives the following example from an account of one of his patients:

> When I realized that I was pregnant, I blocked it off – did not think about it. I must have thought that if I forgot about it, it would go away. Half of me was saying, 'What am I going to do when it happens?' The onset of labour came as a surprise. (Brockington, 1996, p. 67)

Brockington (1996) notes that there are extreme cases in which both pregnancy and childbirth are denied. In one instance a childless woman of fourty-two was in labour for ten hours without any suspicion as to the cause of her pain (Gould cited in Brockington, 1996). In another case, reported by Finnegan, McKinstry and Robinson (1982), a woman complained of abdominal pain. When told she was in labour, she said it was impossible and indeed ridiculous, because she was not married. When the baby died one minute after delivery, she smiled at the doctor as he walked by carrying her dead baby. She continued to deny both pregnancy and childbirth.

The literature then clearly acknowledges dissociation as a psychological mechanism that could account for the failure to recognize pregnancy. It does not, however, seem to clearly distinguish dissociation from other defense mechanisms such as denial. In fact, Brockington seems to use these terms interchangeably. In considering the usefulness of viewing low-income women's non-acknowledgement of their pregnancies in terms of a dissociative paradigm, it is necessary to further investigate how dissociation is conceptualized in the literature, whether, and how, it can be distinguished from other defense mechanisms such as repression and denial, and, finally, how it relates to trauma and stress.

3. DISSOCIATION: A CONCEPTUALIZATION

3.1. Defining the term "dissociation"

The concept "dissociation" lacks a single, coherent referent or conceptualization that all investigators in the field embrace (Cardeña, 1994), and has been the subject of much discussion and debate (Gershuny & Thayer, 1999).

West (cited in Putnam, 1993) defines dissociation as a process that produces a discernible alteration in a person's thoughts, feelings or actions so that for a period of time certain information is not associated or integrated with other information as it normally or logically would be. As such, the term "dissociation" implies some kind of divided or parallel access to awareness (Spiegel, 1990), in which two or more mental processes or contents are not associated or integrated (Cardeña, 1994; Classen et al., 1993). In a similar vein, some authors refer to dissociation as a fragmentation of consciousness (Marmer, Weiss, Metzler & Delucchi, 1996; Steinberg, 1995) in which experience is compartmentalized (van der Kolk, van der Hart & Marmar, 1996).

According to Krippner (1994), dissociation involves the occurrence of experiences and behaviours that are thought to exist apart from, or have been disconnected from, the mainstream of one's conscious awareness, behavioural repertoire, and/or self-concept. The latter reference to a disruption of "self" is and important one. Tillman and colleagues (1994) note that most contemporary descriptions of dissociation include a disturbance in self-cohesion. According to the DSM-IV, "[t]he essential feature of the Dissociative Disorders is a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment" (American Psychiatric Association, 1994, p. 477). Kaplan and Sadock (1998) describe dissociation as a process which temporarily but drastically modifies an individual's character or sense of personal identity. Spiegel (1988) suggested that dissociation results in the loss of self or in self-fragmentation.

Lerner (cited in Tillman et al., 1994), from the vantage point of psychoanalytic ego psychology, describes dissociation from four perspectives: defense, memory, consciousness and self. Integrating these four domains, Lerner defines dissociation as a defensive process in which experiences are split off and kept unintegrated through alterations in memory and consciousness, with the resulting impairment of the self. The function of dissociation as a defensive process through which awareness of one's emotions or thoughts are diminished or avoided is well-recognized in the literature (Foa & Hearst-Ikeda, 1996). This particular aspect of dissociation will be examined more closely in section 3.3 below.

The above conceptualizations of dissociation support an understanding of low-income women's non-acknowledgement of their pregnancies in terms of a dissociative paradigm. The interview data suggests a disconnection from their physical, pregnant bodies, representing a disruption in consciousness and a modification of an integral part of their experience of self. Bearing in mind the potentially stressful nature of pregnancy to some women, and perhaps even

more so to low-income women, the function of dissociation as a defensive process through which awareness of distressing emotions and thoughts are minimized, is furthermore useful in understanding why these women might resort to such drastic measures.

3.2 Dissociation as a multidimensional phenomenon

Janet regarded dissociation, or the "splitting of consciousness", as a primary feature of the mental change in hysteria (Erdelyi, 1990), and hence, inherently pathological. For him it was based on an innate weakness of the capacity for psychical synthesis, on the narrowness of the 'field of consciousness', which in the form of a psychical stigma, is evidence of the degeneracy of hysterical individuals (Erdelyi, 1990). Freud did not agree with Janet that dissociation was strictly a psychopathological condition absent in normal people or that it resulted from poverty of psychological energy that gave rise to a failure of mental synthesis, hence dissociation (Erdelyi, 1990). Instead, Freud believed that dissociation was a motivated act, which could be employed by mentally healthy individuals, the motive being to avoid (consciousness of) some unbearable distressing memory or impulse (Erdelyi, 1990).

Most researchers today describe dissociation as a multidimensional phenomenon (Cardeña, 1994) that exists on a continuum from such normal everyday experiences as daydreaming to psychiatric disorders such as psychogenic amnesia and dissociative identity disorder (Bernstein & Putnam, 1986; Shor, Orne & O'Connell, 1962; Spiegel, 1963; Tellegen & Atkinson, 1974). Evidence supporting the concept of a dissociative continuum comes from studies of hypnotizability by Hilgard (1986), Spiegel (1963), and others and from studies of depersonalization and dissociation using questionnaires and rating scales such as the Dissociative Experiences Scale (Bernstein & Putnam, 1986).

If one conceptualizes dissociation on a continuum, and therefore as a normative process that becomes pathological only in certain circumstances, the question of

what separates pathological dissociation from normal dissociative experiences becomes relevant (Putnam, 1999). Nemiah (1981) has identified two principles that can be used to differentiate pathological from non-pathological dissociation. The first is that the individual undergoing a pathological dissociative reaction experiences a significant alteration in his/her sense of identity. The second principle is that the individual manifests disturbance of memory, typically amnesia (partial or complete), for events in the dissociated state.

It is debatable whether a distinction of pathological vs. non-pathological dissociation is at all useful to consider in our understanding of some low-income women's non-acknowledgement of their pregnancies. A distinction in terms of functionality is arguably more valuable. As such, a dissociative response to pregnancy may not necessarily be inherently pathological. After all, it represents a general way of coping for these women, which is, initially at least, a very adaptive one. However, when such defensive processes continue until late into their pregnancies (such as was the case with Maggie, for example), endangering the woman's health and that of her unborn child, it becomes less adaptive, and arguably, more pathological.

Cardeña (1994) stresses that one of the most important challenges remaining for any researcher or theoretician in the area is to explain how dissociative processes and phenomena, which may have originally been neutral or even beneficial, become maladaptive. He suggests that one can speculate that factors such as a benign environment and good psychological resources would lead to a situation in which these processes and phenomena would remain adaptive. Arguably, for low-income women then, a limiting environment, exposure to continuous stressors, and a diminished repertoire of coping resources, would increase the risk of dissociative processes becoming maladaptive.

According to Bourbuignon (1968), the recognition of a continuum of dissociative phenomena, which forces clinicians to draw a line where normative experiences

stop and psychopathology begins, is a culture-bound process. He points out that the degree of culturally sanctioned dissociation varies greatly from societies that promote dissociation as part of religion, ritual, healing, and magic to those that discourage or suppress dissociative behaviour (Bourguignon, 1968).

The DSM-IV notes that:

> [a] cross-cultural perspective is particularly important in the evaluation of Dissociative Disorders because dissociative states are a common and accepted expression of cultural activities or religious experience in many societies. Dissociation should not be considered inherently pathological and often does not lead to significant distress, impairment, or help-seeking behaviour. However, a number of culturally defined syndromes characterized by dissociation do cause distress and impairment and are recognized indigenously as manifestations of pathology. (American Psychiatric Association, 1994, p. 477)

Swartz (1998) reiterates that part of the difficulty in studying dissociation lies precisely in the fact that dissociation is not "inherently pathological" as the DSM-IV puts it. It is not always easy to distinguish between what is an acceptable form of dissociation and an unacceptable form, a factor which Swartz (1998) believes, is further complicated when one looks at dissociation cross-culturally.

3.3 A functional definition: dissociation as a defense mechanism

Kaplan and Sadock (1998) refer to dissociation as an "unconscious defense mechanism involving the segregation of any group of mental or behavioural processes from the rest of the person's psychic activity" (p. 285). Similarly, Lerner (cited in Tillman et al., 1994) defines dissociation as a defensive process in which experiences are split off and kept unintegrated through alterations in memory and consciousness, with the resulting impairment of the self.

A defense mechanism is a theoretical construct that refers to the intentional disavowing of information that would cause anxiety or pain (Cardeña, 1994). Cognitive defenses such as repression, denial, suppression and dissociation, serve to distort, block, or prevent threatening material from entering conscious awareness, or to minimize its impact (Sandberg, Lynn & Green, 1994). The function of dissociation as a defensive process through which awareness of one's emotions or thoughts are diminished or avoided is well-recognized in the literature (Foa & Hearst-Ikeda, 1996). When confronted with an ongoing danger or threat, a dissociative mechanism is initiated to safeguard the individual's psychological integrity (Cardeña, 1994).

3.3.1 Dissociation distinguished from other defense mechanisms:

Disagreement exists about whether dissociation, as a defense mechanism, can be meaningfully distinguished from other defenses (Lynn & Rhue, 1994). This poses a challenge for clearly delineating the phenomenon observed in some low-income women who fail to acknowledge their pregnancies. That *some* defensive mechanism is at play is probably less arguable. What poses more of a problem is distinguishing exactly which mechanism that may be, and whether our observations can indeed be limited to a dissociative process.

Tillman and colleagues (1994) argue that dissociation is a complex defensive process which has commonalties as well as distinctions from other defenses such as repression, suppression and denial. Kaplan and Sadock (1998) provide the following definitions: the authors describe denial as "avoiding awareness of some painful aspect of reality by negating sensory data" (p. 220), despite evidence to the contrary, repression as "expelling or withholding from consciousness an idea or feeling" (p. 221), suppression as "consciously or semi-consciously postponing attention to a conscious impulse or conflict" (p. 221), and dissociation as "temporarily but drastically modifying a person's character or one's sense of personal identity to avoid emotional distress" (p. 221). There clearly exists an extensive degree of overlap between these concepts and it is

arguable whether any meaningful distinctions can, in fact, be made. At its most basic level, denial, repression, suppression and dissociation seem to involve a 'turning away' of information, and keeping it at a distance from conscious awareness, the purpose being, to ward off anxiety. It would, however, seem that dissociation is regarded as a more drastic measure of warding off emotional distress, in that it contributes to some disruption of the experience of "self".

In particular, much debate has centered around the issue as to whether dissociation can meaningfully be distinguished from repression. Cardeña (1994) notes that for any proposed distinction between repression and dissociation to be meaningful, both constructs will have to be operationalized unambiguously, which, so far, has not been the case. Erdelyi (1990) emphasizes that the distinction between dissociation and repression did not operate in Freud's thinking – he often used the two terms synonymously. Similarly, more recently, only a minority of collaborators in a book on repression and dissociation distinguished between the two terms (Singer & Sincoff, 1990). Nevertheless, one way of distinguishing between repression and dissociation has been to regard repression as a defense against anxiety-provoking internal stimuli, that is, primitive, forbidden, id impulses, while describing dissociation as a defense against external stimuli (Cardeña, 1994). This distinction has been shown to be problematic (Cardeña, 1994). Freud used the general term defense mechanism, which he at times equated with repression, to account for the disavowal of material from both "the real external and from the internal world of thoughts and impulses" (Freud, 1936/1984, p. 454, cited in Cardeña, 1994). For instance, when a person suffers form dissociative amnesia, the warded off material, namely memories, is by definition internal, even though the trigger for the amnesia may have been environmentally caused distress (Cardeña, 1994). A further distinction which has been made in the literature refers to repression as involving "horizontal" splits and dissociation as involving "vertical" splits in consciousness (Hilgard, 1986; Kohut, 1971). This means that in repression mental contents are transferred to the unconscious where it remains inaccessible

and not part of the individual's reality. To access repressed material, it has to be brought into consciousness and integrated into current reality. Dissociated material, however, can, according to this conceptualization, coexist in parallel consciousness and be accessed in a parallel or different reality. In other words, a person can "know" or "remember something in one context, but not in another.

In the context of multiple, and often ambiguous conceptualizations, and the seemingly great overlap between defenses such as denial, repression, suppression and dissociation, it may indeed not be possible to limit the phenomenon observed in some low-income women who fail to acknowledge their pregnancies, to an exclusively dissociative process. At the essence of all of these defenses lies a disallowing into consciousness of some anxiety-provoking aspect of reality. As such, these women's responses to the stress engendered by their pregnancies could equally be viewed as one of denial, repression, suppression, dissociation, or even a combination of these. Dissociation, however, does appear to be a more drastic defensive strategy, in that it sometimes results in a disruption of the individual's experience of "self". The fact that these women's responses similarly entail a disconnection from such an integral part of their experience of self, namely their physical, pregnant bodies, lends weight to viewing the observed phenomenon in terms of a dissociative paradigm. Furthermore, the description of dissociation as involving "vertical" splits or parallel streams in consciousness (as opposed to a "horizontal" split in the case of repression), seems to support our observations with regard to low-income women who fail to acknowledge their pregnancies. Preliminary data has raised the question whether these women may be able to "know" or "remember" the fact of their being pregnant in certain contexts, while "not knowing" or "forgetting" it in others. A final motivating factor for viewing such a response in terms of a dissociative (as opposed to any other) defensive mechanism, comes from the literature on trauma and stress, and it's acknowledged link with dissociation. This link is explored more fully in the following section.

4. DISSOCIATION, TRAUMA AND STRESS

4.1 The link between dissociative phenomena, trauma and stress

Most of the literature on dissociative psychopathology has been written in the context of trauma. Janet first made the connection between dissociative psychopathology and traumatic experiences (Putnam, 1999) and claimed dissociation as the primary psychological process with which the individual reacts to overwhelming trauma (van der Kolk & van der Hart, 1989; van der Hart & Horst, 1989).

Today it is widely accepted that dissociative phenomena are closely linked to traumatic experiences (Carlson & Rosser-Hogan, 1991; Putnam, 1985, 1989a; Spiegel, 1986; van der Kolk, 1987). Investigators have found that dissociative pathology is associated with a variety of traumatic experiences, including childhood physical, sexual and psychological abuse (Bernstein & Putnam, 1986; Briere, 1988, 1992; Briere & Runtz, 1988; Chu & Dill, 1990; DiTomasso & Routh, 1993; Goodwin, Cheeves & Connell, 1990; Putnam, 1989a; Sanders & Giolas, 1991; Sandberg & Lynn, 1992; Sanders, McRoberts, & Tollefson, 1989; Strick & Wilcoxon, 1991; Swett & Halpert, 1993; Wogan, 1987), combat exposure (Brende, 1986; Branscomb, 1991; Bremner et al., 1992), being a refugee of war (Carlson & Rosser-Hogan, 1991), bereavement after a homicide (Rynearson & McCreery, 1993), witnessing a violent death during childhood (Putnam, Guroff, Silberman, Barbau & Post, 1986), and rape in adolescence or adulthood (Coons & Milstein, 1986). In turn, it has been hypothesized that dissociation is a normal defensive process that is employed to cope with traumatic experiences (Evans, 1988; Terr, 1991; Spiegel, 1986; Beahrs, 1990).

Dissociation may occur at the time of the traumatic event (Bremner et al., 1992; Classen et al., 1993; Marmar et al., 1994; Tichenor, Marmar, Weiss, Metzler & Ronfeldt, 1996) and/or after the traumatic event has ended (Bremner, Steinberg,

Southwick, Johnson & Charney, 1993; Chu & Dill, 1990; van der Kolk et al., 1996).

Gershuny and Thayer (1999) give a review of the recent empirical literature on the relation between traumatic events (for example, childhood physical and sexual abuse) and dissociative phenomena. They conclude that, in both clinical and non-clinical samples, individuals who experienced a traumatic event reported higher levels of dissociative phenomena than individuals who did not experience such an event. The authors warn, however, that in adult survivors of childhood abuse, family pathology, which itself might have been traumatic, may account for the relation between abuse and dissociation, particularly in non-clinical samples.

Similarly, Tillman and colleagues (1994) problematize the relationship between trauma and dissociative pathology, arguing that simplistic notions of cause and effect are not sufficient. The authors point out that many studies have failed to control for other contributing pathogenic factors that could explain the association between trauma and dissociation. As a result, there may be a tendency to underemphasize the evidence of dissociation occurring in the absence of trauma, and of trauma not leading to dissociation, and to overemphasize data which links dissociation to trauma (Tillman et al., 1994).

Although the relationship between dissociative phenomena and traumatic experiences has been well documented (Dell & Eisenhower, 1990; Putnam, 1989b; Ross et al., 1990; Sanders & Golias, 1991; Spiegel, 1988; Van der Kolk & Van der Hart, 1989), literature examining the relationship between everyday stress and dissociative phenomena is less copious. Janet mentioned that experiences that precede dissociative phenomena might include everyday stressors such as financial and marital problems (Van der Kolk & Van der Hart, 1989). Case studies have shown a relationship between everyday stress in the form of family and relationship problems and dissociative phenomena (De Wachter & Lange, 1996; Lange, 1994), between inconsistent parental behaviour

and dissociative phenomena in children (Mann & Sanders, 1994), and between environmental / situational factors and dissociative phenomena (Nash et al., 1993). A study by De Wachter, Lange, Vanderlinden, Pouw and Strubbe (1998) examined the relation between daily stress in the form of pending unemployment and dissociative phenomena in a non-clinical population. The results showed a correlation between stress levels and dissociative experiences: respondents reported more dissociative experiences when daily stress was high; furthermore, a decrease in stress levels lead to a decrease of dissociative experiences (De Wachter et al., 1998). These results, according to De Wachter and colleagues, lend support to the hypothesis of Nijenhuis and Vanderlinden (1996) that dissociation may act as a defense mechanism against excess anxiety and tension.

The link between trauma/stress and dissociative phenomena should be seen against the background of the current move in the literature towards an understanding of trauma which is more inclusive in experience, less constrained by the notion of uncommonness, and which, as in conceptualizations of stress, recognizes the importance of personal evaluation in determining the stressful/traumatic nature of the event. Furthermore, contemporary literature similarly refers to traumatic and stressful situations as those that exceed the individual's (perceived) adaptational capacity or ability to cope (Cohen et al., 1986; Evans, 1982; Evans & Cohen, 1987; Fleming et al., 1984; Graig, 1993; Herman, 1997). As such, the concept of trauma has become closely aligned to that of stress. An argument can be made in favour of a stress-trauma continuum reflecting the degree to which an individual perceives his/her natural coping abilities as being threatened, with stressful experiences at the bottom half, and traumatic experiences at the top half of the spectrum. Such an understanding would lend support to a relationship between stress and dissociative phenomena, notwithstanding the fact that most of the literature on dissociative psychopathology has been written in the context of trauma.

The value of a recognized link between dissociation and trauma/stress is that it arguably lends support to viewing the response of low-income women who fail to acknowledge their pregnancies in terms of a dissociative phenomenon. In short, if pregnancy is regarded as a stressful experience for low-income women, and there is a recognized link in the literature between dissociation and trauma/stress, then dissociation becomes a plausible paradigm in which to view these women's responses to the stress engendered by their pregnancies. Granted, the fact that the concept "dissociation" has to date not been unambiguously defined or operationalized, and, as such, is not always clearly distinguishable from other defense mechanisms, problematizes the exclusivity of the link between trauma/stress and dissociation somewhat. It is nevertheless useful to consider the function of dissociation in response to trauma and stress, as it adds to our conceptualization of dissociation as a defensive strategy through which awareness of distressing emotions and thoughts are diminished or avoided, as well as to our understanding of the phenomenon observed in some low-income women's responses to their pregnancies.

4.2 The function of dissociation in response to trauma and stress

During times of trauma and overwhelming stress, dissociation may serve as a means of psychological escape when physical escape is not possible (Herman, 1997; Ludwig, 1983; Kihlstrom, 1990; Spiegel, Hunt & Dondershine, 1988; Steinberg, 1995; van der Kolk, 1987, 1996). Gershuny and Thayer (1999) point out that the "fight or flight" response, typical of threatening situations, may arise, but fighting or taking flight physically from the situation may not be possible. Thus, the individual flees cognitively and emotionally by altering consciousness (Gershuny & Thayer, 1999). Similarly, dissociation may act to deny introspective access to certain mental contents (Kihlstrom, 1990) and thus protect the individual from conscious awareness of the full impact of what is happening or what has happened (van der Kolk, 1996). In so doing, painful trauma-related affects and memories are eluded (Litz, 1992).

In addressing the question as to why dissociation is mobilized as a reaction and defense against trauma, Yalom (1980) argues that physical threat and damage undermine many basic assumptions by which people live, including their sense of control over their bodies and physical environment, and their myth of invulnerability. It is therefore not surprising that the psychological reaction to trauma should incorporate discontinuities of experience such as dissociation (Spiegel, 1993).

Dissociative strategies may therefore be adaptive in that they help individuals separate themselves from the full impact of traumatic experiences (Spiegel, 1993). Putnam (1989a), argues that dissociation can be functional since it provides: (1) escape from the constraints of reality; (2) the compartmentalization of traumatic memories and affect outside of conscious awareness; (3) alteration or detachment from the trauma; and (4) analgesia. Dissociative strategies serve as a defense against pain, fear, helplessness, and panic, providing a welcome feeling of detachment from a terrifying physical reality and the emotions associated with it (Spiegel, 1993). As Spiegel (1993) puts it, when physical control is lost, mental control becomes paramount, and one way to maintain such control is to distance oneself from one's body. This "psychological detachment" from the physical environment may take the form of a general numbing of responsiveness to all stimuli, or a more specific detachment form one's body, personal experience, or certain somatic sensations, such as pain (Spiegel, 1993). Serving to block the immediate experience of a painful event from awareness, dissociative processes allow the individual to go about his or her life as if nothing traumatic had happened, and this can be viewed as adaptive (Sandberg et al., 1994).

Ludwig (1983) has proposed an explanation based on evolution. He maintains that dissociative processes bring about an experiential disengagement from overwhelming physical or psychological events because they have had species survival value and served many diverse, adaptation-enhancing functions. He

states that the sham death reflex among slow animals may be analogous to dissociation, and that, besides survival, dissociation may have other functions such as the automatization of certain behaviours, efficiency and economy of effort, the resolution of irreconcilable conflicts, escape from the constraints of reality, the isolation of catastrophic experiences and the cathartic discharge of certain feelings (Ludwig, 1983). In a similar vein, Ironside (1980) argues that alterations in consciousness and behaviours (for example, "being in a daze", or passivity) that some humans exhibit after a catastrophe is a biological response of conservation / withdrawal to save physical and psychological resources when dealing with inescapable trauma.

Janet believed that dissociation comprises the initial stages of responding to trauma and that dissociation is the critical factor that determines eventual adaptation to a traumatic experience (van der Kolk et al., 1996). Dissociation was conceptualized by Janet as a means of coping with the trauma, but he believed that people who continue to dissociate over time become emotionally constricted and develop various forms of psychopathology (van der Kolk et al., 1996). Indeed, findings of a study conducted by Bremner and Brett (1997) in which they examined dissociative responses to traumatic events and long-term psychopathology in Vietnam combat veterans, were consistent with Janet's hypothesis that individuals who respond to traumatic events with dissociative responses are at increased risk for psychopathology.

The fact that dissociative defenses, which allow individuals to compartmentalize perceptions and memories in an attempt to manage their pain, fear, anxiety and helplessness, seem to carry a cost, has been well recognized since (Spiegel, 1993). The control dissociative strategies may provide the individual at the time of the trauma may result in a delay or failure to work through the experience and put it into perspective - the result being that the self-concept is fragmented, with disjunctive views of the self stored separately (Spiegel, 1993). Once the self is divided in a powerful way, the experience of unity becomes problematic, since

ordinary self-consciousness is no longer synonymous with the entirety of self and personal history (Spiegel et al., 1999).

Similarly, Classen and colleagues (1993), Herman (1997) and Terr (1995) argue that, though dissociation may offer a means of escape when no other form of escape is possible, its use over a prolonged period may be at too high a price and ultimately become harmful and interfere with everyday functioning. For example, long-term use of dissociation may result in an almost complete sense of disconnection from others (van der Kolk, 1996; van der Kolk et al., 1996). In addition, long-term use of dissociation may result in a hindrance of informational and emotional processing of the traumatic event, which in turn maintains and perpetuates posttraumatic stress (Foa & Hearst-Ikeda, 1996). From an emotional/informational processing perspective, symptom structures must be activated for emotional healing to occur (Foa & Kozak, 1986); dissociative phenomena may prevent the activation of these structures and thus act to exacerbate rather than ultimately alleviate symptoms. Indeed, empirical evidence for the hindrance of information processing in dissociated individuals comes from Waller, Quinton and Watson (1995), who found that women with higher levels of dissociation, particularly absorption, took longer to respond to threatening information on a test of cognitive processing than did women with lower levels of dissociation. Thus, presence or continuance of dissociation long after the traumatic event may be a hindrance to adaptive functioning.

Some writers have taken the process further to suggest that continual reliance on dissociation as a coping strategy can place the individual at risk for subsequent revictimization. For example, Chu (1992) postulated that adult women with histories of childhood sexual abuse, who rely heavily on cognitive defenses such as dissociation, frequently lack the anticipatory anxiety that would normally signal the presence of danger, and thus are at substantial risk for revictimization. Similarly, Becker-Lausen, Sanders and Chinsky (1992) suggest that individuals who dissociate lack awareness of the nuances of interpersonal interactions.

Because these individuals have learned to tune our, or block from conscious awareness potentially painful information in their environment, their relationships are, in fact, poor, although they are not perceived that way (Sandberg et al., 1994). Psychological detachment allows dissociators to be less sensitive to interpersonal hurt and rejection, but as Sandberg and colleagues (1994) point out, when people are detached from hurt and rejection, they are also increasingly at risk for subsequent victimization. They detach from reality and disregard cues that lead non-dissociators to perceive and react to danger signals appropriately (Sandberg et al., 1994). Or, as Becker-Lausen and colleagues (1992) put it, high dissociators may have difficulty learning from their experiences to avoid danger because they tend to detach themselves from those experiences, and in the process compartmentalize rather than integrate important information.

In conclusion then, what does an understanding of the function of dissociation in response to trauma and stress in general, mean for the phenomenon observed in some low-income women who fail to acknowledge their pregnancies? Essentially this: the function of a dissociative strategy in response to pregnancy would similarly be to act as a defense against feelings of fear, anxiety and helplessness engendered by the crisis of pregnancy. A dissociative response may serve to protect the expectant mother from conscious awareness of the full impact of what is happening, in other words, to provide psychological escape when physical escape is not possible. For these women, pregnancy may represent a loss of physical control, signaling the need for mental control. One way to maintain such control would then be to distance themselves from the bodily experience of being pregnant by disallowing into full consciousness the fact that they are, in fact, pregnant. Such a response may initially be adaptive in that it provides these women with a means of coping; it allows them to go about their lives as if nothing traumatic has happened. For one thing, an "experiential disengagement" from the knowledge that they are pregnant allow these women to keep their pregnancies away from the work place and to continue working, and earning a much-needed income, right up until the end of their pregnancies. Furthermore, dissociative

processes allow, in the context of an inescapable crisis, the economizing of already limited physical and psychological resources. However, when dissociative processes continue to be utilized until late into pregnancy, endangering the woman's health and that of her unborn child, it may become a hindrance to adaptive functioning. The implications of the prolonged use of dissociative strategies in response to pregnancy are considered in the concluding section of this paper.

5. CONCLUSION

This paper attempted to explore the appropriateness, from a theoretical perspective, of the use of the specific psychological paradigm of dissociation as a possible response to pregnancy in low-income women. In doing so, three bodies of literature were explored: that on women's - and especially low-income women's - experience of pregnancy as a stressful event, that on dissociation, and that on trauma and stress in as far as it is associated with dissociative phenomena.

Pregnancy is generally regarded as a stressful experience, requiring the pregnant woman to make adjustments on physical, psychological and interpersonal levels (Bibring, 1959, Brockington, 1996, Lederman, 1984, Reading, 1983). However, it is recognized that the pregnancy experience varies from woman to woman (Bibring et al., 1961). As such, the role of subjective appraisal is regarded as a critical factor in determining the degree to which the expecting mother experiences the pregnancy as stressful/traumatic.

The influence of variables such as ethnicity and culture, and its association with socioeconomic status, on pregnancy, is well-recognized (Aneshensel, 1992; Hobel, 1996; Hughes & Simpson, 1995; Kramer, 1987; Pearlin, 1989; Rini et al., 1999; Taylor & Aspinwall, 1996; Taylor et al., 1997). In terms of poverty, female

farm workers have been identified as one of the most vulnerable, marginalized and disadvantaged groups in South Africa (Moeller, 1998; Salgado, 1994). As such, pregnancy represents an especially stressful period for them. Low-income women of colour in South Africa experience the life adjustments and increased demands on physical and emotional resources, time and finances which pregnancy entails, in the context of reduced resources and high levels of environmental stress (Cameron et al., 1996).

Research shows that low-income female farm workers in the Western Cape predominantly deal with stress by means of emotion-focused coping mechanisms that include escape, avoidance and distancing strategies (Spies, 2001). As such, a dissociative response on the part of some low-income women to the crisis of pregnancy could plausibly fall under the umbrella of emotion-focused coping. The reasons advanced for the prevalent use of emotion-focused coping mechanisms amongst low-income women are linked to a diminished repertoire of coping resources as a result of a limiting environment and exposure to continuous stressors (Barnyard & Graham-Bermann, 1988; Dill et al., 1980). It is arguable that, given their limiting environment, some low-income women experience the crisis of falling and being pregnant as stressful to such an extent that the only way they perceived themselves as able to cope with it, is to distance themselves from the pregnancy experience, and, as such, from an integral part of their experience of self.

Several factors highlighted in the literature support the hypothesis of viewing the response of some low-income women to the stress engendered by pregnancy in terms of a dissociative paradigm. Firstly, there exists a body of literature that acknowledges dissociation as a psychological mechanism that could account for the failure to recognize pregnancy (Brockington, 1996). Furthermore, although the concept "dissociation" lacks a single, coherent conceptualisation in the literature (Cardeña, 1994), most contemporary descriptions of dissociation include a disturbance in self-cohesion (Tillman et al., 1994). Our interview data of

Maggie and Elize seems to suggest more than a mere "cognitive" non-acknowledgement of pregnancy; rather, these women seem to attempt to distance themselves from the bodily experience of being pregnant, and as such from an integral part of their experience of self.

An additional factor that supports the viewing low-income women's non-acknowledgement of their pregnancies in terms of a dissociative paradigm, comes from the fact that there exists a well-recognized link in the literature between dissociation and trauma (Carlson & Rosser-Hogan, 1991; Putnam, 1985, 1989a; Spiegel, 1986; van der Kolk, 1987). Literature examining the relationship between stress and dissociative phenomena is less copious. However, the current move in the literature is towards an understanding of trauma which is closely aligned to that of stress in that (1) conceptualizations of both trauma and stress emphasize the role of individual appraisal, and (2) traumatic and stressful situations similarly refer to those that exceed the individual's (perceived) adaptational capacity or ability to cope (Cohen et al., 1986; Evans, 1982; Evans & Cohen, 1987; Fleming et al., 1984; Graig, 1993; Herman, 1997). As such, an argument can be made in favour of a stress-trauma continuum. Such an understanding would lend support to a relationship between stress and dissociative phenomena, notwithstanding the fact that most of the literature on dissociative psychopathology has been written in the context of trauma. As such, a dissociative response provides these women with a general way of coping with the stress engendered by their pregnancies. However, as in the case of trauma, it may serve a dual function. On the one hand, it may be adaptive in that it provides a form of psychological escape/detachment from the physical reality of being pregnant, thereby, for example, enabling these women to continue working, and earning a living, right up to the end of their pregnancies. On the other hand, the prolonged use of dissociative strategies may be maladaptive in a number of ways. The implications of the use of dissociative strategies in response to pregnancy are considered more extensively below. Arguably, for low-income women, factors such as a limiting environment,

exposure to continuous stressors, and a diminished repertoire of coping resources, would increase the risk of prolonged use of dissociative processes, and these becoming maladaptive.

Finally, the description of dissociation as involving "vertical" splits or parallel streams in consciousness (as opposed to a "horizontal" split in the case of repression), seems to support our observations with regard to low-income women who fail to acknowledge their pregnancies. Preliminary data has raised the question whether these women may be able to "know" or "remember" the fact of their being pregnant in certain contexts, while "not knowing" or "forgetting" it in others. Such access to different realities would indicate the existence of mental contents in parallel consciousness and lend weight to an argument in favour of viewing low-income women's non-acknowledgement of their pregnancies in terms of a dissociative paradigm.

The literature seems to suggest then that a systematic study of dissociative defenses during pregnancy seems warranted, especially as a strategy used by low-income women. Such a study also seems important as the use of dissociative strategies during pregnancy may have far-reaching implications. In the first place, it may endanger the woman's health and that of her unborn baby. Women who fail to acknowledge their pregnancies may fail to take adequate care of themselves and may, for example, continue to use alcohol throughout their pregnancies. Such neglect may have detrimental effects on their unborn babies in terms of foetal alcohol syndrome. Furthermore, these women may fail to seek medical support during pregnancy; they may even, as was the case with Maggie, forgo medical intervention at the time of labour.

A failure to acknowledge pregnancy to self, often also implies a failure to plan and prepare for the birth of the baby. Apart from the psychological ramifications that this may have for the mother during the actual birth experience, it also has practical implications. These women inevitably fail to acquire the essentials that

expecting mothers would normally acquire for their newborn, such as baby-clothes, nappies, feeding bottles etc. Furthermore, their often being single parents and sole-providers, these mothers inevitably have to return to work soon after their babies are born. By not acknowledging their pregnancies and by failing to make the necessary preparations for birth, they naturally also fail to make advance arrangements for child-care.

Not acknowledging her pregnancy to others also keeps the expecting mother isolated from her family and friends, and prevents her from getting support during a time when she may need it most.

All in all, by postponing the inevitable, these women increase the number (and arguably the intensity) of the stressors they eventually are forced to confront. Moreover, once confronted with the reality of the event, they also place a sudden and tremendous strain on their (already limited) ability to cope with such stress.

The prolonged use of dissociative strategies may furthermore, through preventing informational and emotional processing (Foa & Hearst-Ikeda, 1996), hinder the integration of the pregnancy experience, resulting in a fragmented experience of self and possibly an increased risk for psychopathology. In addition, it may cause these women to become emotionally constricted, which, in turn, may result in a sense of disconnection from others and impact negatively on their interpersonal relationships. Moreover, in line with the trauma literature on dissociation and revictimization (Becker-Lausen et al., 1992; Chu, 1992; Sandberg et al., 1994), one could possibly argue that these women may, by detaching themselves from the experience of being pregnant, and thus compartmentalizing rather than integrating important information, "desensitize" themselves to situations that would bring about pregnancy and so be more vulnerable for repeated "risk" of pregnancy.

In addition, the use of dissociative strategies during pregnancy may have far-reaching implications in terms of attachment and the social transmission of relationship patterns across generations. In recent times it has been realized that the mother "bonds" or "affiliates" with the unborn child in a way analogous to the formation of the mother-infant relationship after birth. Prenatal affiliation may be compromised where women continue to behave as if they are not pregnant (Cohen cited in Brockington, 1996). Brockington (1996) notes that research into prenatal attachment is in its early stages. There is conflicting evidence as to whether prenatal bonding predicts post-partum attachment. Cranley (1981) found no correlation with a measure of mother-infant attachment, but this was only a neonatal perception inventory, given three days after birth. On the other hand, Leifer (1977) claims that, in her small sample, there was a high association between attachment to the fetus during pregnancy and maternal feelings for the baby after the birth. This was especially true of the 4/19 women who had not planned their pregnancy.

The fact that many low-income women's pregnancies are unplanned and out-of-wedlock is important in considering the implications for later mother-infant attachment. Brockington (1996) notes that empirical evidence supports clinical impressions that unwelcome pregnancy is a factor in a disturbed relationship with the newborn. There is an association between out-of-wedlock pregnancy and a poor mother-infant relationship: Pare and Raven (cited in Brockington, 1996), studying refused termination, found that 16/59 women who kept their babies, were burdened by the extra child, regretted the pregnancy and resented the baby. Robson and Moss (1970) had six mothers among their sample of 54, who admitted to not wanting their babies, and three of those suffered from delay in developing positive feelings. Robson and Kumar (1980) found that negative attitudes to the pregnancy were associated with initial indifference to the infant. As a corollary to this, the absence of affiliation to the fetus may be a predictor. Robson and Kumar (1980) found that not perceiving the fetus as a person at 36 weeks was associated with indifference to the newborn.

It is clear then that the use of dissociative strategies during pregnancy has far-reaching implications for both mother and child. With regards to low-income women, it seems tragic that such mechanisms, initially resorted to as a means of coping with the stress engendered by pregnancy, could carry such terrible costs. While an overview of the literature suggests that dissociative responses to pregnancy are likely and therefore warrant research, the possible implications of such a defensive strategy make further study of this phenomenon an imperative. Such research would be especially valuable given the paucity of literature on the defense strategies and coping mechanisms of low-income women in South Africa. One also wonders to what extent dissociation is a more general defensive strategy used by low-income women. In other words, it may not be specifically connected to pregnancy, but may represent the general way in which low-income women cope with stress, be it the stress of poverty, the stress of illness, etc. This possibility also calls for further exploration. An important objective of further research into these areas would ultimately be to contribute towards more effective primary health care for pregnant low-income women.

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