

**POSTNATAL DEPRESSION: EXPLORING ADOLESCENT WOMEN'S
EXPERIENCES AND PERCEPTIONS OF BEING DEPRESSED.**

By

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ABSTRACT

POSTNATAL DEPRESSION: EXPLORING ADOLESCENT WOMEN'S EXPERIENCES AND PERCEPTIONS OF BEING DEPRESSED.

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Adolescent pregnancy has been of longstanding societal concern primarily because of the inability of most young mothers to provide adequately for their infants. Depression often results in disengagement from mother-child interaction. Adolescent mothers identified as depressed are at increased risk of future psychopathology, with additional deleterious effects on their infants' lives. The purpose of this study was to explore adolescent mothers' experiences of motherhood and memories of feeling depressed during or after the birth of their babies. The first aim was to explore the young women's experiences of mothering, by focusing upon the practice of being a mother. The second aim was to explore the young women's experiences of depression, by focusing on their physical behaviour and emotional experiences. The third aim was to explore their perceptions of the causes of their depression. The rationale for this study was that these issues will further enhance the body of knowledge available to practitioners working with adolescent mothers. It will also provide a source of insights and hypotheses for preventive intervention research. The study was located within a feminist

standpoint framework that begins from the perspective of women with the aim to explore women's accounts of their experiences in relation to depression as an important source of knowledge. A qualitative research design and methodology was employed in the region of the Western Cape. Eight adolescent mothers between the ages of 16 and 19 were recruited and interviewed. The interviews were semi-structured and consisted out of open-ended questions. Interviews were recorded, transcribed verbatim and thematic analysis of data was carried out. The findings of this research yielded some interesting areas for future research and implications for treatment and intervention with first-time adolescent mothers. The adolescent mothers in this study experienced similar depressive symptoms to adult mothers in previous research. All the participants revealed that they feared their parents' disappointment in them for being pregnant. This factor contributed to their depression, because they received very little (if any) support from their parents or the father of their baby. The participants discussed that their pregnancy or giving birth was linked to various aspects of themselves that they had lost as an adolescent. Before they received counselling, none of the participants understood why they experienced depressive symptoms or what was happening to them at the time after their pregnancies.

DECLARATION

I Simone Moses-Europa of the Faculty of Community and Health Sciences in the University of the Western Cape sincerely declare that the copy of the research project submitted by me in 2005 is the original work and the true result of my efforts.



Signed: Simone Moses-Europa

Dated: 2005

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CHAPTER1:
INTRODUCTION

Adolescent motherhood continues to be a common and complex phenomenon in the world. Adolescent mothers can be defined as young women between the ages of 19 years or younger (Ex & Janssens, 1998). As many as 48% of adolescent mothers internationally experience depressive symptoms (Deal & Holt, 1998), compared to 13% in adult mothers (O'Hara & Swain, 1996). Adolescent mothers identified as depressed are at increased risk of future psychopathology (Leadbeater, Bishop & Raver, 1996). The term 'motherhood' firstly, refers to the practice of motherhood and secondly, refers to the discourse of motherhood, i.e. the assumption of social norms, values and ideas about 'the Good Mother' (Walker, 1995). Elvin-Nowak and Thomsson (2001) emphasises the need for a good mother to take her mothering responsibilities seriously and act maturely. The attempt to become a better mother is illustrated when women sacrifice themselves and their needs in the perceived interest of their child/ren. With regard to the practice of mothering Walker (1995) argued that motherhood includes the act of childbirth, the emotional care or nurturing and the physical care for the baby.

Postnatal Depression (PND) is a mental illness that can begin during pregnancy or occurs in the 6-12 weeks or months after birth. It refers to morbid and persistent depressive episodes that begins in or extends into the postpartum period (Cox, Murray & Chapman, 1993). It can also be defined as a condition that describes a range of physical and emotional changes that

many mothers can have after having a baby. These psychotic or non-psychotic traumatic events may have lasting effects on a women's confidence in the mothering role and interactions with her infant (Fowles, 1996).

In a South African study that was conducted in all the provinces, it was found that the age for first sexual intercourse for urban women was a slightly older age than rural women (Kaufman, de Wet & Stadler, 2000). Rural adolescents tend to start childbearing earlier than urban adolescents (21% compared to 13%). Research showed that more than 35% of South African adolescents became pregnant before they reach the age of 20 (Republic of South Africa, 1998). These figures are even higher for black and coloured adolescents. Age at first sexual intercourse for women in the Northern Province was earlier than in any other province. Age at first sexual intercourse for women aged 20-49 in the Western Cape was later than in the other provinces. Women with the highest educational level had their first sexual encounter at a later age across all age groups.

The definition of these historical racial categories emphasises external physical characteristics e.g. skin colour (Bornman, 1999). In South Africa, the term race has acquired a political connotation, meaning that a person's membership in a particular race that was used to determine whether they belonged to the privileged group or the oppressed group. South Africans who felt oppressed were generally associated with being Black. There were many Coloureds (non-Whites of mixed origin) and Asian who viewed themselves as

Black. Many continue to do so. The privileged people were designated as White (Bekker, 1993).

Gauteng has the lowest proportion (10%) of women aged 15-19 who had ever been pregnant, while Mpumalanga has the highest proportion (25%) of women aged 15-19 who had ever been pregnant (Republic of South Africa, 1998). Other provinces with high levels of early pregnancy are Northern Province, Eastern Cape and the Northern Cape. African women had their first sexual intercourse at a younger age than the other population groups. Coloured teenagers have the highest levels of adolescent pregnancy (19%) while whites and Asians had the lowest levels (2% and 4% respectively).

Some women in South Africa view pregnancy as a way of gaining access to adulthood (De la Rey, 1997). Girls who become pregnant in South Africa are not expelled nor are they forbidden from returning to school after giving birth (Lee-Rife, 2002). Most women's schooling was not disrupted when they became pregnant, as 60% of them had already left school and were unemployed at the time (De la Rey, 1997). Fuller and Liang (1998) found that many girls appear to return to school after giving birth. Maharaj, Kaufman and Richer (2000) found that about 35% of black girls aged 19 and younger who had given birth at least once were attending school after giving birth.

Depression, especially in mothers, has been extensively studied during the last few decades. Having a child is a time of changes in a woman's life, both in the biological, psychological and in the social sense. These changes can

contribute to personal growth, but can also result into mental disorders.

Postnatal depression (PND) occurs in approximately 10-15% of childbearing women studied worldwide (O'Hara, Zekoski, Philipps & Wright, 1990) and may begin anywhere from 24 hours to several months after delivery. Almost 25% of cases of postpartum depression start during pregnancy.

Worldwide, more than 10% of all births are to women 15 to 19 years of age.

Young mothers are often unprepared for the tasks of parenting (Leadbeater *et al.*, 1996), which may lead to the mother doubting her own abilities and competence in nurturing her infant (Tarkka, Paunonen & Laippala, 1999).

Depression often results in mothers distancing themselves from their infants (Hubbs-Tait *et al.*, 1996), because they often experience negative perceptions of themselves and/or the baby (Heneghan, Silver, Westbrook, Bauman & Stein, 1998). Many women have relatively high rates of depression and experience anxiety and confusion during this period (Ex & Janssens, 2000).

Maternal depression during the postpartum period has an impact on the child's development as well as the mother's own health and ability to act as a mother (Najman, Andersen, Bor, O'Callaghan & Williams, 2000). Garrett and Tidwell (1999) reported that many women with postpartum depression may suffer from delusions and/or hallucinations. They are often preoccupied with anxious, distressing and recurrent thoughts about harming their babies.

This study will target young mothers who gave birth as adolescents, because adolescent depression remains underrecognised. A large number of

adolescents are undiagnosed, because they do not meet the DSM-IV criteria for depression (Lewinsohn, Rhode & Seeley, 1998). In this study, adolescent mothers will describe their memories of feeling depressed during or after the birth of their babies. This study attempts to understand the experience of adolescent mothers. Firstly, the researcher will explore the young women's experiences of mothering, by focusing upon the practice of being a mother. Secondly, the researcher will explore the young women's experiences of depression, by focusing on their physical behaviour and emotional experiences. Thirdly, the researcher will explore their perceptions of the causes of their depression.

Previous research studies on postnatal depression, focused mainly on adult mothers. This study will add focus on the experiences and perceptions of adolescent mothers that are diagnosed with postnatal depression. The findings will explain the experience of depression for adolescent mothers. These issues will further enhance the body of knowledge available to practitioners working with adolescent mothers. It will also provide a source of insights and hypotheses for preventive intervention research.

Feminist standpoint theory will be utilized to explore what unrecognized powers might be found in women's lives that could lead to knowledge that is more useful for enabling women to improve the conditions of their lives. It has three political goals. The first goal is to prove that women are oppressed, with the assumption that there is such a thing as truth. The second goal is to expose the system that oppresses women, its mechanisms and the way it

reproduces itself. The third goal is to liberate women by improving women's everyday lives.

Chapter 2 proceeds with the previous literature that also explored adolescent mothers that were diagnosed with postnatal depression depression. Chapter 3 presents the research design and the methodology employed in gathering and analysing the data. Chapter 4 constitutes the research findings, the analysis of the results and discussions of this study. Chapter 5 concludes the research area, with a discussion of the study limitations and the directions for future research.




CHAPTER 2:
LITERATURE REVIEW

2.1 DEFINING ADOLESCENCE

The term 'adolescence', as described by Greene (2003), refers to the development stage in the human life cycle which begins in puberty and ends with adulthood. Owens (2002) defined the adolescent phase in terms of chronological age, as starting between the ages of 11 to 13 years and ending between the 17th to 22nd year. Adolescence is a difficult phase during which a variety of changes take place. It represents the transition process of individuals, which involves biological, physical and hormonal changes as well as social adjustments. Adolescents develop into complex beings with intellectual, emotional and social qualities that are needed for their future development. Individuals differ from each other, depending on their social context (Gouws, Kruger & Burger, 2000).

Physical development concerns the growth and development between different parts of the body (Lefrancois, 2001). During puberty body growth accelerates, the reproductive organs become functional, sexual maturity is attained and secondary sexual characteristics appear. Fitting a new body image into a sense of self is an important developmental task of adolescence. If the development of the adolescents' body does not conform in every detail to that of their peers, or to the model prescribed by society, they may regard themselves as unattractive and experience their body as unacceptable

(Sugar, 1993). Adolescents (especially girls) are often preoccupied with their bodies. As a girl's body turns into that of a woman she confronts the meaning of what it is to be an adult woman in her culture. Girls appear to react negatively to bodily changes which they perceive to be in a direction that is socially undesirable. Body image is closely related to self-concept. Most adolescents who regard themselves as unattractive have a negative body image. They also have a negative self-concept. In contrast, adolescents who regard themselves as attractive are better adapted, happier, more successful, more self-confident and more extrovert than their peers, who regard themselves as less attractive (Cobb, 1995).

Biological changes that occur during this stage make the adolescent capable of reproduction (Lefrancois, 2001).  This phase is marked by a crisis of identity as adolescents seek acceptance in the adult world and their peers. This process involves possibly experimenting with drugs, alcohol, sex and putting their health or other people's lives in danger. During this time of experimentation with high- risk behaviours, individuals may engage in early sexual activity which could result in early pregnancy. This in turn is can be associated with increased maternal mortality and increased infant morbidity, social, psychological and economic effects.

Adolescence also involve the changes in individual's relationships with other people and the influence of society and specific persons on the individual, e.g. their parents, siblings, other adults, peer groups and friends (Owens, 2002). This phase can be viewed as a period with its own features and demands.

Individuals develop unique identities by questioning societal or community values or beliefs. Modern society and social values or beliefs on the adolescent are very demanding. Sometimes society demands a lifestyle from adolescents that is contrary to their norms and values, e.g. pregnancy and abortion, alcohol and substance abuse, etc. (Gouws, Kruger & Burger, 2000).

Emotional and moral development include both the conative (will-related) and the cognitive aspects of their development and are influenced by their progress towards independence and identity (Owens, 2002). Individuals achieve emotional independence from their parents or other adults and become more dependent on their peers. Individuals will achieve their independent status through experimenting with their feeling, ideas and roles, acquiring their own set of values in order to achieve socially responsible behaviour. Adolescents acquire values and norms that enable them to distinguish between behaviour that is regarded as 'correct' and 'acceptable' or which is considered wrong and unacceptable by members of their community and cultural group (Gouws, Kruger & Burger, 2000).

The previous paragraphs described adolescence as a period of development during which dramatic life changes and transitions occur. Attempting to deal with the psychological adjustment from adolescence to adulthood and the transition to parenthood often creates a variety of stressors. The effect of such transition on the adolescent involves adaptive challenges such as shifting their role definition, role behaviour and reconstructing their social supports

(Trickett & Buchanan, 2001). The next section will focus on teenage pregnancies especially South African adolescents.

2.2 ADOLESCENTS IN THE SOUTH AFRICAN CONTEXT: TEENAGE PREGNANCY

Boulter's (1995) research found that South African adolescents are faced with issues of self-confidence, self-esteem, emotional stability, self-assuredness, health, family influences, personal freedom and group sociability. This study focuses on one social issue that South African adolescents face i.e., adolescent pregnancy and parenting. Along with the increase in the percentage of adolescents who are sexually active, there is an increase in the number of teen pregnancies. In South African communities, teenage pregnancy is not always viewed as a completely negative experience (De La Rey, 1997). Nonmarital childbearing is very common and widely accepted in South Africa (Makiwane, 1998). Family members are frequently available to provide childcare and the children of adolescent mothers are usually absorbed into the mother's or grandmother's household (Kaufman *et al.*, 2000).

Although heightened sexuality, a lack of information about fertility and contraception, and a tendency not to use contraceptives are generally cited as reasons for teenage pregnancies, there are several other factors that also have an influence. Fertility plays a central role in South African women's identity (Preston-Whyte, Zondi, Mavundla & Gumede, 1988). Having a baby

may be viewed as a sign of maturity or a kind of status symbol. An adolescent pregnancy may therefore be a more welcome prospect in this context as many teenagers are encouraged to become pregnant by their partners and grandmothers (Preston-Whyte *et al.*, 1990; Richter, 1996; Varga & Makubalo, 1996). Some adolescents grow up in cultural environments where reproductive ability is seen as a sign of strength. Young women are sometimes encouraged to 'prove' their fertility and are often told by their mothers that pregnancy during adolescence is far more preferable than the prospect of infertility caused by contraceptive use (Richer, 1996). Boys, on the other hand, maintain that using condoms reduce their strength and eliminates all pleasure from the sexual encounter.

Pregnancy for an unmarried teenager often poses a serious developmental crises. Of the 10 most common reasons for seeking mental health services in a large high school, pregnancy-related issues was number one (Jepson, Juszcak & Fisher, 1999). Many teenage pregnancies result in a dramatic disruption of the mother's education and career plans (Trad, 1999). Teenage pregnancy and delivery also carry much higher health risks, both for mother and infant. The economic and social conditions in which most teenage mothers are forced to live and the emotional stresses associated with these conditions, as well as with child-rearing, can be a heavy burden. The next section will describe the difficulties pregnant adolescent's faces in the transition to motherhood.

2.3 MOTHERHOOD AND PARENTING

The first few months after having had a baby are a difficult time for first-time mothers. During motherhood women endure social, emotional and economic changes (Gittins, 1993). During this transitional period women also experience complex cognitive, affective and behavioural changes. The term 'motherhood', according to Walker (1995), distinguishes between firstly, mothering referring to the practice of motherhood and secondly, the discourse of motherhood, focusing on the ideas about the acceptable role of the 'Good Mother' according to the particular society. With regard to the practice of mothering, Walker (1995) argued that motherhood includes the act of childbirth, the physical care for the baby and the emotional nurturing i.e. looking after the infant. Special abilities and energy are required in performing the new tasks involved in caring for a baby (Pridham & Chang, 1992).

Children that are restless, weepy or easily irritated decrease the mother's coping abilities by increasing her exhaustion and tiredness. If this increases, the mother can easily question her own capacities and capabilities of caring for her infant and become more dependent on the support from family members, friends or professionals (Tarkka *et al.*, 1999). Many women may also experience feelings of anxiety and confusion, because of their unrealistic expectations of motherhood (Ex & Janssens, 2000).

Women seem to vary in how they perceive and cope with these changes. Since pregnancy extends over nine months there are plenty of opportunities for women to have different reactions at different stages of the pregnancy.

Studies by Lederman (1996) and Mercer (1995) indicate that many women feel unattractive while pregnant, complaining of being fat and ugly. In a society which values thinness, putting on weight even for the gestation of a baby may be hard to tolerate for some women.

Teenage parenthood is a complex phenomenon that touches the lives of the adolescent mother and father, the children born to them, the adolescents' parents, the schools, counseling services and family planning services that have been established to help them cope (Caldas, 1993). Adolescents may not be socially and personally mature enough to assume the new roles imposed on them by parenthood. Young parents lack parenting skills. They are impatient, insensitive, irritable and inclined to administer corporal punishment. Few of these young mothers show that they enjoy their children, for example by playing with them for the pure pleasure of it. Teenage mothers may easily become overwhelmed with their new burden. Without an adequate support system and positive coping skills they may even contemplate suicide (Cronin, 2003).

Adolescent parenting presents challenges to young mothers that they are often unprepared for this may contribute to high rates of depression (Leadbeater *et al.*, 1996). These findings that adolescent mothers were less cognitively prepared for parenting were supported by Sommer *et al.* (1993). The adolescent mothers in Ex and Janssens' study (1998) were less informed or less educated about the normal development of infants than the adult mothers.

Many women leave hospitals with their newborn as early as 8 hours postpartum, or after a short period of hospitalization of one to three days (Fichardt, van Wyk & Weich, 1994). This shorter hospitalization may lead to the possibility of a crisis in the postpartum period. Fishbein and Burggraf (1998) stated that longer hospital stays would allow the medical staff to provide support and education to first-time mothers. Problems may surface after five or seven days when no professional help is accessible. Klein's (1998) study of loneliness in adolescent pregnancy associated lower levels of maternal expressiveness and low self-esteem with depression and anxiety. Herrman, van Cleve and Levisen (1998) argues that teenage mothers need parenting skills to help them feel capable in their approaching parental role.



2.4 ADOLESCENT DEPRESSION AND POSTNATAL DEPRESSIVE SYMPTOMS

In the past several decades there have been enormous changes in the recognition of depression as a problem of adolescence. Perspectives have changed from an initial view that depression could not occur in children and adolescents to an acknowledgement of depression as a major mental concern among children and adolescents. It is now widely recognized that depression during adolescence has a tendency to occur (Gouws *et al.*, 2000). Depression may make adolescents vulnerable to other problems. They may experience scholastic problems, interpersonal and social problems, and they may contemplate and attempt suicide.

The symptoms of depression are not always clearly evident, since they are often accompanied by other behavioural problems. Adolescents often experience symptoms reflecting a mixture of anxiety and depression (Compas, Connor & Hinden, 1998). Depressive symptoms are common amongst postpartum adolescents (Hudson, Elek & Campbell-Grossman, 2000) and this generally leads to increased instances of postpartum depression amongst adolescents (Barnet, Joffe, Duggan, Wilson & Repke, 1996). Feeling depressed as an adolescent mother following the birth of a baby includes characteristics such as experiencing scared feelings with the sudden awareness of motherhood: feeling confused between the responsibilities of adolescence and motherhood; feeling neglected and rejected by partners and peers (Lesser, 1997; Paskiewicz, 2001); and experiencing confusion about their experiences of depression (Clemmens, 2002).



Postnatal depression (PND), which occurs in approximately 10% of childbearing women (O'Hara *et al.*, 1990), may begin from 24 hours to several months after the birth of their infants. When the symptoms are severe, women are more likely to seek help early in the illness. Untreated, PND may resolve within several months but can linger into the second year postpartum.

Depression ratings are the highest at the eighth month of pregnancy and lowest eight months after childbirth. Women may experience symptoms such as emotional swings, crying spells, low self-esteem, hopelessness, irritability and inability to enjoy normally pleasurable activities (Hurlbut, Culp, Jambunathan & Butler, 1997). The symptoms of non-psychotic postpartum

depression include a constant low mood, tearfulness, difficulty in sleeping, extreme tiredness, headaches, chest pain, heart palpitations and panic attacks.

Mothers whose postpartum depression had gone undiagnosed, feel confused and “fear they are losing their minds” (Beck, 1993; 1996). Mood disorders, including states of confusion, fluctuating moods, disordered thinking, disordered behaviour and ‘psychotic’ symptoms of delusions and hallucinations, are the most common cause of maternal psychosis. Garrett and Tidwell (1999) reported that many women with postpartum depression are preoccupied with anxious, distressing and recurrent thoughts about harming their babies. These delusions involve irrational obsessions concerning the newborn baby (Donahue-Jennings, Ross, Popper & Elmore, 1999). In certain cases the baby may be at risk due to the mother’s illness and a medical assessment is essential. Thoughts of harming the infant, of hurting oneself or thinking about committing suicide have been shown to be common in depressive mothers, but actually doing something is rare.

Receiving treatment for postnatal depression is extremely important for the mother in order to cope with her symptoms. A variety of treatments are available, e.g. medication (usually antipsychotic and/or antidepressant medicines) and electroconvulsive therapy (Wisner, Peindl & Gigliotti, 1999). Depressed mothers have an increased risk of relapsing and/or continued

psychiatric illness. The assumption that adolescents presented similar symptoms to those of adults has influenced the identification and description of depression in adolescent mothers (Wilcox, Field, Prodromidis & Scafidi, 1998). Treatments attempted with children and adolescents are basically adaptations of interventions that seem to be successful for adults. The following approaches are being used to treat adolescent depression, e.g. biological therapy, psychotherapy, cognitive-behavioural interventions or family therapy (Cooper, Murray & Hooper, 1997; O'Hara & Swain, 2000).

Studies have found that social support act to mitigate some of the stressors incumbent in adolescent pregnancy and depression. A positive response is facilitated by a socially supportive environment (Passino *et al.*, 1993). Their studies indicate that developing and using social supports from other people seemed to be the central coping strategies that assist pregnant and parenting adolescents during their difficult time. The next section will discuss how pregnant or parenting adolescents will benefit from the support of parents, partners, family-members or friends.

2.5 SOCIAL ISOLATION AND SOCIAL SUPPORT

The first component 'social' of the word social support has been described as consisting of the personal reactions of at least two individual to a shared social interaction and the shared meaning that theses individuals jointly construct and attribute to their interaction (Badr, Aciteli, Duck & Carl, 2001).

The members of the social support networks include the family, close friends,

neighbours, co-workers and professionals. The second component that warrants attention is that of 'support'. Badr *et al.* (2001) identifies firstly, the source of 'support' (e.g. relatives, friends, etc.) and secondly, the types of support (e.g. material aid, behavioural assistance, etc.) as two differing dimensions of support.

Social support has been acknowledged as one of different aspects during the transition to parenthood for adolescents (Passino *et al.*, 1993). Many women feel lonely after childbirth (Hudson *et al.*, 2000) and the demands of motherhood leave little time or energy for other relationships. As a result, the adolescent mother may feel isolated from her family or peers. The pregnant or parenting adolescent mothers may experience a lack of communication, emotional closeness (Rodriquez & Moore, 1995) and support from their parents (Cronin, 2003; Yampolskaya, Brown & Greenbaum, 2002). Although the well-being of adolescent mothers appear to be affected by a variety of psychosocial stressors, the stage of adolescence itself is accompanied by a variety of social pressures, such as establishing autonomy, friendship and familial relations and occupational goals (Prodomidis, Abrahs, Field, Scafidi & Rahdert, 1994).

Falling pregnant while still at school or at an educational institution is generally problematic for the adolescent. If a young mother decides to carry her unborn to full term, she may have to interrupt her studies. Her decision for leaving school or the educational institution may lead to isolation of her peer group

and may also reduce her sources of social support (Bezuidenhout, 1998). Tanga and Uys (1996) investigated the social support system of unmarried adolescents in South Africa and found that both parents and peers gave adolescents the support they needed. While Brage, Meredith & Woodward (1993) found a negative relationship between self-esteem, loneliness, or depression and in feeling disconnected from social support in adolescent groups (Barnet *et al.*, 1996). Prodromidis *et al.* (1994) found that depressed adolescent mothers reported poorer functioning in the areas of physical health, mental health, peer relations, family relations and social skills. The lack of support from family or friends and the isolation during pregnancy is likely to negatively affect mental health. This can be identified as a factor that leads to depression (Clemmens, 2002). Social isolation and the sense of abandonment that many participants experience can deepen depression and emphasize the need to keep these women attached to their families and to their peers.

Mothers with higher levels of knowledge about infant development and social support were found to have greater confidence in providing care for their baby (Ruchala & James, 1997). It is important for the mother to surround herself with a support system before the baby is born. The findings of Nicols and Zwelling (1997) showed that when the baby is happily anticipated, the mother's anxiety of the baby's arrival tends to minimize and the mother's relationship with her newborn seems to be more positive. The next section will describe the affect of postnatal depression on the baby and the interaction between mother and child.

2.6 MOTHER- INFANT RELATIONSHIP

Postnatal depression, according to Murray and Cooper (1997), may affect the child by disrupting the communication and normal interaction between mother and child and that clinically depressed mothers often display very little affection towards their toddlers. In this study, the toddlers showed greater sadness, talked less often and engaged in less exploratory behaviour.

Women suffering from postpartum depression often experience negative perceptions of themselves, their partner and/or their baby (Heneghan *et al.*, 1998). Even the prenatal depression of the mother is argued to have both direct and indirect adverse effects on the fetus, because of the mother's associated poor health behaviours, the possible physiological effects of depression and the mother's negative feelings toward the unborn child (Green & Murray, 1994).



Murray *et al.* (1996) analysed face-to-face interaction of two-month-old babies and their depressed mothers. The depressed mothers were less affirming and less sensitively attuned towards their children than non-depressed mothers. Beck (1996) found that depressed mothers separate themselves emotionally and physically from their children and they may withdraw from interaction situations. The mother's failure to respond to infant cues results in their children's poor cognitive and emotional development (Beck, 1998). Beck's (1995) findings of his study showed that depressed mothers may not pick up their infants' signals, smiles, gestures or vocalisations and, thus the synchrony of the interaction may not be found and the infant's needs not be

satisfied. This may affect their infants' language development, problem-solving ability, mastery motivation and social competence.

Postnatal mental illnesses of the mother has been claimed to cause insecurity, avoidance of attachment on the part of infant and problems of bonding between the mother and her newborn (Kumar, 1997). Infants are highly sensitive to a mother's sadness, silence and inattentiveness. Children of adolescent parents have an increased risk of being maltreated (Goerge & Lee, 1997) and experiencing behavioural and developmental problems (Coley & Chase-Lansdale, 1998). Mothers with chronic depression have babies that are often irritable and lethargic, with sleeping and eating problems and temper tantrums (Campbell & Cohn, 1997). These newborns may grow into infants who are underweight, slow learners and emotionally unresponsive, with behaviour problems such as aggression (Rogers, Peoples-Sheps & Suchindran, 1996). Infants and preschool children of mothers with depressive symptoms showed decreased responsiveness, increased hostility and anxiety, and deviant cognitive and linguistic development that may have long-lasting results (Heneghan, Silver, Bauman & Stein, 2000). Older children and adolescents of depressed mothers are more likely to experience depression, substance abuse and conduct disorder during their adolescence.

Although adolescent depression is not as well-researched as adult depression, it is important to understand what adolescent depression is, what may cause it and what can be done in order to help and support adolescents that are experiencing depressive symptoms (Gouws *et al.*, 2000). In an

attempt to unpack the experiences of adolescent mothers who suffer from PND, this project will draw on feminist standpoint theory. This theory proposes to place women's experiences at the centre of one's theorizing and analysis. In doing so, the standpoint feminist theory would try to explain what women experience. This would help us to understand women's perspectives on depression.

2.7.1 FEMINISM

This research will utilise a feminist theoretical framework. Feminism, according to Busfield (1996), is a philosophy suggesting that women have been systematically disadvantaged and this needed to change. Terre Blanche and Durrheim (1999) argued that feminist theorists aim to change this by investigating the situations and understanding the experiences of women in society and in doing so, providing a better world for women (towards the emancipation of women). Feminist research is opposed to patriarchal societies, which attempt to understand the world in order to control and exploit its resources. Feminists also describe the male point of view as objective, logical, task-oriented and instrumental. It reflects a male emphasis on individual competition, on dominating and controlling the environment (Neuman, 1997).

Feminist theory, according to Doyle and Paludi (1998), is usually based on a philosophical critique of society wherein women are seen as having less political and economic power than men. A major goal of feminists is for

women to learn to strive for and acquire economic and psychological independence. Feminists argue that society's definitions of gender roles and the opposing complements expected between women's and men's behaviour must end. Feminist researchers are committed to eradicating power imbalances between the researcher and her/his subjects. Feminist theory makes women the central focus in the research investigation process. This theoretical framework attempts to see the world from the vantage point of women in the social world.

2.7.2 FEMINIST STANDPOINT THEORY

Feminist standpoint theory claims that a woman's everyday experience is filled with authority, and her interpretation of the experience is believed to be true and accurate. This theory validates the knowledge of women and it also validates women as producers of valid and useful knowledge. It has three goals. The first goal is to focus on women that are oppressed, with the assumption that there is such a thing as truth. The second goal is to expose the system that oppresses women, its mechanisms and the way it reproduces itself. Harding (1993) claims that feminist standpoint theorists have wanted to identify ways that male supremacy and the production of knowledge have co-constituted each other in the past. They also sought to explore what unrecognized powers might be found in women's lives that could lead to knowledge that is more useful for enabling women to improve the conditions

of their lives. The third goal is to liberate women by improving women's everyday lives.

Standpoint theorists see important differences between men and women that affect their communication. These differences are a result of cultural expectations and the treatment that each group receives from the other.

Women are perceived as the underadvantaged and men are overadvantaged.

Hartsock (1997) proposed that someone in a position of power and someone who is oppressed would have radically different viewpoints. In addition, the person in power will have a more perverse and less accurate view. The

oppressed have a more advantageous view because they can see clearly their own view than the one forced on them by those in power. Minority

groups like women, according to Hartsock (1998), will always have a better view of the world than their oppressors. What makes a woman's minority

viewpoint a feminist standpoint is its combination with the ability to critically analyze a situation using the tools of feminism. This critical awareness

combined with the viewpoint of the oppressed is the feminist standpoint,

which can be used to find ways of resistance to gain powers for

underprivileged groups.

Harding (1993) stressed the importance of researchers being critically self-reflexive of their own personal and cultural biases in the formation of their theoretical perspectives of the social world. The relationship between researcher and participant should not be separated, but engaged (Harding, 1993). The goal of a researcher is not to justify truth claims, but to enable

different forms of knowledge to emerge that challenge power (Harding, 1993). The aim should be to uncover social processes that consist of a diversity of historically, locatable, subjugated perspectives and standpoints. Strong objectivity cannot be achieved by removing oneself from the world, but by acknowledging our situated location and being reflexive of our position within it.

Collins (1990) took the theory of a feminist standpoint and expanded on it, creating a theory of a Black feminist standpoint. She described how being oppressed as a woman and an African American gave a black women twice the standpoint advantages of a white woman. Feminists must be aware of the ways in which their multiple identities intersect and be conscious of the ways in which their viewpoints are limited.



2.7.3 STANDPOINT THEORY APPLIED TO DEPRESSION

In seeking to understand depression, standpoint feminist research begins from the perspective of women (Stoppard, 1997). The first aim is to explore women's accounts of their experiences in relation to 'depression' as an important source of knowledge. Such accounts provide a source of knowledge about the lived 'realities' of women's everyday lives and also provide a starting point for an understanding of the experiences of women's depression. Stoppard (1997) explored two approaches to explain depression in women. Firstly, the women's bodies approach, focuses on the biological body with the emphasis on the reproductive female body. Women's vulnerability to

depression is claimed to reside in the specific nature of the biology of the female body. Secondly, the women's lives approach, deals with the social circumstances of women's everyday lives, as well as gendered foundation of stress and their impact on women. Women's vulnerability to depression arises in the social circumstance of women's everyday lives.

If a woman seeks an explanation for her depressive experiences (low mood, lack of energy, etc.) in terms of bodily processes (e.g. hormonal changes associated with menstruation or menopause), she attributes them to something outside her control and also removes the possibility that her own actions and subjective experiences are implicated (Stoppard, 1997). Women feel that it's not their fault and they are not to blame. In removing blame from the individual and transferring it to women's bodies, this approach implies that women can take the preventative action of ingesting medically prescribed substances (antidepressant drugs, hormonal replacements) to compensate for their bodily weaknesses. If a woman attributes her depressive experiences to her social circumstances, according to Stoppard (1997), this may aggravate feelings of distress, given the powerlessness of most women to change their situation.

According to Karp (1992), many women attempt to make sense of their depressive experiences through the exploration of their lived experiences. Research from women's accounts provides an important source of knowledge about the experiences of individual women and their definition for depression (Nicolson, 1995). As long as depression continues to be conceptualised as an

individual problem within a positivist methodological frame, women will continue to blame experiences currently classified as 'depressive symptoms' on their bodies or their lives (Stoppard, 1997).

2.8 CONCLUSION

Feminist standpoint research allows these adolescent mothers in this study to describe their perspectives or experiences of mothering and depression. The women's lives approach allows them to deal with the circumstances of their everyday lives and to help them to understand what is happening to them at that time when they were feeling depressed. This process would lead to the empowerment of women in order to regain control over their lives and helping them to change their situation.



CHAPTER 3:
RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This qualitative study focuses on exploring adolescent mother's experiences of their pregnancy and perceptions of being depressed. Feminist methodology attempts to give a voice to women who are opposed to the male-oriented standpoint that has dominated the social sciences. Feminists argue that women learn and express themselves differently than men (Neuman, 2003). A feminist approach would help to seek to advance feminist values.

This study attempts to explore the experience of mothering and depression for first-time adolescent mothers with the intention to provide insights into postnatal depression, from each participant's viewpoint. This chapter will outline the particular research methodology utilized in this study and describe how it was useful in accomplishing the aims of this research. The following section will illustrate the research methodology employed in this study.

3.2 METHODOLOGICAL FRAMEWORK

This study utilised a feminist qualitative framework. Qualitative research, according to Babbie (2001), is about understanding the world of the participants. This can be achieved by listening to their voices and allowing


those voices to be heard in the report. This means that the information must be analysed from the words used by the participants, rather than the perspective of the researcher. A qualitative framework allowed the participants to describe their own experiences of motherhood and depression as young adolescent mothers. This involved listening to the stories of the young mothers, their feelings and the sense they made of their own lives in order to understand how depression affected them (Plummer, 2001), in ways that quantitative methods would be unable to detect.

3.2.1 FEMINIST APPROACH

This research was conducted within a qualitative paradigm that provided a rich account of the phenomenon. The validation of women's experiences through listening to their voices has been fundamental to feminism (Seale, Gobo, Gubrium, & Silverman, 2004). Feminist social scientists criticize positivism, in which men define reality on their own terms to justify their experiences and their own particular version of events, while women are denied or deprived from their experiences. In contrast, feminism emphasizes developing human bonds, viewing people that are linked together by feelings of trust and mutual obligation. The primary goal of feminists involved reclaiming women's experiences by listening to women and understanding their realities.

The feminist standpoint perspective is useful for explaining the gender inequalities and patriarchal structures that are inherent in society (Harding,

1987). The aim of this standpoint is to understand women's lives by means of a feminist exploration of women's experiences of oppression. It therefore emphasizes the role of research in bringing about social change. Feminist research is conducted by people, most of them women, who consciously use a feminist perspective. Feminist research proposes research for as opposed to research merely about women (Olesen, 2000).

A qualitative research design as described by Stake (1994) enables an in-depth description and exploration of a small group of South African women. This type of research is known as the collective case approach that allows each participant to represent a unique case study. Individual meanings and common themes of women's lives were elicited, specific to women living within the South African context. Quantitative studies do not provide the richness or detailed responses of each participant as being achieved by qualitative research (Johnson, 1999).  Miles and Huberman (1994) proposed the collection of qualitative data as the best strategy for exploring a new research area (such as postnatal depression).

The central focus of feminist research is on women who were previously disadvantaged. This process helps to understand the experiences of women in order to provide a better world for them. Feminist researchers value women's position and perspective in the research process and proposes research that benefits women and contributes to social change (Neuman, 2003). Feminist researchers are not objective or detached from their research, but they interact and collaborate with the people they study. They fuse their

personal and professional lives e.g. feminist researchers will attempt to comprehend an interviewee's experiences while sharing and incorporating their own feelings and experiences into the research process. This may create an empathic relationship between researcher and interviewee that might mature over time and eradicate power imbalances between the researcher and participant (Pope, Ziebland & Mays, 2000).

In reality, the researcher remains in the more powerful position (Letherby, 2002), because the researcher interprets the interview data. In feminist research, participants contribute in the research process, by speaking in their own voice and describing their experiences, while being listened to by someone (the researcher) who understands and who can fully represent their voice (Harding, 1991). Data analysis in qualitative research is an ongoing recursive process of continuous analysis that is not possible in quantitative research. Continuous data collection takes place that provides the opportunity to go back to participants in order to clarify unclear information that was collected during the interview.

Feminist research highlights the awareness of women's subjective experiences (Olesen, 1994). Feminism tends to emphasize empathy and subjectivity. This process will improve the status of women i.e. increase their competence and productivity. The next section will explain how feminist standpoint theory can be employed to understand the young mothers' experiences of motherhood and depression.

Feminist standpoint research begins from women's perspective that would erase boundaries between the researcher and participant. The qualitative in-depth study of women helped to explore women's perspectives and realities of motherhood and depression, which clarified how they live their 'realities' of their everyday lives. Feminist qualitative research promotes policy formation and social change that has become increasingly important (Pope *et al.*, 2000). Feminist standpoint theory, according to Harding (1986) argues that men's dominating position in social life results in partial understandings, whereas women's subjugated position provides the possibility of more complete understandings.

3.3 PARTICIPANTS



A group of eight adolescent first-time mothers between the ages of 16 and 19 participated in this study. These young females were recruited via referrals from one participant in the Western Cape. Criteria for inclusion in the study included adolescent mothers who (a) were 19 years of age and younger, (b) have been diagnosed with postnatal depression. The participants in this study included young females from two of the historical racial categories. The greater part of this study consisted out of "Coloured" females, while "White" females represented the lesser part of this research.

The recruitment of young adolescent mothers diagnosed with postnatal depression was a difficult process, because of the sensitive nature of depression and ethical issues of working with these participants. In the

beginning of this year, these young mothers received both individual and group counselling. The attendance of their individual counselling sessions decreased, but they still attend group counselling sessions that allow them to share their experiences and their coping strategies with other first-time mothers. The participants were purposefully selected. This research study is not representative of all South African adolescent mothers and is not generalizable to the broader South African population.



TABLE 1: DEMOGRAPHIC DETAILS OF PARTICIPANTS

Initial Information	1 Tarryn	2 Tanya	3 Eden	4 Britney	5 Yolanda	6 Michelle	7 Melissa	8 Celine
1) Mother age	19	17	18	16	18	19	19	17
2) Sex of baby	Boy	Girl	Boy	Boy	Girl	Girl	Girl	Boy
3) Age of baby	13	8	8	6	10	7	19	9
4) Race	Coloured	White	Coloured	White	Coloured	White	Coloured	White
5) Education level	University	Grade 11	Grade 11	Grade 9	Grade 11	Matric	Matric	Grade 10
6) Living arrangements	Own	Parents	Parents	Parents	Parents	Parents	Parents	Boyfriend
7) Infant health	Good	Excellent	Good	Good	Good	Excellent	Excellent	Excellent
8) Place of birth	Private	Private	Private	State	State	State	State	State
9) Type delivery	Caesarian	Normal	Normal	Caesarian	Normal	Normal	Normal	Caesarian
10) Hrs of labour	10 hrs	12	8	16	12	9	8	14
11) Feeding method	Breast	Breast	Breast/Bottle	Bottle	Breast	Breast	Breast	Bottle
12) Length of stay in hospital	1 night	1	1	2	3	2	4	1
13) History of depression	None	-	-	-	-	-	-	-
14) Diagnosed with PND	2005	2005	2005	2005	2004	2004	2004	2004
15) Treatment	Counseling	Counseling	Counseling	Counseling	Counseling	Counseling	Counseling	Counseling
16) Length	6 months	3	4	6	6	7	7	8
17) Pregnancy planned/ unplanned	Unplanned	Unplanned	Unplanned	Unplanned	Unplanned	Unplanned	Unplanned	Unplanned

* The names of the participants have been changed to ensure anonymity.

3.4 DATA COLLECTION TOOL

The study was designed to collect in-depth verbal accounts of the experiences of motherhood and depression from a small sample of eight young adolescents. The interviews were tape-recorded. During the interviews, detailed biographical material (Appendix D) and detailed accounts of the birth were obtained. Participants described their explanations of their behaviour and emotional reactions as well as their social context (Nicolson, 1998).

Babbie (2001) discussed when interviews are appropriate to use for research. Interviews produce data which provides an in-depth and detailed insight into the research area, provided by fewer participants. The goal of an interview is to investigate emotions, experiences and feelings rather than issues that are more straight-forward or factual. Qualitative research using interviews gives participants the freedom to discuss sensitive issues, in order to get the participant to be open and honest about their experiences. The in-depth information provided by participants (e.g. their feelings, thoughts or opinions) during the interviews can produce valuable or greater insight to the research topic. After the initial interview, participants have the opportunity to expand or clarify their views and identify what they regard as fundamental issues.

The interviews were structured and consisted of open-ended questions (Appendix D). The open-ended questions explored the women's experiences of motherhood and depression. In-depth interviews were used to collect and to validate data. The qualitative in-depth, face-to-face interview allowed the

participants to describe their own experiences of motherhood and depression. The structured conversation was used to gather data to provide a subjective perspective on the context of the respondents' daily lives. Respondents had been recruited in the knowledge that the researcher was interested in postnatal depression and that they would be asked about any previous experiences of depression. Working within a feminist standpoint framework (Nicolson, 1998), allowed the researcher to focus on how participants understood depression as a concept in their lives.

The goals of feminist research vary, but two common goals are to give greater visibility to the subjective experience of women and to increase the involvement of the respondent in the research process (Neuman, 2003). I strived to create collaborative and non-exploitative relationships in the research process, drawing on skills of being open, receptive, and understanding. Most of the mothers were curious about the reasons why the researcher was interested in providing insight to adolescent mothers' experiences with postnatal depression. I hope that this study will make medical practitioners and nurses aware that adolescent mothers are also suffering from postnatal depression. These mothers need some support from professionals in order to help them cope with their depressive symptoms. The mothers became more open and eager to share their experiences and their stories, because they were motivated in helping other first-time adolescent mothers facing the same problems. By carefully listening to the young mothers, I became emotionally engaged with respondents. I tried to

understand the meaning underlying women's experiences and encouraged respondents to express themselves in ways that they were most comfortable. The creation of social connections and building a trusting relationship with participants, lead to a sense of empowerment among women.

3.5 PROCEDURES

A letter was sent to the institutions, to request medical practitioners to provide referral names of adolescent mothers, who were diagnosed with postnatal depression (Appendix A). Counsellors denied access to their patients, because of the sensitive nature of depression and ethical issues of working with these participants. The eight participants were recruited via referrals from one participant in the Western Cape. Mothers were telephonically contacted and asked to consent to an interview. A letter was sent to the participants in explaining the purpose of the study (Appendix B). Anonymity and confidentiality was assured.

Participants signed a consent form (Appendix C) requesting their permission in this study. The participants were informed about the ethical issues of confidentiality, anonymity, their right to terminate the interview at any stage or not to respond to sensitive questions. The interviews took place at the homes of the participants in their environment in which they felt comfortable and protected. An in-depth, face-to-face interview was carried out privately, audiotaped and transcribed verbatim. The interview ranged from 45 to 60 minutes. All of the interviews were conducted in English, because the

participants were predominantly English-speaking. The interviews were held at a convenient time for the mothers to encourage their participation.

The interviews were conducted in a relaxed conversational style. Reflective and clarifying communication techniques were used to obtain rich narrative descriptions of the women's experiences of motherhood and depression. After the interview, debriefing took place with each participant. This process helped to reduce any stress or to address sensitive feelings experienced during the session. The researcher went back and asked for the participant's feedback and adjustments were made to the data that was collected. During this process, the young women described their own experiences and made their voices heard.

3.6 CREDIBILITY OF STUDY



In qualitative research quantitative issues such as internal and external validity, reliability and objectivity or generalisability do not carry the same connotations (Babbie *et al.*, 2001; Creswell, 2003). Qualitative researchers are more interested in authenticity i.e. giving a fair, honest, and balanced account of social life from the viewpoint of the participant who lives it everyday. Qualitative researchers are more concerned with giving an honest interpretation of social life that is true to the experiences of people being studied. Most qualitative researchers concentrate on ways to capture an inside view and provide a detailed account of how those being studied feel about and understand events (Neuman, 2003).

In qualitative methodology, the relationship between the participant and its representation is dealt with by the notions of credibility, transferability and dependability to evaluate the trustworthiness (Cresswell & Miller, 2000) of a study. Qualitative researchers use a variety of techniques (e.g., interviews, participation, photographs, document studies, etc.) to record their observations consistently. Qualitative researchers want to be consistent in how they make observations over time, similar to the idea of stability reliability. The value of a changing or developing interaction between the researcher and what he/she studies is also emphasized. Qualitative researchers believe that the subject matter (or data) and a researcher's relationship to it should be a growing, evolving process (Neuman, 2003).

Credibility refers to whether the researcher has accurately interpreted reality as the participants of the study view it (Creswell, 2003) to determine whether the findings are authentic, accurate or trustworthy from the standpoint of the researcher and the participant (Creswell & Miller, 2000). There were some practical checks the researcher made in order to determine the credibility of the participants' information (Denscombe, 1998). Credibility can also be attained by triangulation i.e. using a variety of data sources or perspectives on a study (Janesick, 2000); peer debriefing; and member checks (having members of the study check whether the data collected is accurate and the interpretations are correct). To achieve credibility, I received valuable feedback from my research supervisor and the eight participants, who gave their interpretations of their realities.

Transferability is the extent to which the results of a study can be applied outside of the context of the study and/or with other members. Johnson (1999) argues that the transferability of a study to wider settings can only be judged if the specifics of situations and settings are made known. Due to the very nature of qualitative studies generalization is not the endpoint of the study. This can be achieved through: a) thick description (enough data that is described within context and is reported with detail and precision); and b) purposive sampling (maximizing the range of information that can be secured about a specific context from different locations and members) (Babbie, 2001). The researcher attempted to do so by linking the experiences of the women in this study to theory and other related studies. The eight participants in this study were interviewed specifically, because they were in a position to know about the issues that interested the researcher (Denscombe, 1998) about postnatal depression.



Dependability refers to the notion that similar findings should be found if a study is done using the same or similar participants and within the same or similar context. However the same respondents at a different time will never be in the same context. A method employed to ensure dependability is through a systematic and clearly documented approach to data collection and analysis (Babbie, 2001). In this study all the documents or data, interview notes and the researcher's journal was compared to the data that was collected during the interviews. The transcriptions were read by the participants to clarify all the recorded data that was collected during the

interviews and to clarify statements that were misunderstood by the researcher.

This qualitative research does not fully represent all the women of South Africa that are diagnosed with postnatal depression. Reflexivity was used to increase the study's validity, truthfulness and trustworthiness. During the research process in this study, the researcher kept a journal documenting her own feelings, personal reactions or thoughts and keeping track of the developments which occurred (Hall & Hall, 2004). This led to conceptual insights into this research area.

The next section will explore some of the ways in which the researcher attempted to reduce the gap between the participants in this study and their representations. For the purpose of easier reading, the first person will be used.

3.7 REFLEXIVITY AND RESEARCHER'S VOICE

Feminist social scientists, according to Terre Blanche and Durrheim (1999), insist on being familiar with the shared characteristics of the researcher and participants. They are self-conscious of the role their identification with the participants might play in the research process. Reflection, according to Hall & Hall (2004), entails clear and critical thoughts of how to improve the depth of the study that was produced. Reflection enables researchers to describe and analyse their feelings as the research proceeds. This allows researchers to

evaluate themselves and to be critically aware of their strengths and limitations during the research process. Critical researchers should be aware that conducting an interview is not a one-way transfer of information from the participant to the researcher, but a dialogue between the participant and the researcher.

As the participants described their experiences of feeling depressed postpartum, I kept a journal to help keep track of the different intonations or gestures that accompanied the verbal statements, along with personal reactions and thoughts. Research diaries enable researchers to record their feelings, to track the developments and decisions which occur in their research and write down ideas about conceptual insights (Hall & Hall, 2004).

As a married woman without any children, I gained valuable insight to the lives of the young mothers. During this process, I was able to empathize with the participants' feelings.

It was a very difficult process to recruit or to gain access to first-time adolescent mothers that are diagnosed with postnatal depression. Young mothers are seldomly diagnosed with postnatal depression, because it is not always detected by medical practitioners. During the few occasions when it is detected, occurs when the mother is suicidal.

The first-time mothers in this study felt that young pregnant adolescents are labelled by society as being promiscuous, without taking the father's role in the pregnancy into account. I was emotionally involved with this young

mothers and hope that society would try to help them, rather than only criticizing them. The participants were interested in the reasons why I was conducting this specific research. Sharing my intention for the purpose of this study with the participants e.g. creating awareness about first-time adolescent mothers with postnatal depression in order to make practitioners attentive to the needs of these mothers, created a safe environment for them to share their stories and experiences. The interviews elicited emotional responses from participants and provided a comfortable space to express their feelings. It also gave the young mothers the opportunity to express their feelings to another female who is not in their position, but who is not judgemental.

The follow-up interview allowed the participants to reveal more information about themselves and their relationship with their babies, which was not captured in the initial interview. All the mothers appreciated being part of this research and reported feeling a sense of validation and satisfaction that their experiences and voices were being heard. After they read their transcripts, they felt that their stories would empower other young mothers that are in their position and that the research process allowed them a sense of closure that was not reached in their counselling sessions.

The researcher plays a significant role in the production and interpretation of the qualitative data. Some feminist researchers argued that their racial identities, values or beliefs actually permit the research and that only women can truthfully capture the significant factors concerned with the subordination of women in society (Denscombe, 1998). My own position as a “Coloured”

researcher did not create any boundaries between myself and the “White” young mothers. Although I did not share their experiences with motherhood or postnatal depression, other issues that were raised during the interviews allowed me to share my own experiences of being a female and being in a relationship. Since feminist standpoint theorists argue that researchers and participants are co-constructors of reality, I acknowledge that the data presented is a result of my interaction with the participants.

3.8 ETHICAL CONSIDERATIONS / ISSUES

The interviews were scheduled, once informed consent was obtained from the adolescent mothers. The interviews took place at the homes of the participants to create a safe and comfortable environment. In the initial meeting, time was taken to explain the purpose of the study. Some initial information from each individual was collected (age, sex of baby, living arrangements, place of birth, type of delivery, hours of labour, method of feeding and length of stay in hospital). The researcher started each interview by asking the participant about the birth. To gain a deeper understanding of their experiences, the individual was asked to describe specific instances relating to themselves and their baby. This allowed the mother to tell her own story in her own way.

Participants were assured of complete confidentiality and privacy in the research. They were informed that their participation was voluntary. Before the interviews, the young mother’s permission was gained for the presence of

another female (that would be taking notes) while the interviews were taking place. During interviews, enough time was allowed for participants to describe their own experience and to discuss sensitive issues. They felt confident that their identities would not be known by anyone other than the researcher. The interviews allowed anonymity to ensure greater responses. The young mothers were informed that they are free not to participate or to terminate participation at any point during the study if they wished to do so.

The participants were aware that the researcher was not acting as a counsellor or psychologist. These young mothers are receiving individual and group counselling. The respondents were informed that allowing the audiotape during the interview was voluntary. Debriefing after interview took place with participants about the questions and the scribe's verbal and non-verbal observations. At the end of each interview, social support service referrals (such as counselling) were offered, but all participants declined the offer because they have access to a counsellor and belong to a support group for first-time mothers. After the initial interview, the young mothers were telephonically contacted to enquire about their well-being and to offer referral to social support services for assistance and counselling.

A follow-up meeting was scheduled with the participants to clarify any information on the typed transcripts. The researcher went back to the interviewees with the typed transcript to check with that person whether the data was accurate. The interviewees listened to a copy of the tape so that

they would know what appeared on the typed transcript was actually what they had said. The interviewees confirmed that what they had said at the time of the interview was what they really meant. This created the opportunity to ensure that the facts or the information on the typed transcripts were accurate.

Each participant viewed the typed transcripts to ascertain whether they had anything to add and to accurately represent their voices. This interaction between the researcher and the participants created a collaborative and trusting relationship with the young mothers. The participants were provided with the opportunity to describe their perspectives and to experience equality or empowerment in the research process.



3.9 DATA ANALYSIS: THEMATIC ANALYSIS

The analysis of the interview transcripts covers the stages of organizing, reducing and making sense of the collected data (Mouton, 2001). Data collection and analysis involves the researcher formulating ideas on the basis of the participants' responses and other useful information that was collected. The data that was collected at the individual interviews were tape recorded, transcribed verbatim, thematically analysed and validated with the participants. The purpose of this process was to verify if the data was interpreted accurately.

Thematic analysis focuses on identifiable themes that emerge during the interviews. The recorded data was transcribed soon after each interview while the information was still relatively fresh in the researcher's mind. The participant's actual words were used in the transcripts. Their names were changed to ensure anonymity. The information was organized into a form suitable for analysis by using full transcriptions of the audiotapes. The information on the transcriptions was checked by the participants to clarify whether their stories were interpreted accurately.

The researcher started the analysis by using the interview transcript summaries and created a list of themes or emergent concepts (Mouton, 2001) while the interview process was continuing. Themes were identified by bringing together ideas or experiences, which often are meaningless when viewed alone (Terre Blanche & Durrheim, 1999). The themes indicated specific issues which were shared among the eight young mothers (Denscombe, 1998). A qualitative data matrix was drawn up to show the responses of the different interviewees to each theme (Hall & Hall, 2004), which signified an overview of all the interviews. Different codes were created from emergent themes and were then applied to the interview transcripts, enabling the identification of patterns within the participants' interview. The codes that were used identified the themes mentioned by the interviewee that appeared significant and indicative to the researcher. Peer review was used in co-coding the transcripts and to create a list of themes. Five female Masters Research Psychology students, studying at the same university as the researcher, were involved in identifying themes that were emerging from the

interview transcripts. These students that were involved in identifying themes from the transcripts, were completing their first year level in the Masters Research Program. They were useful because of their adequate knowledge in qualitative research.

After the initial interviews, emerging themes from the collected data were presented to the participants for their explanations or clarifications (Denscombe, 1998). Narrative data has been used to describe and represent the first-time mothers' experiences. The researcher received continuous feedback from the participants throughout the research process, with the intention of capturing the young mothers' voices.

3.10 SIGNIFICANCE OF THE STUDY



Previous research studies on postnatal depression, focused mainly on adult mothers. This study will focus on adolescent mothers. The findings will explain the experience of depression for adolescent mothers. These issues will further enhance the body of knowledge available to practitioners working with adolescent mothers. It will also provide a source of insights and hypotheses for preventative intervention research.

3.11 CONCLUSION

Feminist standpoint theory highlighted the subjective experiences of women (Olesen, 2000), by placing them as the central focus of the research, with the attempt to give them a voice and to be heard. By allowing young mothers to explore their own perspectives or realities, would improve the status of women, to increase their self-confidence and self-esteem. Feminist qualitative research interprets the reality as the participants of the study view it. Most qualitative researchers strive to capture an inside view and provide a detailed account of the participants feelings and understanding of their everyday lives.



CHAPTER 4:
RESULTS & DISCUSSION

4.1 INTRODUCTION

This study yielded many interesting results regarding first-time mothers' emotional experiences and perceptions around motherhood and depression. In this chapter the researcher has attempted to interpret key themes by using quotations, which will appear in italics.

4.2 COMMON THEMES

Themes depicted common patterns of experiences, feelings, attitudes and opinions, as previously discussed. Where significantly different voices were heard, it was noted as a contrasting opinion. The results will be presented using narrative data from the mothers to discuss the key themes emerging from the data. The findings will be divided into three central analytical categories according to the aims of this study and will be linked to the research question:

- (1) Psychological and emotional issues the mothers faced during pregnancy;
- (2) The first-time mothers' experiences of mothering; and
- (3) The perceptions of the mothers about the causes of Postnatal Depression (PND).

4.2.1 PSYCHOLOGICAL & EMOTIONAL ISSUES DURING PREGNANCY

4.2.1 (a) Strong emotional reactions and discovery of pregnancy

All the mothers stated that their pregnancies were unplanned. Only two mothers admitted that they used protection and this led to the shocking discovery that they were pregnant, as portrayed in the following quotes:

“The pregnancy came as a shock. My partner and I always used protection.” (Tarryn, 19)

“I could not believe this has happened to me. Me and my partner always used protection and I did not understand how this could have happened.” (Yolanda, 18)



Most of the first-time mothers experienced great fear in revealing to their parents that they were pregnant. One mother said:

“I was shocked, because I did not know what to tell my parents.” (Eden, 18)

Some of the participants in this study stated that they engaged in sexual activities, because all their friends were experimenting with sex. They believed that their friends' influence would explain their sexual exploration with boys they barely knew, which resulted in their pregnancies (Lefrancois,

2001). Very few of these young mothers explained that they lacked information about contraception and sex (Jepson *et al.*, 1999), while others stated that they relied on condoms to be 100 percent safe and would prevent pregnancy at an early age.

4.2.1 (b) Contemplating an abortion

The discovery of the mothers' pregnancies led to mixed feelings. All the mothers viewed their pregnancies as a negative experience. Some mothers were contemplating aborting their babies, but for various reasons they decided against it. One mother stated the following:

“At first I wanted an abortion, but when I found out I was pregnant it was too late. I kept telling myself that I wanna get rid of the “thing” inside of me. I was actually hoping for a miscarriage.” (Michelle, 19)

Another mother stated that she was not financially able to go for an abortion and she did not have enough money to support her baby after its birth:

“At the beginning, I was upset about the pregnancy. It was unplanned, seeing that we used protection. I didn't want to accept it and thought about having an abortion, which of course I didn't have the money for.” (Melissa, 19)

Previous studies such as Ex and Janssens (2000) indicated that pregnancy or motherhood can be overwhelming. Without adequate support from loved ones, the mothers may contemplate suicide as a last resort in coping with their pregnancies. As the results showed in this study, Leadbeater *et al.* (1996) described that adolescent pregnancy presents challenges to adolescents and may contribute to high rates of depression.

4.2.1 (c) Parents' disappointment

Most of the mothers were terrified about revealing to their parents that they were pregnant, because they feared the parents' disappointment in them.

Some comments were:



"I was so nervous about my parents finding out that I was pregnant. I could not sleep at night. I couldn't bear walking around and pretending. They were so shocked and disappointed in me." (Britney, 16)

According to Owens (2002), young people acquire their own set of values in order to achieve socially responsible behaviour. Adolescents acquire values and norms that enable them to distinguish between behaviour that is acceptable or unacceptable in their community. The young mother in this study knew that her pregnancy would not be accepted in her family and that they would be disappointed in her, once she reveals that she is pregnant.

4.2.1 (d) Participants' disappointment in themselves

Beside the parents' disappointment, their friends or family-members rejection, the mothers own disappointment in herself for falling pregnant played a major role in the reasons why they experienced negative feelings and depressive symptoms during their pregnancies.

"I felt disappointed in myself, because I wasn't ready for what was about to come. I felt rejected by my friends and parents were disappointed." (Michelle, 19)

Gouws *et al.* (2000) refer to adolescence as the phase where individuals achieve emotional independence from their parents and become more dependent on their peers. In this study however, the mothers sought the approval of their parents as well as the support from their peers during their pregnancies or after childbirth. They also acquire their own set of values in order to achieve socially responsible behaviour. They acquire values and norms that enable them to distinguish between behaviour that is regarded as 'acceptable' or 'unacceptable' in their homes or community. The adolescent mothers in this study were aware that their pregnancies would be unacceptable in their families. This was one of the main reasons why they were reluctant about revealing their pregnancies to their parents.

4.2.1 (e) Participants' suicidal tendencies during or after pregnancy

One of the many emotional problems some of the mothers faced was to end their own lives, because they did not know how to deal with their pregnancy or how to take care of a newborn baby. Without an adequate support system or coping skills, some mothers contemplated suicide. Some participants admitted that they were suicidal during or after their pregnancies, as two mothers discussed the following:

*"I felt like dying. I even considered taking my own life. I wasn't prepared for this and I wanted to stop feeling this way. I was ashamed of myself."
(Michelle, 19)*



"I didn't want to be alive anymore, I wanted to disappear." (Tanya, 17)


Dalton and Holton (1996), described that the changes of childbirth can bring on feelings of frustration, confusion and worry. The participants in this study tried to ignore their pregnancies until reality kicked in and their bodies changed physically. They encountered a big life-changing experience by being pregnant or having a baby. Many of the adolescent mothers did not have any expectations about motherhood before their pregnancies. They realised that they had to deal with their pregnancies and taking care of their baby after birth. The pressure of not knowing how to take care of themselves while they were pregnant and nurturing their baby after childbirth, led to their solution of coping with their problems by contemplating suicide.

4.2.1 (f) Regretting having sex

Most of the mothers were not too thrilled about their decision to have sex and fall pregnant.

“I did not think much about having the baby. I wished that I could go back in time and erase my experience of having sex.” (Britney, 16)

Another mother regretted her choice of sleeping with her boyfriend at such a young age, as stated below:

“Having a baby at such a young age is very terrifying. I would not suggest it to anyone. I would  recommend teenagers to avoid sex until they are older or married. I'm avoiding sex and told my boyfriend that I want to wait until we are married. I do not want to become pregnant again.” (Celine, 17)

Previous studies (Dittus, Jaccard & Gordon, 1999; Jaccard, Dittus & Gordon, 1996) suggested that maternal-adolescent communication about sexual matters may contribute to the reduction of adolescent pregnancies. These studies showed that parents have an impact on the attitudes that adolescents have about getting pregnant by discussing with them the consequences of adolescent pregnancy. Jaccard *et al.* (1999) reported that perceived maternal disapproval of an adolescent engaging in sex and the quality of the relationship between the parent and adolescent are predictors of sexual risk

behaviour. It seems reasonable to assume that these parental variables may impact an adolescent's attitude towards pregnancy. Adolescents whose parents effectively convey strong disapproval of them engaging in sex may feel more negative towards getting pregnant (Jaccard, Dodge & Dittus, 2003), because a pregnancy would reveal to the parent that the child had engaged in sexual risk behaviour. The minority of the adolescent mothers in this study described that they had a good relationship with their mothers. Even though this minority of adolescent mothers had a strong relationship with their mothers, their mothers did not educate them about pregnancy or using contraceptives.

4.2.1 (g) Lack of social support during pregnancy (emotional or financial)



The majority of the participants lacked the support from their family or friends.

Some comments were:

“My parents were so disappointed in me, because they had such high hopes for me. The other relatives were all unsympathetic and just said that I knew what I was doing at that time. The father of the baby also just disappeared.” (Melissa, 19)

All the mothers claimed that they needed the emotional and physical support from people in dealing with the pregnancy, especially their parents, family and friends. Instead, they experienced the rejection of their loved ones, as stated below:

“I was confused, disappointed and rejected and judged by people especially school peers.” (Tanya, 17)

“I was very frustrated because I had very little support because both my parents also rejected me.” (Yolanda, 18)

This study makes us aware that these pregnant adolescents went through a difficult transition process of adolescence and pregnancy. Gouws *et al.* (2000) described adolescence as a difficult phase during which a variety of changes take place. Individuals go through a transition process, involving biological, physical and hormonal changes as well as social adjustments. The participants in this study indicated that they needed the emotional support from their parents, family or peers to help them through their pregnancies and taking care of their newborns. The lack of support from their parents, partners, family or friends and the isolation during or after their pregnancies had a negative affect on their mental health. Clemmens (2002) identified that the lack of support may lead to postnatal depression. Herrman *et al.* (1998) also makes us aware that teenage mothers need parenting skills to help them feel capable in their approaching parental role.

4.2.2 EXPERIENCES OF MOTHERING

4.2.2.1 Unpleasantness of childbirth

All the participants agreed that the birth process was a very painful and negative experience for them. They appeared shocked and unprepared for what actually transpired during the birth. Mothers recalled the unpleasantness of internal examinations. The study of Cronin (2003) presented similar findings to this study. The first-time mothers' experience of childbirth was considered painful and undignified, as portrayed in the following quotes:

“The internal examination was unpleasant. I really was embarrassed. It felt as if I was butchered.” (Celine, 17)



“I felt like I was going to die, because it was such a painful experience for me. It felt like a never-ending delivery experience.” (Tanya, 17)

*“Besides the pain, I felt that the whole experience was degrading.”
(Celine, 17)*

Three mothers reported that they gave birth in a private hospital, while five mothers reported that they gave birth in a state hospital. Five mothers reported that they had normal vaginal deliveries, while three mothers had babies born by caesarean section. The average hours of their duration of

labour were 11, which ranged from 8 up to 16 hours. The average days the mothers spend in hospital were 2 days, which ranged from 1 up to 4 days.

4.2.2.2 Ambivalent about keeping the baby

After the birth of their babies, the mothers went through different stages and were confused about whether they were prepared for the arrival of their babies. They were not clear about how to take care or nurture their baby after its birth. They were not prepared for their new parental role.

“My emotional state was confused at the time as I was unsure whether I was going to keep the baby as I was unclear about the future.”

(Tarryn, 19)



“I still didn’t know whether I should keep the baby or not. A lot of thoughts went through my head, for example what I was going to do, how am I going to take care of this baby, who’s gonna help me. I was so confused.” (Michelle, 19)

The first-time mothers recalled that their first few months after having their babies were a difficult time for them. They experienced different depressive symptoms and did not understand what they were going through. Gittins (1993) explains that a woman endures social, emotional and economic changes during motherhood. This transitional period also involves the complex cognitive, affective and behavioural changes in mothers. This

emphasizes the notion that first-time mothers need to develop parenting skills before their baby's arrival. It is also important that pregnant women are well-informed about the hormonal, physical, emotional and psychological impact of having a baby, as well as facts regarding ante- and postnatal depression.

4.2.2.3 Symptoms of PND

None of the participants experienced any depression before their pregnancies. They started to experience depressive symptoms while they were pregnant. They experienced more negative and depressive symptoms after the birth of their babies. The duration of their negative experiences or depressive symptoms averaged 5 months. Four of the mothers were diagnosed with PND in 2004, while 4 mothers were diagnosed in 2005.



Gouws *et al.* (2000) discusses the enormous changes which took place in the recognition of depression as a problem during adolescence. Previously depression was only viewed as an adult mental condition. Perspectives have changed to an acknowledgement of depression as a major mental concern among adolescents. It is now widely recognized that depression during adolescence has a tendency to occur.

This section will discuss the symptoms of depression the first-time mothers experienced in this study. The symptoms included experiencing mood swings, feeling stressed, feelings of shame and embarrassment, feelings of frustration, confusion, crying spells, inability to enjoy previously pleasurable

activities and murderous thoughts. Hurlbut *et al.* (1997) state that these symptoms of depression also include low self-esteem, hopelessness, irritability, a constant low mood, tearfulness, difficulty in sleeping, extreme tiredness, headaches, chest pain, heart palpitations and panic attacks.

4.2.2.3 (a) Experiencing mood swings

Most of the mothers reported that they experienced mood swings after childbirth:

“I started to become very moody and disrespectful towards people especially my parents.” (Tanya, 17)



“I was happy sometimes and then cried sometimes, because I was concern about my future.” (Eden, 18)

“I was very moody and experienced mood swings. I would feel happy the one moment then the next I would yell at anyone just looking at me.” (Celine, 17)

The first-time mothers in this study described their feelings about becoming a mother as unready, drained, alone and lost (Barclay *et al.*, 1997). They explained that they would feel unhappy, but would not really know what to do in order to feel happy. Dalton and Holton (1996) described that postnatal depressed mothers experience mood swings after giving birth to their babies.

4.2.2.3 (b) Feeling stressed

Some mothers reported that they were stressed about their pregnancies. One mother did not want to acknowledge that she was pregnant until her body changed.

“I was very stressful. I did not want to acknowledge the fact that my pregnancy would change my physical and emotional state until I saw the physical changes.” (Tarryn, 19)

One of the most stressful events was to inform their parents about their pregnancies. This resulted in hiding their pregnancies, because they did not know how to inform their parents that they were expecting a baby.

“In the beginning it was really stressful hiding my pregnancy from my parents. I felt uncomfortable in my body. I had no-one to talk to besides my boyfriend. I felt more relieved after I told my parents about the pregnancy.” (Britney, 16)

Another reason for feeling stressed, as one mother discussed below, was that they did not know how to take care of their newborn.

“I felt that my life came to an end. I was very depressed. I was very stressed not knowing how I am going to take care of a baby. I hated myself.” (Yolanda, 18)

It is clear from the quotations of the participants in this study, that mothering a newborn can be stressful, especially when the young mother is also experiencing depressive symptoms while nurturing her baby. Klein's (1998) study emphasis how important it is to assist first-time mothers in helping them to feel capable of adjusting to their new role as mothers.

4.2.2.3 (c) Feelings of shame and embarrassment

Most mothers experienced feelings of shame and embarrassment, because they believed that their pregnancies would not be accepted in their families, as one participant stated below:

"I felt ashamed and embarrassed. It felt as if I ruined my teenage life. I always wondered whether my parents would forgive me. My life was shattered." (Eden, 18)

This adolescent mother discussed that she was ashamed and embarrassed about being pregnant, because she realised that her parents would not approve of her pregnancy and her baby. She realised that she cannot go back living just for herself, but she had to accept her responsibilities as a mother and take care of her baby. Preston-Whyte *et al.* (1998) described that the young women in their study viewed adolescent pregnancy to be a sign of womanhood. In contrast, the young mother in this study regarded her pregnancy as the end of her teenage life and the beginning of her new burden as a mother.

4.2.2.3 (d) Feelings of frustration

One mother became frustrated, because her body was changing and she did not know how to deal with it.

“I didn’t like myself, especially during the 5th month period. I couldn’t do anything. I was fat and the morning sickness was terrible. I was stressed out because I still needed to study. I became frustrated and depressed.” (Michelle, 19)

Many women, according to Lederman (1996) and Mercer (1995), feel unattractive while being pregnant. The young mother in this study experienced feelings of frustration, because her body image, which was a component of her identity was altered during pregnancy. She described her body as being big and awkward, which affected her perception of her body image in a negative way (Fox & Yamaguch, 1997).

4.2.2.3 (e) Experiencing confusion

Another symptom which was common amongst most of the first-time mothers experienced was confusion, because of their unrealistic expectations of motherhood. They were unclear about how to nurture their babies.

“After my pregnancy, I felt happy but also confused. I loved yet hated my baby at the same time.” (Tanya, 17)

“I felt so confused and drained. I did not know what to do with the baby.” (Britney, 16)

One mother stated that she received some comfort and support from her parents, which was very helpful.

“I felt depressed, confused and alone, but I was also relieved, because my parents helped me a lot.” (Michelle, 19)

Ex and Janssens (2000) explain that many mothers may experience feelings of anxiety and confusion, because of their unrealistic expectations of motherhood. The first-time mothers in this study also experienced similar feelings. Compas *et al.* (1998) agreed that adolescents often experience symptoms reflecting a mixture of anxiety and depression. Depressive symptoms, according to Hudson *et al.* (2000), are common amongst adolescents. This generally leads to increased instances of PND amongst adolescents. Depressed adolescent mothers experience anxious depressive feelings with the sudden awareness of motherhood, including feeling confused between the responsibilities of adolescence and motherhood (Clemmens, 2002).

4.2.2.3 (f) Experiencing crying spells

After the birth of her baby, one mother reported that she experienced crying spells.

“After 2 weeks after birth I experienced depressive symptoms. I cried a lot, I blamed myself for allowing this to happen to me; for sitting with a baby. I did not enjoy the things I did with my friends before the pregnancy. I could not go out with my friends, because I had to look after my baby.” (Eden, 18)

Some of the participants in this study experienced crying spells, because they could not understand what they were going through. They felt trapped, frustrated, overwhelmed and helpless. The adolescent mothers did not realise that they had a serious illness, because they believed that they were to blame for their pregnancies and feeling depressed. The research of Dalton and Holton (1996) found that if mothers are continuously experiencing crying spells after the first two weeks of childbirth, then they are most likely to be diagnosed with postnatal depression. Postnatal depressed mothers will benefit from receiving treatment.

4.2.2.3 (g) Could not enjoy things they previously enjoyed

These participants expressed their frustration after childbirth, in not enjoying life as they previously enjoyed before their depression and their pregnancies.

“Everyday I cried, I didn’t enjoy what I enjoyed before I had my baby. I pushed my friends away from me.” (Yolanda, 18)

“My friends rejected me. I couldn’t do the things I used to enjoy doing. My family was talking about me behind my back and my parents were disappointed.” (Michelle, 19)

*“I did not enjoy the things I did with my friends before the pregnancy.”
(Eden, 18)*

Most of the adolescent mothers in this study described that their relationships with their friends and family changed, because they did not have time to socialize with anyone else besides their babies. They felt that their friends rejected them, because they did not have a baby of their own. The participants tried to come across as completely normal and happy when they were with other people, but when they were alone they blamed themselves for feeling moody and depressed. Hurlbut *et al.* (1997) identified women with depressive symptoms as being unable to enjoy normally pleasurable activities.

4.2.2.3 (h) Murderous thoughts

One mother reported that she had murderous thoughts towards her baby. She could not describe what was happening to her at that time. One of her family members noticed that she was very distant from her baby and talked her into speaking to her doctor.

“There were times when I felt like murdering my baby (between the 2-5 month period after childbirth), but as soon as that began to happen, I went to a psychologist who explained that I just had to remain calm and that my past and feelings during the pregnancy was affecting the way I felt.” (Tanya, 17)

Wilcox *et al.* (1998) explain that adolescents present similar depressive symptoms to those of adults. This assumption has influenced the identification and description of depression in adolescent mothers. Garrett and Tidwell (1999) reported that many mothers with postpartum depression are preoccupied by anxious, distressing and recurrent thoughts about harming their babies. Donahue-Jennings *et al.* (1999) describe that these delusions involve irrational obsessions concerning the newborn baby. Mothers who are depressed experiencing thoughts of harming their babies, of hurting themselves or thinking about committing suicide are less likely to act on those thoughts.

4.2.2.4 Difficulty in coping with new role of being a “good” mother

Each mother had similar reactions to the birth of her baby and was anxious about her role as a mother. The major concerns were coping with mothering i.e. taking care of the baby and taking care of themselves. Coping with their lifestyle changes proved to be difficult for these new mothers. All the mothers questioned their own capabilities of caring for their baby.

“I felt bad about myself and felt that I had no mother qualities.”

(Yolanda, 18)

“I thought that I was crazy and not being a good mother. It felt as if my mother and sister were doing a better job of looking after my baby.”

(Britney, 16)

“I thought that a mother has mothering innate abilities and I was not one of them. That was the best way to describe what I was going through.” (Celine, 17)

“I realized that I had more responsibilities as a mother. It did not feel that I had the motherly instincts.” (Eden, 18)



Walker (1995) discussed the discourse of motherhood i.e. society's acceptable role of the 'Good Mother'. She also described mothering as the practice of motherhood. This includes the act of childbirth, the physical care for the baby and the emotional nurturing i.e. looking after the infant. Elvin-Nowak and Thomsson (2001) discussed that the woman who becomes a mother is expected to become responsible. The good mother is supposed to take her mothering responsibilities seriously and act maturely. The mothers in this study discussed how difficult it was to cope with their depressive symptoms and to nurture their babies. They became inferior about not being a good mother and for experiencing unpleasant feelings towards their babies. According to Terre Blanche (1996), the media in South Africa portrays

motherhood to be a pleasant, positive and absolutely worthwhile experience. However, the mothers in this study did not share this view.

Pridham and Chang (1992) discuss that special abilities and energy are required in performing the new tasks involved in caring for a baby. Children that are restless, weepy or easily irritated decrease the mother's coping abilities by increasing her exhaustion and tiredness. The study of Tarkka *et al.* (1999) show that if the mother's inability in coping with her baby increases, the mother can easily question her own capacities and capabilities of caring for her infant. Adolescent parenting, according to Leadbeater *et al.* (1996) presents challenges to young mothers that they are often unprepared for parenting. This may contribute to high rates of depression.



4.2.2.5 Mother-infant relationship – problems with bonding

In this study, the first-time mothers described the first few days returning home with their newborns as a stressful experience. These findings are supported by the research of Cronin (2003). All of the mothers in this study found caring for their baby difficult and it took some time to get used to the reality and the responsibilities involved. They spoke openly about their feelings of motherhood, adjustment and role change. The mothers separated themselves emotionally or physically from their infants and withdrew from interactive situations, as shown in the following statements:

“I did not want to interact with the child in the first few months. I did not want to get too close to him. I was more concerned about my studies and my relationship.” (Tarryn, 19)

“I did not know how to react or how to nurture him. My mother and older sister helped me in caring for my baby.” (Britney, 16)

“There was a time when I didn’t even want to touch the baby.” (Melissa, 19)

“I was quite distant towards the baby. I was a bit angry and disappointed at myself that he (the baby) had come along. I spent limited time with him. I limited any sort of interaction with him.” (Tarryn, 19)



The study of Goerge and Lee (1997) show that children of adolescent mothers have an increased risk of being maltreated. Beck (1996) and Kumar (1997) found that depressed mothers experience problems of bonding with their newborn and they separate themselves emotionally and physically from their children. Depressed mothers often display very little affection towards their babies (Murray & Cooper, 1997) and often experience negative perceptions of themselves and/or their baby (Heneghan *et al.*, 1998). Green and Murray (1994) discussed that even the prenatal depression of the mother have direct and indirect effects on the fetus. The mother directs her poor health behaviours, the possible physiological effects of depression and her

negative feelings toward the unborn infant. Beck's (1995) research showed that depressed mothers may not pick up their infant's signals, gestures, smiles or vocalisation and this means that the infant's needs are not satisfied. This may affect their infant's language development, problem-solving ability, mastery motivations and social competence.

4.2.2.6 Lack of social support after childbirth (emotional or financial)

Many mothers felt lonely before and after childbirth, which was also found in the research of Hudson *et al.* (2000). Adolescent mothers may experience a lack of communication, emotional closeness and support from their parents (Rodriquez & Moore, 1995). The participants in this study discussed their lack of support from their loved ones.



“My mother just left me. I stressed because I had no money for myself, everything I had, had to go to my baby.” (Yolanda, 18)

“I did not have enough money to support myself or my baby. I had barely enough money to support my baby and to buy her milk. All my money was invested in my baby. My boyfriend could not support me.” (Eden, 18)

After childbirth, the participants described their dependency on the support of their parents, family members, friends, partners or professionals. Although the support of these people were not always available.

“The fact that my boyfriend and the father of the baby rejected me and didn’t even want to see the baby. My friends’ rejection me put major strain on me, because I didn’t have anyone to talk to about my situation. My parents’ rejection threw me totally off-guard and drove us away from each other.” (Melissa, 19)

The demands of motherhood leave little time or energy for other relationships. Passino *et al.* (1993) describe social support as one of the different aspects during the transition to parenthood for adolescents. Many of the adolescent mothers experienced a sense of abandonment which deepened their depression. The fact that adolescent mothers who experience a sense of abandonment may deepen their depression, emphasized the need to keep depressed mothers attached to their families or their peers.

“Not only did my boyfriend leave me, but I felt that I am stuck with a package for the rest of my life.” (Yolanda, 18)

Some mothers experienced a lack of support from their parents. This was also found in the research of Yampolskaya *et al.* (2002). Clemmens (2002) agrees that the lack of social support from family or friends during the mother’s pregnancy has a negative effect on the mother’s mental health. This is one of the factors that leads to depression.

4.2.2.7 Received social support (emotional or financial)

Support emerged as a strong theme, with multiple sources. These sources included the participants' mother, partner, partner's parents, family-members and professionals. The first-time mothers mostly received support from parents or family members during and after childbirth. They helped in caring for the baby by providing financial and emotional support. Support was available to some of the young mothers, during the first few days after childbirth. One mother reported that her partner provided her with both physical and emotional support.

“My boyfriend is very supportive. He showered us with his attention. His family was also helpful. We are trying our best to make the relationship work and to be responsible for our baby. My boyfriend has a casual job while he is studying. He contributes a lot financially and emotionally”. (Celine, 17)

Many participants identified their mothers as the central person in providing support. These participants have a close relationship with their mothers. The participant's mother provided direct childcare or became the main carer of the baby. The study of Cronin (2003) also identified the mothers of the participants as the main source of providing support to the depressed participants.

“My mother always helped to keep calm and reassured me that things will become easier. She stood-up during the nights to feed the baby so that I could get my rest and get enough sleep. My family also helped to change the baby’s nappies. I do not know what I would have done without the help of the family.” (Britney, 16)

All the first-time mothers were asked whether other means of support were required. Services most often requested related to group support, which would provide other young mothers with the comfortable environment to share their experiences, express their feelings without feeling guilty and the comfort that people would listen to your problems without being judgemental. This clearly has implications for future practice and service development.



4.2.2.8 Loss

The identification of “loss” as a theme emerged from the interviews of the depressed mothers about motherhood and depression. They identified a range of feelings, which had a negative affect following childbirth and discussed what they had lost during and after their pregnancy. This theme was also identified in the study of Nicolson (1999).

All the first-time mothers described their experience of becoming a mother as a life-changing event. This process involved their realization of putting another human being’s needs first and losing their youth identity in order to incorporate their new identity as “mother”.

4.2.2.8 (a) loss of relationships with partner / friends / parents/ family members

Most of the mothers became overwhelmed with their new burden and needed the support from their parents, family members or the father of the baby. Instead, the mothers were abandoned by their loved ones. They had to deal with the responsibilities of their newborn and the rejection or loss of their relationships with their family or partner.

“The baby was unplanned, I had to leave my studies and I lost my boyfriend.” (Yolanda, 18)

“... my parents were disappointed in me. My friends rejected me. My family was talking about me.” (Michelle, 19)



The research of Tanga and Uys (1996) about the social support system of unmarried adolescents in South Africa found that both parents and peers are important to provide pregnant mothers with the necessary support they needed. Most of the young mothers in this study, however, did not receive emotional (or financial) support from their parents, partner or peers. These mothers described their negative experiences of being rejected or abandoned by the people who were close to them before their pregnancies.

4.2.2.8 (b) loss of former appearance or body

Some participants reported that they had lost their former appearance. They expressed their anxieties, because their appearance had changed in a negative way. They identified this as a source of their depression.

Appearance, especially body size was on everyone's mind at some stage during and after pregnancy.

"I gained a lot of weight. My feet were swollen and brown marks formed in my face." (Melissa, 19)

"My body was changing and my personality as well. I got fat and felt ugly and hated my new look." (Yolanda, 18)



"My body started growing in all directions and I hated it. I wasn't myself at all. I felt hopeless and ugly and I wanted to die." (Michelle, 19)

"I did not care about myself. I did not care about my hair and usually wore a ponytail. I seldom had time to take care of my body and usually washed myself late afternoons. I walked around in my pajamas. I felt so sloppy." (Eden, 18)

"I had a low self-esteem. I was always worried about my image, but now I washed my hair once a month. I wore my only 2 tracksuits almost every day." (Yolanda, 18)

In the phase of adolescence, body image and the self-image are important developmental tasks. Sugar (1993) describes how adolescents regard themselves or their bodies as unattractive or unacceptable if their bodies do not conform to their peers' bodies or to the image portrayed by society. Girls appear to react negatively to bodily changes which they perceive to be in a direction that is socially undesirable. The research of Lederman (1996) and Mercer (1995) indicate that many mothers feel unattractive while being pregnant. Putting on weight even during pregnancy may be intolerant for some women, especially in a society which values slender females. In this study, body image was closely linked to the female's self-image. Most of the adolescent mothers regarded themselves as unattractive females and complained of being fat and ugly.



4.2.2.8 (c) loss of independence and youth

Spending time on themselves, socializing by themselves and being able to put themselves first on their list of priorities was no longer possible for the first-time mother if they were to maintain their (desired) identity as a responsible mother. The change in becoming a responsible mother led to the participants' confrontation with the loss of their previous identity as a teenager.

"I was sick and tired of devoting my life entirely to my baby. I forgot what it used to be like to just take care of myself and come and go as I please." (Celine, 17)

“It felt as if I ruined my teenage life. My life was shattered.” (Eden, 18)

*“I did not enjoy the things I did with my friends before the pregnancy. I could go out with my friends, because I had to look after my baby.”
(Eden, 18)*

“I did not get enough sleep. I couldn’t cope with my colic-baby. It was difficult to get used to the baby’s routine. It felt that I lost my own identity.” (Eden, 18)

Pregnancy for an unmarried adolescent, according to Jepson *et al.* (1999), poses a serious developmental crisis. The pregnant adolescent is still in the phase of getting to know themselves and they are still discovering who they are. Going through the adolescent phase or changes and having to deal with the transition to motherhood, manifest higher levels of stress and depression. The participants in this study went through a difficult time while they were pregnant and after childbirth. They had to be responsible mothers in putting their needs aside and had to be in-tuned towards their infant’s needs.

4.2.2.8 (d) loss of academic career or occupational identity

Their new babies represented a significant change for them, because it meant a loss of their “expected” future”, especially the loss of the expectation of returning to school.

“I just wanted to get my life back to normal and wanted to start studying again and getting my life sorted out.” (Tarryn, 19)

“I had to leave my studies and went job-hunting, but am not qualified for the jobs advertised.” (Yolanda, 18)

“I was stressed out because I still needed to study. I became frustrated and depressed.” (Michelle, 19)

“The hard decision that I had to make after the birth was to marry the father despite our issues. Having to deal with being a mother, being a wife, taking care of the family, and to work to maintain our finances.”

(Tarryn, 19)



The ideal perception of childbirth would be that a mother is starting a new and exciting life full of cheerfulness and the pleasant bonding experience with her newborn (Elvin-Nowak & Thomsson, 2001). This means that the mother should be overjoyed with the arrival of her newborn. However this proved to be the opposite for the participants in this study, as the analysis of the women’s accounts revealed. Many teenage pregnancies, according to Trad (1999), result in a dramatic disruption of the mother’s education and career plans. The mothers described in this study that they are not gaining anything by having a baby, but rather are losing their positive vision of their academic future.

4.2.3 PERCEPTIONS OF THE CAUSES OF PND

All the mothers experienced negative perceptions of themselves. They could not understand or describe what was happening to them at that time. The mothers tried to rationalise their behaviour or thoughts by giving the following examples:

4.2.3.1 (a) Avoidance

“I did not think or I wanted to forget the fact that everything was going on around me and I wanted to go on as usual. So I did not think about it much.” (Tarryn, 19)



“I did not think much.” (Britney, 16)

“I did not really think about what was happening to me at that time. I just wanted to get my life back to normal and getting my life sorted out.” (Tarryn, 19)

“I didn’t think, I just lived day to day.” (Yolanda, 18)

It seems to be extremely important for a mother who is experiencing postnatal depression, to receive treatment as soon as possible. A variety of treatments (Wisner *et al.*, 1999) are available for the mother in order to cope with her symptoms. The mother in this study, however tried to avoid the symptoms of

postnatal depression, because they did not know how to address or cope with their symptoms.

4.2.3.1 (b) Religious discourse

“I thought that God was punishing me for having a baby and having sex before marriage.” (Tanya, 17)

One of the participants in this study described that she did not seek help for her depressive symptoms, because she believed that God was punishing her for engaging in sexual activities before marriage. Beck (1998) reported that mothers that are suffering from postnatal depression must break their silence, because the earlier postnatal depression is recognised, the earlier it can be treated.



4.2.3.1 (c) Biological explanations

“At first I thought that it was just a hormonal thing and then I went to the doctor.” (Celine, 17)

Stoppard (1997) described that if women seek an explanation for their depressive experiences in terms of bodily processes (e.g. hormonal changes associated with pregnancy), she removes the possibility that her own actions and experiences had an influence on her depression. These mothers feel that they inherit depression and it cannot be controlled or treated. Stoppard (1997)

further explained that women's vulnerability to depression arises in the social circumstance of women's everyday lives. Depressed mothers need to deal with their circumstances of their everyday lives and to understand what was happening to them at that time. This process leads to the empowerment of women in helping them to regain control over their lives and to change their perception of their depression.

4.2.3.1 (d) Lack of understanding

"I did not understand what was happening to me. I felt useless and disappointment." (Eden, 18)

"I really can't explain what were the causes of my depression." (Britney, 16)



Susman (1996) explained that despite the high prevalence of postnatal depression, many times the symptoms of PND are dismissed as normal physiological changes associated with childbirth. Postnatal depression can cause significant functional impairment that can create havoc not only on mothers, but also on the entire family. This emphasises the fact that this is important for general practitioners or physicians to identify the symptoms of PND in mothers and assist them with the necessary support.

4.3 KEY FINDINGS

The study has raised a number of issues in relation to needs, perceptions and experiences of first-time mothers. Valuable insights was achieved by gaining details concerning young mothers' experiences of childbirth, relationships between families or professionals and how they coped through the various stages from childbirth.

The study revealed that first-time mothers were unprepared for the birth of their baby and motherhood. After childbirth, the first-time mothers reported a great dependence on their mothers in helping them in their new mothering role. The need for physical, emotional and social support emerged during the participants' pregnancies, the birth experience and after childbirth. The maternal mother emerged as a central figure in providing support for the depressed participant. Mothers of participants provided childcare, advice and emotional support. Participants who moved more easily into their maternal role were those who were supported by their mothers or partners.

Support continued to remain important during the first few months of the baby's life. This was seen to vary with each mother in terms of who gave the support, when it was given and its quality. The findings suggest that those in long-standing relationships received support from their partner either by him taking some responsibility for childcare or providing emotional support. Overall support from participants' mothers remained central throughout the first few months after birth.

The first-time mothers appeared to be bonding with their babies after receiving counseling and they understood what PND was all about. The quotations of the participants' experiences of receiving counseling were not reported in this study, because it was not linked to the aims of this study. The mothers referred to receiving individual and group counseling as a positive experience. They also referred to the therapy-sessions as a supportive environment for first-time mothers to describe what they were going through at the time of their depression. This process empowered them firstly, in recognising their depressive symptoms and experiences; and secondly, by helping other adolescent or first-time mothers in sharing their stories. There is clearly a need to enhance support systems for first-time or adolescent mothers and also providing them with the necessary information about childbirth or taking care of a newborn baby.



CHAPTER 5:
LIMITATIONS OF THE STUDY AND
RECOMMENDATIONS FOR FUTURE RESEARCH

5.1 LIMITATIONS OF THE STUDY

Although this study tried to give a voice to adolescent mothers about their experiences of motherhood and being depressed, it has very specific limitations. The eight participants who shared their experiences of motherhood and depression were from urban, middle-class families. They were from two of the historical racial categories. The greater part of this study consisted out of “Coloured” females, while “White” females represented the lesser part of this research. The voices of certain groups such as “Black” females, women living in rural areas and women belonging to lower-class or upper-class families were not represented in this study. In addition, participants’ attitudes and perceptions were strongly influenced by factors linked to the unique socio-cultural and historical context of South Africa, such as race, age, religion and culture. This suggests that women, far from being a universal and homogenous group, have needs that are unique to the South African context. Although an exploration of all these dimensions was outside the scope of this study, it has also been questioned to what extent the standpoint researcher was able to understand women’s fragmented identities (Olesen, 2000). Although some of the contexts in which women’s experiences are differentially constructed were explored, a richer and more detailed understanding of how such constructions are formed was not attempted here.

Notwithstanding these limitations, it is hoped that this study highlighted the complexity of young women's lives and the importance of implementing programs about using contraceptives or information about childbirth and teaching parenting skills to first-time mothers.

According to Olesen (2000), within the context of the feminist research knowledge production is an ongoing, dynamic process. In this light, the researcher is aware that the knowledge gained here is only partial knowledge; being constructed in interaction between the researcher and participants, at a particular point in time. The findings of this study can provide a platform for action and restructuring, as the contexts of women's lives continually change and give way to new ideas.



5.2 RECOMMENDATIONS FOR FUTURE RESEARCH

Children are also the victims in families where women are experiencing depression. As Samuel (2001) stated that even in times of severe resource limitations, the vulnerable members of society must be protected. Future studies could identify these vulnerable populations, thereby perhaps supporting a case for selective rather than universal screening, which targets high risk groups like pregnant women.


As delineated by this study, a primary prevention approach is thus essential, as are long-term studies of the experiences of first-time or adolescent mothers. As standpoint theory reminds us, the insider knowledge of women

with experience of postnatal depression can be a valuable resource in the designing of such interventions. The findings of this study can be used in a broader study in order to gain more in-depth insight to PND by using a combination of quantitative and qualitative research, which will provide statistical and in-depth data.

5.3 CONCLUSION

the young women's voices in this study are essential in terms of rebuilding our assumption of social norms, values and ideas about the definition of a mother. Many women are suffering in silence, because they do not know the implication of Postnatal Depression on their lives and the loved ones around them. Hopefully feminist research will help women to regain control over their lives by sharing their stories with other women. The stories of these young mothers in this study will lay a foundation of knowledge to practitioners or nurses working with first-time adolescent mothers that are suffering from Postnatal Depression in order to help them to deal with their illness.

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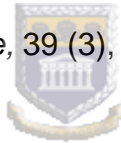
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APPENDIX A: PERMISSION LETTER TO ACCESS PARTICIPANTS

05 September 2004

Dear Doctor/s

Thank you for reviewing my request to access participants at the clinic. My name is Simone Moses and I am a Masters Research Psychology student in the department of Psychology at the University of the Western Cape. I am interested in exploring young women's experiences and perceptions of Postnatal Depression. Previous research studies done on postnatal depression focused mainly on adult mothers. This study will only focus on adolescent mothers and the information that will be obtained from this research will explain the experience of depression for adolescent mothers. These issues will further enhance the body of knowledge available to practitioners working with adolescent mothers.

Please find the full research protocol, approved by the senate committee of the University of the Western Cape. If you require any further information, I will be contactable on (021) 959-2838/2617.

Your contribution is very valuable and your time will be appreciated.

Kind regards,

Simone Moses

APPENDIX B: LETTER TO PARTICIPANT

05 September 2004

Dear Mother

This research project explores young women's experiences and perceptions of Postnatal Depression. Previous research studies done on postnatal depression focused mainly on adult mothers. This study will only focus on adolescent mothers and the information we obtain from our research will explain the experience of depression for adolescent mothers. These issues will further enhance the body of knowledge available to practitioners working with adolescent mothers. You will be asked to share or talk about your own experience with postnatal depression and your experience of being a mother. The individual interviews will be held in the comfort of your own home for about one hour. The session will be audio-taped to assist the researcher in keeping an accurate record.

All information gathered from this research will be treated confidentially. The written report about the research will not mention the names of the mothers or the babies. You are welcome to change your mind at any time during the interview, about participating in the project. If you have any questions please contact Simone Moses on (021) 959-2838/2617.

Your contribution is very valuable and your time will be appreciated.

Kind regards,

Simone Moses

APPENDIX C: CONSENT FORM

Dear participant

The information that will be gathered during the interview will be used in a research thesis. The thesis is in partial fulfilment of a Masters Research Psychology Degree in the Department of Psychology at the University of the Western Cape. Your identity will remain anonymous at all times. The interview will be conducted in the privacy of your own home. You can change your mind at any time about participating in this research project. After the interview, you will receive a copy of the interview to read, in order to make any changes to the transcript. The process will ensure that the researcher captured what you were saying or feeling. After the thesis has been written, all the interview tapes will be erased to ensure confidentiality. During the interview, the researcher will take on a role as a researcher and not as a therapist. If you experience any emotional distress, the researcher can assist you by referring you to an appropriate counsellor. Your participation in this research project will be greatly valued and appreciated.

Please tick the relevant box:

Participant's Name: _____	Age of Participant: _____
Gender of Baby: _____	Age of Baby: _____
Today's Date: _____	Daytime Contact Numbers: _____
<input type="checkbox"/> YES , I will participate in the research. Signature: _____	<input type="checkbox"/> NO , I will not participate in the research. Signature: _____

APPENDIX D: INTERVIEW SCHEDULE


DEMOGRAPHIC DETAILS OF PARTICIPANTS

Age of the mother (participant)	
Sex of baby	
Age of baby	
Education level of the mother	
Living arrangements (Living with parents/own)	
Infant health (Excellent/ Good/ Poor)	
Place of birth (State/ Public Hospital)	
Type of delivery (Normal/ Ceasarian)	
Hours of labour	
Method of feeding (Breast/ Bottle)	
Length of stay in hospital	
History of depression (1 st diagnosis)	
Year diagnosed with Postnatal Depression	
Treatment received for Depression	
Length of treatment	
Was your pregnancy planned or unplanned? Yes/ No	

A PREGNANCY

1. Tell me about your pregnancy.
2. What were the (physical, psychological, emotional) things or changes that you went through while you were pregnant? (PND symptoms)
3. How did you feel about those changes that you went through at that time?
4. What did you think about what was happening to you at that time?
5. How did you feel about your baby while you were pregnant?

B BIRTH OF THE BABY

1. Tell me about your (physical, psychological, emotional) experience of giving birth to your baby. 
2. How would you describe the birth of your baby?
3. How did you feel about the birth of your baby?

C AFTER THE BIRTH OF YOUR BABY

1. Tell me about your (physical, psychological, emotional) feelings after the time of your pregnancy.
2. How do you feel after the birth of your baby? (Is there a difference?)
3. How did you react towards your baby? (With love, anger, etc.)
4. What (physical, psychological, emotional) changes did you go through after giving birth to your baby?

5. What did you think was happening to you at that time?
6. Tell me about the difficult things or experiences you went through after the birth of your baby.
7. How long did the negative experiences last?
8. How did you understand or what did you think were the causes or contributing factors to these feelings, thoughts or behaviours (to the specific way you were thinking or feeling)?
9. Was there anything positive that came out for you?

