The Perinatal Mental Health Project: A qualitative evaluation.

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ABSTRACT

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This study evaluates, qualitatively, the PMHP (Perinatal Mental Health Project), which involves routine screening of women, during the antenatal period, for postnatal depression (PND) and other mental conditions related to childbirth. This antenatal screening facility is offered at the LMOU (Liesbeeck Maternity Obstetric Unit). Women who appear to be at risk are offered counselling by a volunteer psychologist or clinical social worker providing a potentially excellent intervention for women during the perinatal period. Women, particularly mothers, in South Africa are subject to social stressors, which are exacerbated by class inequalities within the health care system. Motherhood also requires a total change of role, resulting in the loss of former psychological identity and adds the stress of mediating family relations as the balance of relationships and power are affected. However, most societies glorify motherhood and refuse to consider that it may have a dark side and this contributes to the imprisonment of women within a sometimes-difficult role. Feminist Standpoint theory provides a theoretical framework for this study as this woman centred viewpoint suggests that there should be caution when labelling women with postnatal depression whereby it is seen as an illness, interpreting distress as individual pathology. On the whole perinatal mental health problems have been pathologized and medicalized, denying the social conditions that women may endure and simultaneously marginalizing the validity of women's voices. This study was essentially exploratory

in nature, using qualitative methods to obtain the data. The research drew from Guba & Lincoln's Fourth Generation Evaluation method as it views cultural and political elements as enhancing the evaluative process. Consistent with this method, the major stakeholders of the PMHP were selected as participants. This included six women who and been screened and counselled at the LMOU as well as six midwives, two counsellors, a psychiatrist and the project manager. The data was analysed thematically. The results suggest that the PMHP has provided an excellent source of social support but also highlights the difficulties of implementing a project of this nature within an under resourced biomedical context. This research will hopefully contribute towards a paradigm shift by highlighting women's social location within the construction of perinatal mental health problems.

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DECLARATION

I declare that *The Perinatal Mental Health Project: A qualitative evaluation* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Full name: Julia Chesselet Date: November 2005

Signed: _____

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CHAPTER ONE

INTRODUCTION

1.1 OVERVIEW

The rhetoric of motherhood reflects the belief that the birth of a child is a consistently 'happy event' and that motherhood itself is a universally fulfilling experience for women (Lewin & Oleson, 2000). Psychological research, however, indicates that the first three months postnatally represents an extremely high risk period for significant emotional distress (Beck, 2002; Austin & Lumley, 2003) and that women are more prone to suffer debilitating depression after childbirth than at any other time (Boyce 2003; Cutrona, 1984; Pfost & Stevens, 1990)

The biomedical model refers to postnatal depression (PND) as a depressive episode that extends into the postpartum period, which has a clinical picture similar to that of non-psychotic major depressive disorder. There is little evidence to support a hormonal aetiology, although oestrogen sensitivity may play a role for some women (Boyce, 2003; Cutrona, 1984; O'Hara, Schlechte & Lewis 1991). "Postpartum depression" is a clinical term for postnatal depression, which refers to a major depressive episode that is temporally associated with childbirth (Epperson, 1999).

There is little consensus as to the incidence of PND (Nicholson, 1989; 1999). Generally it is suggested that PND affects 10- 15% of mothers in developed countries (Holden, Sagovsky & Cox, 1989) but prevalence statistics do vary. In developing countries, such as South Africa, the reported prevalence is very high, for example, in Khayelitsha, in the Western Cape, the incidence is 34.7% (Cooper, Tomlinson,

Swartz, Woolgar & Murray, 1999). This staggering statistic resulted in the founding of the Perinatal Mental Health Project (PMHP), a pilot project, which was started at the Liesbeeck Maternity Obstetric Unit (LMOU) in Mowbray, Cape Town.

This study aims to evaluate, qualitatively, the PMHP, which involves routine screening of women, during the antenatal period, for PND and other mental conditions related to childbirth. The best predictor of PND has been shown to be during pregnancy, and the optimum time for diagnosis and management is antenally (Boyce, 2003; Spenelli, 1998). This suggests that the antenatal screening facility, that the LMOU offers, is important so that intervention and care planning can take place most effectively. This project could potentially provide an excellent source of social support and treatment for women during the perinatal period.

Women who appear to be at risk are offered counselling by a volunteer psychologist or clinical social worker. Research has indicated that at least 23% of PND starts during pregnancy and onset varies from twenty four hours to months postnatally (Wynchanck, 2002). As the prevalence of PND is higher than other perinatal mental health conditions, it is the main focus of the project and this study. The screening of women at the LMOU occurs as part of a routine antenatal check up which ensures that both the emotional and the physical needs of the women are attended to. The project uses the Edinburgh Postnatal Depression Scale (EPDS), which is a depression rating scale that has been validated for South Africa and has been developed for screening during both the prenatal and postpartum period. In addition, a Risk Factor Assessment (RFA) is used, which has been specifically adapted for this client population. If the

results indicate that the client has, or is at risk for developing perinatal mental health problems, counselling is offered.

The LMOU is part of the Peninsula Maternal and Neonatal Services (PMNS), which is the state-run obstetric and neonatal health system. It consists of eight MOUs, mainly in the Cape Flats, two secondary hospitals, Mowbray Maternity and New Somerset, and a tertiary referral unit at Groote Schuur Hospital. The LMOU was chosen to host this pilot project because it is the best resourced of all the MOUs. The intention is to extend the project to the other MOUs in the Western Cape. Recently funding has become available from the Provincial Government Metropolitan District Health Services to extend the project to Hanover Park and Heideveld MOU's (Honikman, 2005).

The PMHP was started by a group of health workers who were concerned about the high prevalence of PND and other perinatal mental health problems, in South Africa, especially in the impoverished communities who are most at risk for these mental health disorders (Cooper et al., 1999). It is also hoped that an awareness of mental health problems in the public health sector could result in an improvement in obstetric health care. This project was started against a backdrop of overburdened health resources and an unmet need for women's mental health care (Honikman, 2003).

The department of National Health and Population Development in South Africa's mission for primary health care is "to ensure the provision of cost effective primary health care to all the inhabitants of South Africa (Department of National Health and Population Development 1992: p6 – cited in Dennill, King & Swanepoel, 1999). A

key priority is the health care of women and children, and it has been indicated that by promoting their health, the social and economic burdens on the community can be reduced (Dennill et al., 1999). In 1995 the Maternal, Child and Women's Health Plan (MCWH) was developed and the South African government became a signatory to the Convention of Rights of the Child. Soon after this the Government of National Unity announced free health care for mothers and children under the age of six years.

However, the implementation of the MCWH policy has been slow and under resourced. The facilities on the whole are swamped and overextended to meet the needs of the people, which has, in many instances, resulted in a frustrated and demotivated work force (Dennill et. al., 1999). Studies have shown that patients using parts of the Cape Town obstetric service experience clinical neglect and even verbal and physical abuse, particularly towards disempowered black woman patients. Research has demonstrated that origins of the problems are complex but partly lie in poor conditions within the workplace. (Jewkes, Abrahams & Mvo, 1998).

The PMHP began with a series of workshops, developed by a multidisciplinary team, pertaining to perinatal mental health. The four-hour workshop was run for the nursing staff of the LMOU, and was presented by two facilitators. A Perinatal Health Handbook was developed to complement the workshop training and to act as a permanent resource for each unit (Honikman, 2003). The introduction to the workshop involved an exploration of personal or professional experiences of the perinatal period. The staff were encouraged to reflect on how these experiences affected their relationships with clients. This was followed by a presentation of common perinatal mental conditions with a didactic training on risk factors, signs,

symptoms, management and prognosis. Listening and basic counselling skills were introduced through narrative and role-play techniques. The workshop ended with an introduction to the Perinatal Mental Health Handbook with its referral directory and screening tools, a discussion of local resources and important issues in referring with a proposed management protocol (Honikman, 2003).

1.2 RATIONALE FOR THIS STUDY

Women centred approaches suggest that the term 'postnatal depression' is a misnomer if it implies that the woman herself is 'ill' and the distress is caused by an internal dysfunction resulting from childbirth (Ussher, 1997). Nicholson's (1999) study suggests that depression following childbirth is not a clinical condition but the origins are located in the context of problematic relationships, economic and political factors as well as women's expectations and inadequate preparation for childbirth and early motherhood. From this perspective the depression appears to be reactive and is embedded in female psychology and wider cultural values, rather than determined by individual pathology (Nicholson, 1999).

A feminist or women centred viewpoint suggest that there should be caution when labelling women with postnatal depression whereby it is seen as an illness, interpreting distress as individual pathology (Ussher, 1997). It is clear that many women are distressed after childbirth but as Nicholson (1999) notes that the etiology of postnatal depression is ambiguous. She argues that the depression may be a normal part of the experience of motherhood or even an adaptive process allowing the woman to grieve for her lost self. On the whole perinatal mental health problems have been

pathologized and medicalized denying the social conditions which women may endure (Nicholson, 1990).

Both feminist and biomedical research indicates that if left unrecognised perinatal emotional disturbances can linger for months, or even years postpartum (Boyce 2003; Coghill, Caplan, Alexandra, Robson & Kumar, 1986; Nicholson, 1989; Ussher, 1997) and has potentially significant long-term effects on the mother, the child, and their relationship (Fuggle & Haydon 2000; Cooper et al.1999) as well as on the mother's relationship with her partner and other family members (Boyce, 2003; Kumar & Robson, 1984).

It is, therefore, of great concern when depression is not identified. The rationale of this study arises out of a realization of the lack of perinatal social support for women in the Western Cape, with deep divisions between private and public health facilities and resources (Chadwick, 2003). It is therefore of great importance that the PMHP is evaluated within a feminist framework, which considers the social, political and economic influences on women's mental health.

1.3 AIMS AND OBJECTIVES

In an attempt to ensure that the needs of the clients are effectively met, it is essential that the effectiveness of the PMHP is assessed. The present study is in response to this need. The primary aim of this study is to explore the adequacy and efficacy of the PMHP as an intervention, through an exploration of the perceptions and experiences of the staff and clients who are involved with, or have been exposed to the project.

This was achieved through an exploration of the perceptions of all the participating staff and clients with regard to the positive and negative aspects of the project. This includes the key benefits as well as concerns and issues that have arisen. A further aim was to develop recommendations intended to improve the services offered by the project, and thereby improve the care given to women during the perinatal period. This study allowed for shared viewpoints from the staff, without these perceptions being perceived as biased, and from the clients, by giving the mothers a 'voice'. The intention of the study is to be both educative and empowering, a method consistent with the feminist theoretical framework.

The focus with regard to the midwives includes how the screening process has impacted on their daily routines and their perceptions of the client's responses to being screened. A further aim is to assess whether the project has impacted on their awareness of the psychological and social implications of childbirth as well as self-awareness. It is important to ascertain whether the project has enhanced or hindered their roles as midwives. With regard to the counsellors, psychiatrist and project manager, the aim is to explore their perceptions of how their roles have impacted on the project and whether they perceive the environment and context conducive to effective consulting.

The project aims to provide a mental health service to women at the LMOU and to achieve this *all* pregnant women are screened in order to identify those at risk or suffering with perinatal mental health problems. This study aimed to explore the participating client's perceptions of being screened as well as their experiences relating to being counselled. In relation to this, the intention is also to ascertain the

client's perceptions of their mental health postnatally. The objectives of the study are, therefore, to:

- Explore the experiences and perceptions of a sample of staff who have been involved in the PMHP.
- Explore the experiences and perceptions of a sample of mothers who have been serviced by the project, and to identify their needs and expectations.
- Make recommendations on how interventions can be improved, and suggestions with regard to the potential rolling out of the project to other MOU's in the Western Cape.

1.4 SIGNIFICANCE OF STUDY

This evaluative study of the PMHP could have a significant impact on future strategies, in South Africa, for care and management of women antenatally and postnatally. The findings of this study could also increase knowledge about the social world, with regard to the patriarchal society's constructions of pregnancy, birth and motherhood.

Given the above the rest of the thesis will be structured as follows. In Chapter Two the salient literature regarding PND is presented, followed by a reflection on the Feminist Standpoint perspective, as well as an overview of the South African medical context. In Chapter Three, the methodology used to collect and analyse the data is described. The procedures, instrumentation, participants and ethical considerations are also presented. In Chapter Four the data is analysed and discussed within a Feminist Standpoint framework. Finally, Chapter Five concludes with a summary of the results together with recommendations, as well as the limitations of the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter begins with a historical overview of the medical model's development and definitions of postpartum conditions, which includes brief etiological descriptions of the 'baby blues', PND and postpartum psychosis. This is followed by a review of the literature pertaining to the detection, identification of those at risk, prevention and treatment of PND. The literature relating to the effects of PND on children is also discussed. This mainstream perspective is then placed within a feminist standpoint theoretical framework. The chapter concludes with an overview of the South African medical context.

2.2 MEDICAL MODEL DEFINES PERINATAL MENTAL HEALTH

The ongoing debate of the clinical characteristics and etiology of postpartum mental disorders began in the mid 19th century. In 1845 Esquirol described a variety of postnatal mood syndromes and contested their purported association with lactation (Nonacs & Cohen, 2002). In 1858 the French psychiatrist Marce first identified postpartum illness as separate from other psychiatric disorders and suggested that it could be classified into two groups: those with early onset marked primarily by cognitive symptoms such as confusion or delirium, and those with late onset characterized by a predominance of physical symptoms (Nicholson, 1990; Nonacs & Cohen, 2002).

By the turn of the century, the suggestion that postpartum disorders were clinically distinct from mental disorders occurring at other times was disputed. Consequently the American Psychiatric Association removed the term postpartum from the psychiatric nosology and constructed a diagnostic scheme that relied on the presenting symptoms of the illness. Postpartum mental illnesses were thereafter commonly termed *schizophrenic, affective, or toxic* disorders (Nonacs & Cohen, 2002).

Much research emerged from psychiatry (Kumar & Robson, 1987; Nonacs & Cohen, 2002) clinical and social psychology (Elliot, 1983; Nicholson, 1990), and sociology and feminism (Oakley, 1992; Ussher, 1997). However, there has been little cross-fertilization of ideas and findings despite reported work from multidisciplinary teams (Nicholson, 1989).

The medical model identifies a disorder or illness in individual women, who are either congenitally predisposed to depression which is triggered by childbirth or have a history of depression prior to childbirth (Paykel, 1980) or when there is no psychiatric history, PND is attributed to hormonal changes in late pregnancy and childbirth (Dalton, 1971, 1980). Feminists and the social science model implicates social factors rather than individual women, with PND conceptualised as a realistic response to birth, the maternal role in combination with other life stressors (Kumar & Robson, 1984; Nicholson, 1991; Oakley, 1992).

2.2.1 Postpartum Blues

Research suggests that 6 – 85% of women experience mild depressive symptoms, tearfulness, anxiety, irritability, mood lability, increased sensitivity and fatigue

(Epperson, 1999). This has been labelled as the *'baby blues'* and typically occurs four to five days after delivery. Symptoms of the postpartum blues include mild depression, irritability, confusion, mood instability, anxiety, headache, fatigue and forgetfulness. For most women the experience is short-lived but evidence suggests that 20% of women who experience the 'baby blues' are at risk for PND later in the postpartum period (O'Hara, Schlechte, & Lewis, 1991; Nonacs & Cohen, 2002).

Nonacs & Cohen (2002) suggest that careful observation of symptom progression during late pregnancy and the early postpartum period is warranted. Commonly reported risk factors for postpartum blues are: a personal or family history of depression, recent stressful life events or poor social adjustment, depression or anxiety during pregnancy, pessimism during late pregnancy, ambivalence about pregnancy or a view that the pregnancy was emotionally difficult (Newport, Hostetter, Arnold & Stowe, 2002).

2.2.2 Postnatal Depression

PND refers to a non-psychotic depressive episode that begins in or extends into the postpartum period. *Postpartum depression* is a clinical term referring to a major depressive episode that is temporally associated with childbirth (Epperson, 1999). It is not recognised by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) as being diagnostically distinct from major depressive episode, although it stipulates a postpartum-onset specifier if the onset is within four weeks of delivery.

The similarities between symptoms of depression and the normal sequelae of childbirth often complicate the diagnosis of PND. The diagnostic symptoms of Major

Depressive Episode and Postpartum Major Depression (PMD) are depressed mood, lack of pleasure or interest, agitation or retardation, feelings of worthlessness or guilt and thoughts of suicide. Other symptoms for PMD are weight loss, loss of energy, diminished concentration and sleep disturbance. Epperson (1999) suggests that the latter symptoms are easily confused with normal responses after childbirth.

2.2.3 Postpartum Psychosis

According to American studies postpartum psychosis occurs in 0.2% of childbearing women. This condition is the most severe of the postpartum syndromes and usually presents initially as mania. The onset is usually within the first three weeks and often within a few days of delivery (Newport *et al.*, 2002). Early warning signs include sleeplessness, agitation, expansive or irritable mood and avoidance of the infant. Postpartum psychosis is considered as an emergency, as delusions and hallucinations often involve the infant. For example, a mother may experience auditory hallucinations 'telling' her to kill the infant. Approximately 5% of women with this condition commit suicide and 4% commit infanticide (Knopps, 1993 cited in Newport *et al.*, 2002). Puerperal psychosis should be considered a psychiatric emergency.

2.3DETECTION OF PERINATAL MENTAL HEALTH PROBLEMS

Studies are evenly divided in reporting postnatal depression as either more or less severe than depression at other times (Nicholson, 1990) and there is little evidence that the nature of symptoms differs between postnatal and non-postnatal depression (Nonacs & Cohen, 2002). In diagnosing depression in the postnatal period, there is a risk that normal emotional changes may be mistaken for depression or may mask depressive symptoms (Cooper *et al.*, 1997). According to Epperson, (1999), the

detection of PND is complicated by several factors. Firstly, most women expect a period of adjustment after having a baby, Therefore, first time mothers may not recognise that what they are experiencing in not within the norm. Secondly, societal pressures to be a 'good mother' are such that if a woman does recognise that something is wrong, she may withhold her feelings out of shame and fear. Another complicating factor is that woman often do not know who to turn to if they are feeling distressed after childbirth (Epperson, 1999).

2.4. IDENTIFYING THOSE AT RISK

Risk factors, according to Beck, (1998) are characteristics that have been shown to increase the probability of developing PND. They are indicators of an increased probability of developing PND but are not directly related to the cause (Beck, 1998). Methods of identification and intervention for women particularly at risk of PND depression should be given prominence. It has frequently been suggested that a checklist of risk factors would help clinicians assess the possibility of postnatal depression occurring and identify high-risk mothers early in pregnancy. (Beck, 1998; Sheldon, 1991).

The majority of mainstream research identifies multifactorial risk factors. This includes external and environmental influences such as stressful events and inadequate social support as well as psychological and physiological factors, which arise from 'within' the women. However, there is an increasing realization that conventional risk factors are able to explain only a small part of the picture of individual and group differences in health, death and disease (Oakley, 1992). Because the exploration of health has traditionally required the search for factors causing

disease, it has resulted in an explanation of health not towards identifying 'benefit' factors, but rather towards an understanding towards 'risks' (Oakley, 1992). The risk factors are also presumed to be generalisable to all women, not taking into consideration the context of women's experience, and their different positions in the social structure (Harding, 1991).

The following is a synopsis of the most commonly recognised risk factors leading to PND. However, much of this research has been conflicting, presumably because women's experiences are context bound.

2.4.1 Family or Personal History of Depression/Anxiety

Most studies have found a significant relationship between prior history of depressive symptoms and postnatal depression (Cutrona, 1982). A family history, or personal history of depression has been reported in many retrospective, cross-sectional and prospective studies (Beck, 1995; Dennerstein, 1989; Gotlieb, Whiffen, Mount, Milne & Cordy 1989; Sheldon, 1991; Whiffen, 1992). Specifically, Watson's 1984 British study found that 60% of postnatally depressed women had a history of emotional problems. This was confirmed by Paykel, Emms, Fletcher & Rassaby, (1980) who reported that 63% of depressed women had a psychiatric history as opposed to 13% of the controls. Spangenberg's (1991) South African study, however, compared depressed and non-depressed groups postnatally, and concluded that previous depressive episodes were of no significance.

2.4.2 Prenatal Depression and Anxiety

Prenatal depression and anxiety have frequently been identified as the strongest predictors of postpartum depression (Beck, 1998; Boyce, 2003; Dennerstein *et al*, 1989). Prenatal depression can occur during any or all three of the trimesters of pregnancy (Beck, 1998). However, Kumar & Robson (1984) refuted this claiming that their subjects suffered from antenatal or postnatal depression, not both. Another study delineated the influence of maternal stress, social support and coping styles on depressed mood during pregnancy and the early postpartum period. Approximately 16% of the women in a sample of 80 women experienced depressed mood in the postpartum period and 25% of the sample reported a depressed mood only during pregnancy (Da Costa, Larouche, Dritsa, & Brender, 2000).

2.4.3 Social Support

The most frequently recognized risk factor relating to postnatal depression is social support. Numerous studies have identified social support as a key to the prevention of mental health problems (Beck, 1995; Cutrona, 1984; Hargovan, 1994; Spangenberg, 1991). Cutrona, (1984) concluded that the specific components of social support, which were most predictive of postnatal depression, were deficiencies in social integration and reliable alliance. She also noted that social support (which was assessed during pregnancy) was not a significant predictor of depression two weeks after delivery. This could be explained by the hormonal changes on women's moods, which causes emotional lability. However, after eight weeks psychosocial factors are more significant as the hormonal factors were no longer influencing the emotional state (Cutrona, 1984).

Wanderman, Wanderman & Khan (1980) suggest that the term social support is multidimensional and the type of social support should be specified as specific types of support are related to specific types of adjustment. The role of social support is best understood in the total context of adjustment to parenthood (Wanderman *et al.* 1980). Because of the demands of baby care, postpartum women need additional emotional and practical support (Beck 1998; Da Costa 2000; Paykel, 1980). This refers to instrumental support, such as babysitting and help with chores as well as emotional support (Beck, 1998). This risk factor is exacerbated if there is childcare stress, such as infant health, sleeping or feeding problems (Cutrona, 1984; O'Hara *et al.* 1984; Wanderman *et al.* 1980; Whiffen, 1992). Studies have also found that women who were single parents or divorced were more likely to experience postnatal depression (Braverman & Roux, 1978 cited in Cutrona, 1982, O'Hara, 1984), yet Hayworth, Little, Bonham, Priest& Sandler's (1980) study suggested that there is no relationship between marital status and depression.

2.4.4 Social Relationships

Most prior research has used married samples, and have showed that social relationships play a role in postpartum adjustment (Cutrona, 1984). There is a significant relationship between marital or partner discord and postnatal depression (Beck, 1998; Boyce, 2003; Kumar & Robson, 1984; O'Hara, Rehm & Campbell, 1983). Boyce (1979) specifically referred to spouses who provided low care or were over controlling as risk factors for women with high interpersonal sensitivity, and Sheldon (1991) reports the lack of support from the spouse as a prominent risk. Spangenberg, (1991), however, suggests that the cause and effect of such studies are ambiguous as the depression may have contributed to the poor marital relationship.

However, a significant relationship has also been found prior to birth and subsequent postpartum depression (Kumar & Robson, 1984, Watson, Elliot, Rugg & Brough, 1984). Other studies suggest lack of support from persons other than the spouse presents a risk factor (Cutrona, 1984, O'Hara, *et al.,* 1986, Wandersman, *et al.* 1980).

Conflict with parents and the quality of relationship between the women and her parents, especially her mother, has also proven to be a significant risk factor (Da Costa, 2000; Gotlieb, Whifffen, Mount, Milne & Cordy, 1991; Kumar & Robson, 1984; Sheldon, 1991). Paykel *et al.*, (1980) however, fail to validate this theory.

2.4.5 Negative Life events/ Stressors

Negative life events and life stress are frequently identified as causal factors in retrospective studies, particularly around the time of birth (Beck 1996; Hargovan, 1994; O'Hara *et al*, 1984; Sheldon, 1991). Beck (1996) suggested that stressful events included experiences such as divorce or separation, occupational changes and other crises such as illness, financial issues, accidents, victims of violence and abuse. Righetti–Veltema, Conne- Perreard & Manzano's (1998) study suggests that difficult births and separation of the newborn from the mother during early puerperium are risk factors. Research in South Africa as well as Europe indicates that the condition is especially prevalent in women who live in conditions of socio-economic hardship with limited social support (Cooper, Tomlinson, Swartz, Woolgar & Murray, 1999; Gotlieb *et al,* 1989; Harpman, 1994).

2.4.6 Cultural Differences

It has been suggested that PND is culture bound and that Western culture shapes and supports depressive symptomology (Harkness, 1988; Stern & Kruckman,1983). Research carried out by Cox, (1988) however, contradicts this, highlighting a traditional postnatal condition in rural Ganda, which has very similar symptoms to the Western diagnosis.

2.4.7 Chemical/Hormonal Imbalance

It has been hypothesised that women who suffer from postnatal depression have a chemical imbalance or dysfunction that manifests itself in the symptoms of depression (Cutrona, 1982). Dalton's (1971) hormonal theory suggests that women who experience emotional problems in adjusting to hormonal changes of the menstrual cycle will have greater problems adjusting to the even greater hormonal changes following delivery. Other studies have confirmed this (Anzalone, 1977; Bloch, 2000 cited in Boyce, 2003; Nott, Franklin, Armitage, & Gelder, 1976). However, later research has shown no correlation between premenstrual tension and postnatal depression (Boyce, 2003; Cutrona, 1982; O'Hara, 1984).

2.5 ROUTINE SCREENING

Early recognition and treatment is one of the major challenges with PND (Beck 2002; Spinelli,1998). Generally speaking early detection of perinatal mental health problems are possible through routine medical channels, antenatal and paediatric checkups and possibly at private and state clinics (Beck, 2002). Making persons in the 'helping' profession aware of the possible serious emotional sequelae to childbirth, could

possibly contribute significantly to diagnostic and intervention strategies (Sheldon, 1991).

2.5.1 Acceptability of Routine Screening to Women

Boyer (2000) argues that one of the best ways to deal with PND is to prevent it happening in the first place. She suggests that pregnancy is the ideal time to start to implement preventative strategies because of the contact women have with health professions during this time. However, a recent qualitative study explored women's experiences of routine screening by health visitors using the EPDS (Shakespeare, Blake & Garcia, 2004).

This British study concluded that over half of the participants found routine screening with the EPDS to be unacceptable. The women found the process of screening too simplistic and claimed to prefer open questions and an opportunity to talk. The women were anxious of the consequences of screening and were reluctant to answer the questions honestly. They also felt ill prepared for the screening. 33% of the women felt the baby clinic was an inappropriate place to complete the EPDS, as there is inadequate time and privacy. Most preferred screening at home. Women also felt dissatisfied that they received little feedback from the health workers (Shakespeare, 2004).

The study also revealed that some women perceived the screening to be a personal intrusion, and attributed their distress to their social situation rather than an illness. They saw no medical solution to their distress, and therefore resented the questions from health professionals. The participants also commented on the stigma relating to

PND. They claimed that they were reluctant to admit to PND because it related to their image of a good mother. Women felt threatened by a questionnaire that was designed to 'diagnose' this stigmatising illness (Shakespeare, 2004).

Thurtle's (2003) study also revealed that women deliberately provided socially desirable responses to the EPDS rather revealing their truths. This study identified discrepancies between EPDS scores and women's self reported feelings of depression. The behaviour appears to be related to the stigma of positive screening results and the potential effects of the diagnosis of PND. Such a diagnosis is perceived as a threat to the family (Shakespeare, 2004; Thurtle, 2003).

Webster, Linnane, Dibley & Pritchard's (2000) Australian study, assessed the effectiveness of antenatal screening of women at risk for postnatal depression. The programme began at the prenatal booking-in clinic where specific questions about social support and the family's psychiatric history was asked. Identification and management became part of the routine care for those who appeared to be a risk. This study measured the usefulness of the screening method for women at risk for postnatal depression. Compared to a control group of 301 women, women with risk factors were almost 2.5 times more likely to develop postnatal depression. The most significant risk factors were low social support (measured by the Maternity Social Support Scale), a personal history of mood disorder and a past history of postnatal depression. The effectiveness of this study is highlighted by the simplicity of the design, which can be easily implemented in an antenatal setting (Webster, 2000).

2.5.2. Screening Methods

2.5.2.1 Edinburgh Postnatal Depression Scale (EPDS)

The most commonly used screening tool in the postnatal period is the EPDS (Cooper & Murray,1997), and is the tool that is used by the PMHP. Cox, *et al* (1987) argues that a screening tool needs to be simple to complete and not require a health worker to have any specialist knowledge of psychiatry. They developed and validated the EPDS, which has been used effectively as a screening tool. It is a simple, brief self report measure which is easy to administer, simple to interpret and can be readily incorporated within the routine antenatal services (Cooper *et al*, 1997). It is also sensitive to changes in the severity of depression over time, making it a useful indicator of progress in treatment (Cox, *et al* 1987).

According to Beck (1996) to date, researchers have devoted more attention to constructing instruments that screen for PND than devising tools to *predict* PND (Beck, 1996). The Edinburgh Postnatal Depression Scale has, however, been repeatedly assessed and used as a predictive tool. It has been validated for use antenatally as well as telephonically and screens for depression as well as anxiety (Harris, Huckle, Thomas, Johns, & Fung, 1989, Murray & Carothers, 1990.). This screening tool, is therefore, appropriate for the PMHP, as the screening is carried out in the antenatal period.

The EPDS was initially validated for the United Kingdom, but has subsequently been validated for other communities. Lawrie, Hofmeyr, de Jager and Berk (1998), concluded in their validation study that the EPDS is a valid screening instrument for the urban South African community if it is administered verbally. It has been

translated into six South African languages. This validation makes it an appropriate tool for the PMHP.

2.5.2.2 Postpartum Depression Predictors Inventory

Beck, (1995) did a meta-analysis of the predictors of PND and subsequently developed an inventory in the form of a checklist. The purpose of this Postpartum Depression Predictors Inventory is to help identify women at risk for developing PND. The first six predictors can be assessed during pregnancy and the last two, childcare stress and maternity blues are assessed after the women has delivered. A nurse or midwife, in an interview process, asks guided questions. The PDPI is not intended as a self-report questionnaire or as a psychometric testing instrument. Through the dialogue a women is given the opportunity to discuss her experiences and problems and the health care practitioner is given an opportunity to get a picture of each risk factor (Beck, 1996).

2.5.2.3 Postpartum Emotional Disorder (PED) Questionnaire

Braverman and Roux (1978) designed a device for detecting women at risk for Postpartum Emotional Disorder (PED). Women attending an Australian prenatal clinic completed a 19-item "yes-no" type questionnaire. Questions for inclusion in the study were chosen by clinical intuition as well as current knowledge concerning psychopathology in general. Certain items showed predictive value: 1) feeling unloved by husband 2) feeling that pregnancy is undesired. 3) past history of postpartum depression 4) being single or separated 5) marital problems 6) unplanned pregnancy. It remains to be ascertained, however, whether this questionnaire would be appropriate in other sociocultural environments (Braverman & Roux, 1978).

2.5.2.4 Perinatal Posttraumatic Stress Disorder Questionnaire.

Callahan and Hynan (2002) evaluated the Perinatal Posttraumatic Stress Disorder Questionnaire. The study included administering questionnaires to high-risk and low-risk mothers concluding the effectiveness of this tool for identifying emotional distress in mothers. The high-risk mothers scored higher on all levels of emotional distress, suggesting the effectiveness of this screening tool.

2.5.2.5 Microcomputer-Delivered Questionnaire

The Hamilton Depression Rating Scale was adapted for self-rating, and administered by microcomputer. There were significant associations, at all levels of severity, between raised scores antenatally, and those developing postnatally in women completing this study (Ancil, Hilton, Carr, Tooley & McKenzie, 1986). The results indicated that this method of screening proved feasible within general practice in the United Kingdom. It was reported as being non intrusive and fitted into the routine of the antenatal clinic. The staff found the machines easy to operate (Ancil *et al.*, 1986). However, the microcomputer technique is unlikely to be appropriate in the South African context, where resources are limited.

2.6 MANAGEMENT OF PERINATAL MENTAL HEALTH PROBLEMS

General research points towards the importance of treating postnatal depression in primary care supporting the view that 'therapeutic listening' and extra support may be helpful in treating the depression (Adler & Truman, 2002; Cox, Holden & Sagovsky, 1989; Cutrona, 1982). Whitton, Warner & Appleby (1996) reported that routine care for women with postnatal depression includes treatment with anti-depressants, cognitive behavioural therapy and often non-directive counselling from health

visitors. However, many women do not acknowledge their depression and ask for help (Whitton *et al.*, 1996), and women are often afraid of being stigmatised with the 'illness' (Shakespeare, 2004; Thurtle 2003).

Boyer, (2000) suggests that an effective intervention to prevent postnatal depression in high-risk groups would benefit women in reducing depression and its impact on the child and marital relationships. However, the evidence for the effectiveness of interventions to prevent PND are conflicting. Stuart, O'Hara & Gorman (2003) suggest that psychosocial treatments for postpartum depression can be placed in two categories. Firstly, the preventative interventions involving those who are at risk for PND, and secondly an intervention that is designed to treat women who have already developed PND.

2.6.1Prevention

2.6.1.1Educational Support

A cohort study of mothers identified as vulnerable to depression during the antenatal period, found that first time mothers who had taken part in a parenthood educational programme had significantly lower EPDS scores compared with routine care (Elliot, Leverton, Sanjack & Bushnell, 2000) Meager & Milgrom (1996) found that a 10 week programme of educational and social support helped women with persistent depression originating in the puerperium. Antenatal education is suggested to improve women's acceptance and understanding of available treatment, as well as routine postnatal screening (Whitton *et al.*, 1996).

A prevention treatment trial was conducted by Gordon and Gordon, (1999) in which women were randomly assigned to participate in psycho educational classes during pregnancy. The results indicated that only 15% of the women who received classes experienced postnatal 'upsets' as opposed to 37% of the nontreated women. Halonen & Passman (1985) did a prevention study which involved relaxation therapy designed to alleviate postnatal distress. The women were treated in their homes by a trained therapist, and showed lower scores on the Beck Depression Inventory (BDI) compared to the women in the control groups.

2.6.1.2 Antenatal Counselling/Psychotherapy

Gorman (1997), screened women to ascertain those who were high risk for PND. The women who had at least one risk factor out of five (personal history of depression, family history of psychiatric disturbance, depressive symptoms during pregnancy, marital maladjustment and negative life events) were offered treatment. The intervention consisted of two individual counselling sessions during pregnancy and three weekly sessions between two to four weeks postpartum. The results indicated that at one month postnatally the women who received intervention (as opposed to the control group) were less likely to have experienced PND. The difference was not significant at six months.

2.6.2Treatment

2.6.2.1 Postnatal Counselling/Psychotherapy

Empirical data strongly supports the effectiveness of counselling and psychotherapeutic interventions for acute treatment of PND. Most research indicates that between six to ten weekly postnatal therapeutic sessions can be helpful for the

treatment of PND (Beck, 2002; Boyce, 2003). Cox, Holden & Sagovsky (1989) in a randomised controlled trial showed that non-directive counselling was effective in alleviating postnatal depression. In this study 69% recovered as opposed to 38% receiving routine care. The intervention included eight weekly counselling visits by health visitors who had been given a short training in counselling for PND. According to Wickberg & Hwang (1996), twelve out of fifteen women with major depression recovered after six counselling sessions with health nurses compared with four women in a control group using routine care. Cooper and Murray (1997) found that nondirective counselling, psychotherapy and cognitive behaviour therapy were equally effective. Morgan, Matthew, Barnett & Richardson (1997) concluded that there were significant decreases in postnatal depression after eight weekly group psychotherapeutic sessions.

2.6.2.2 Home Visits

Armstrong, Fraser, Dadds & Morris (1999) and Fuggle & Haydon (2000) both evaluated the impact of home visiting of women in the immediate postpartum period. Armstrong, *et al.*,(1999) reported that women who received this intervention had significant reductions in PND as well as improvements in their parental role predicting long term benefits for the healthy development of children. Fuggle & Haydon (2000) compiled resource estimation for setting up a health visiting service for screening and counselling women with postnatal depression. The majority of health visitors reported that the screening visits were supportive to the client. Feedback concluded that clients did not find the screening interview intrusive, but rather resulted in the client having a better relationship with her own feelings and improved the relationship with the health visitor.

2.6.2.3 Debriefing

Gamble, Creedy, Webster & Moyle's (2001) findings suggest that a single debriefing or nondirective counselling session to prevent or reduce depression and trauma symptoms following birth has not significant value in reducing morbidity and may even be harmful. In contrast, however, women reported that an opportunity to talk with someone about the birth was helpful in facilitating recovery (Gamble *et. al.* 2001).

2.6.2.4 Pharmacological Treatment

Hormonal therapies have been the subject of considerable debate, however little reliable evidence is available. No evidence could be identified for the effectiveness of natural progesterone or synthetic progesterones in the treatment of PND (Lawrie & Dalton 2000). A randomised controlled trial of the use of antidepressant therapy in PND carried out in a community setting demonstrated a beneficial effect from fluoxetine combined with at least one session of modified Cognitive Behavioural Therapy (CBT) in women with mild PND (Lawrie & Dalton, 2000)

Evidence from a case control study carried out in the United States suggests that both selective serotonin re-uptake inhibitors (SSRI's) and tricyclic antidepressants (TCA's) are effective PND treatment (Wisner & Gelenberg, 1999). A small case series suggests that SSRI's are not less effective in patients with postnatal depression than in other patient groups (Stowe & Casarella, 1995).

2.7 EFFECTS OF POST NATAL DEPRESSION

There is substantive evidence for the link between PND in mothers and emotional disturbance in their children (Allen & Kumar, 1995; Beck, 1998; Cooper, *et al.*,1999). Evidence indicates that the combination of PND and social adversity have a large impact on the quality of mother-infant relationship (Murray & Cooper, 1997). In South Africa infants of poor communities are particularly vulnerable as they are subject to parenting which is under the strain of both marked socio-economic hardship and high rates of depression. It has been found that these mothers were less sensitively engaged with their infants, and the infants were less positively engaged with their mothers (Cooper, *et al.*,1999). The positive benefits of mother-infant intervention are limited, but early intervention does show short-term benefits (Murray & Cooper, 2003).

Child cognitive development also has been found in some studies to be adversely affected (Coghill *et al.*,1986; Hay & Kumar, 1994; Kjurstens & Wolke, 2001). In India a study of infants of depressed women in a lower socio-economic group revealed that low birth weight and poor mental development scores were associated with PND (Patel, DeSouza & Rodrigues, 2003). A prospective, longitudinal study of the five-year-old children's adjustment to school of postnatally depressed and well women concluded that PND has a persistent effect on children (Sinclair & Murray, 1998). However, family class and the child's gender had the most pervasive influences on adjustment. This study demonstrated that there were raised levels of adjustment to school amongst boys from families with low socio-economic status.

Recent research revealed that children whose mothers suffered from PND showed more diverse and severe aggressive behaviours than other children. This longitudinal study conducted in two communities in South London showed children aged 11, particularly boys, to be involved with fighting with peers (Hay, 2003). Ramchandani's (2005) study suggests that *paternal* depression may hinder children's early behavioural and emotional development, causing hyperactivity, particularly in boy children. This suggests that that paternal influence should not be excluded from mainstream research into infant development and psychopathology. (Ramchandani, 2005).

2.8 FEMINIST STANDPOINT PERSPECTIVE

From a feminist standpoint perspective 'illness' and 'health' and the notion of PND is at least partially constructed within social practices, relationships, language and roles, and is always shaped by culture and history. Standpoint feminists would argue that historically PND is a social category that pathologizes women by placing a biological or medical label on their symptoms suggesting that the defect lies within the individual, ignoring the impact of society and culture. Feminist standpoint assumes that women, and others in social marginality, are ideal sources of knowledge in so far as they do not defend any vested interests and thus are more impartial and objective (Eagleton, 2003).

The premise of the realist perspective is that objects have real existence independent of any perceiver, or cultural knowledge. Alternatively feminists suggest that knowledge must be understood in relation to the historical and cultural context in which it is situated. This knowledge is sustained by social practises, and knowledge and social action go together (Burr, 1995). There are multiple voices and theories

within the framework of feminism, such as feminist empiricism, standpoint theory and postmodernism all of which recognise women's lived experiences as legitimate sources of knowledge (Campbell & Wasco, 2000).

Feminist standpoint theory, the framework in which this study is placed, rejects traditional research, which conceptualises women's experiences within dominant male discourses. The notions of universals and the emphasis on rationality, reason and technology are questioned, and the positive contribution that women can make to knowledge is stressed (Eagleton, 2003). This necessitates critical research from the standpoint, or perspective, of women, so that the social structures that oppress and marginalize women become visible. Such research leads to less distorted claims that are more representative of women (Harding, 1991). It is reflexive, women centred and aims to deconstruct women's lived experiences and aims to transform patriarchy and corresponding empowerment of women (Campbell *et al.*, 2000) by challenging positivism and realism, which underlies medicine, psychology and other mainstream health research (Ussher, 1997).

Within a postmodern feminist perspective, contradictions are to be expected as it is argued that meaning is multiple, fragmented and often contradictory. However, standpoint theorists do not maintain the postmodernist's respect for multiple perspectives. They argue that the unique perspectives of 'oppressors' and 'oppressed' are equally valid, may present a problem in terms of affecting social change. The feminist standpoint perspective affirms the existence of reality, both physical and environmental, but its representations are characterised and mediated by culture,

language and political interests such as race, gender or social class (Campbell & Wasco, 2000).

Standpoint feminism offers a more radical critique than feminist empiricism by offering a critique of the ways in which rationality and objectivity are implemented as a human, social and scientific ideal. This framework assumes that women's socially induced 'difference' is in fact a scientific resource that needs to be infused into what our culture has codified as science (Eagleton, 2003). An important element to this approach is also the critique of power relations, by exposing the relationships of domination and exclusion, which operate within philosophies, social science and medicine. There is systematic attention to power relations, focusing on the position of individuals, in terms of gender, class, race, age and religion (Nielson,1990).

Nicholson's (1999) study argues that the notions of PND need to be reconstructed to place women outside the clinical/medical discourse and seek to understand them as problems individuals experience within and as part of their lives. Such a reconstruction moves outside the medical approach and beyond the social science approach, where PND is seen as an objective phenomenon, even though they may be related to social factors. They argue that the reconstruction of PND is based on subjective experiences of those who identify themselves as depressed, in terms of meaningful life experiences, which may be understood as depressing experiences. This means that these experiences are not distinct from subjective experiences and meanings which individuals construct throughout their lives (Nicholson, 1999). This shifts the focus from the individual to the social context and to the power relations within which experiences and meanings are constructed.

Feminism has been criticised for proposing a universal female truth. It is argued that the idealised form of motherhood is universalised, yet is primarily defined from the experiences of white middle class western women (Ussher, 1997). However, this has been contested by standpoint theorists who focus on multiple standpoints that reveal the complexities of race, gender, class and sexual orientation in women's lives (Oleson, 2000).

Differences in the meaning of motherhood can be starkly contrasted across different cultures and socio-economic groups. Nicholson, (1990), for example, has argued that the social conditions of contemporary motherhood exist within a clearly defined social context that includes heterosexuality, marriage and childrearing that constitute the patriarchal rules which regulates motherhood in western society (Nicholson, 1990). However, in South Africa many women have no access to reproductive rights and basic medical care, and therefore endure a starkly different experience of reproduction and mothering than women in the developed world. A feminist standpoint epistemology provides a useful way of conceptualising PND within the broader context of South African society.

Feminist standpoint theorists maintain that, relative to other strands of feminism, this approach grounds its theory in political activism for social change (Harding, 1991). The basic tenant of this study is therefore, orientated towards change through challenging aspects of the categorization of PND resulting from discursive practices, which historically have been controlled by male medical experts. Feminists have

challenged the concept of pregnancy as an illness and in general women are attempting to assert their voice with regard to childbirth (Nicholson, 1990).

2.9 THE SOUTH AFRICAN MEDICAL CONTEXT

Within the South African context the dominant culture that explains ill health is the biomedical model, also described as the Western or 'technocratic model' (Davis Floyd, 1994 p.172). The main underlying principle of this approach to health care is the norm of separation. The condition, or disease, is separated from the person, and the ill health is understood as external to the person's context (Davis Floyd, 1994).

Davis Floyd, (1994), describes the essence of the medical model as separation – 'of humans from nature, of mind from body, of mother from child' (Davis Floyd, 1994 p.172). It defines the causes of mental health problems as disease related. Mainstream views of perinatal mental health problems are approached from biomedical responses to childbirth and motherhood. Although most modern obstetrical texts advocate pregnancy as a natural and intrinsically healthy process, this is usually overridden by the concept of birth broken into components of standardized measurements and rules. Nature/body is seen as synonymous with femaleness, otherness and inferiority and the medical model strives to transcend this through technology and science, which are considered 'progress' (Davis-Floyd, 1994).

Davis-Floyd (1994) believes that the medical model functions as an agent of social control which moulds and directs individual values, beliefs and actions. Gillespie (2000) explains a variety of reasons for the growth of medicalization. Firstly, it is argued that modern medicine is increasingly used as an agent of social control

(especially over women) making them dependent on the medical profession, and on its links with pharmaceutical and other industries. It has also been seen as a way of controlling deviant behaviour, by defining those who do not conform to social norms as 'ill' or 'mad'. It is also argued that the decline of the religious worldview with the replacement of 'health' as a moral model of the universe has resulted in the spread of medical explanations into areas of life, which it was never designed to deal with. Finally, medicalization is probably also more likely if the body is conceptualised as a 'machine' and stripped of its social and cultural context (Gillespie 2000).

The distorted emphasis on biological and medical causes in defining the causes of health problems, overlooking the promotive and preventative aspects, makes it difficult to analyse health problems in countries such as South Africa, where there are high levels of poverty. In South Africa ill health is rooted in psychosocial, economic and political factors, which impacts on physical and mental health, as well as responses to health seeking (Chadwick, 2003).

2.9.1 Obstetrics

The biomedical model defines birth complications and perinatal mental health problems as disease related, but it has been widely documented and accepted that causes are not only medical but rooted in a wide range of factors – socio-economic, cultural, political and most importantly the weaknesses of the health system (World Health Organisation, 2001). Brems & Griffiths (1993) argue that this model divides health from the setting that produces it. In the context of maternal health, most doctors are trained to see labouring mothers as risk patients, whose normality can only be

proved after the event. Women are not looked at holistically as maternity care is centred on the pregnancy itself.

Chadwick (2003) comments on the relationship between the medical model and the 'developing' world. She notes that research has indicated that whilst birth activists are challenging the western models of birth by questioning unnecessary medical intervention, in the 'developing' world there is urgency for *more* medical technology. This highlights how the operation of difference is possibly the most important factor impacting on how women experience childbirth (Chadwick, 2003).

In South Africa, medical schools produce some of the world's most renowned specialists in obstetrics and gynaecology, at the same time there are deep divisions between private and public health facilities and resources (Chadwick, 2003). However, the private sector, in the year 2000, delivered only 16% of the total births for that year, even though it houses the skills, technology and resources. The public sector was responsible for 84% of the total births for that year (Health Status & Health Services Report, PAWC, 2000/2001 – cited in Chadwick, 2003).

2.9.2 Mental Health

Psychology has traditionally been a male-dominated discipline at all levels of the profession and scholarship. Early researchers and practitioners were male, resulting in the rhetoric and ethos of the profession being developed from a patriarchal perspective, which mirrors the discourse within psychology as an academic discipline. Historically the gender of client groups have been ignored, or seen as irrelevant, with

a startling omission of any discussion of gender issues within the professional or research literature (Ussher & Nicholson, 1992).

Kaplan (1983) argues that psychiatric diagnostic criteria are loaded with masculine-biased assumptions about what behaviours are healthy and what behaviours are 'crazy' (Kaplan, 1983 p.786). More adult women are treated for mental illness than men (Bohan, 1998, Kaplan 1983). Chesler (1972) argues that women's high treatment rates for mental illness reflect a labelling of women as pathological if they do not conform to sex role stereotypes. She asserts that women are diagnosed for both over-conforming and under-conforming to sex role stereotypes (Chesler, 1972). The diagnostic system, like the society it serves, is male centred, and most women who are labelled disordered, are in some way deviating from acting out the traditional female role (Kaplan, 1983). With regard to PND, it is argued that women are conditioned to respond in a certain way with regard to motherhood. However, this role often brings with it economic helplessness, dependency on others and often low self-esteem and few aspirations (Bohan, 1998).

The emotional consequences of childbearing and motherhood have been pathologised and defined by this dominant discourse. On the whole, reproductive mental health problems have been medicalized and viewed as resulting from women's 'raging hormones' (Ussher, 1989). This denies the social conditions that the women may endure and ignores factors such as isolation, lack of support, stress and poverty. It is only relatively recently that feminist psychologists have developed psychological theories to explain the way psychology has traditionally contributed to women's oppression (Nicholson, 1990).

On the surface, public mental health policies in South Africa are statements by governments and health authorities that put forward clear and relevant objectives for the prevention, treatment, care and rehabilitation relating to mental disorders, and the coordination of programmes and services related to mental health (World Health Organisation, 2002). However, these policies are also manifestations of how a society defines and constructs both mental health, and normality and abnormality. A society's formulation and understanding of the concept of mental health also determines the prevailing notions of appropriate treatment for mental conditions (Dennill *et al.*, 1999).

Organised strategies for state management of mental health rest upon underlying medicalized assumptions regarding mental health. These assumptions have a powerful effect on the creation of policy around treatment. The understandings of mental health are not stable over time and do not exist in a vacuum. The social, political and economic environments shape and define the concepts of mental health. And the biomedical model functions as a powerful agent of social control.

State policies and the concept of the nuclear family, as well as psychological constructions of motherhood define the social constructions of health and motherhood. Traditionally psychology only allows for a limited range of accepted maternal behaviours, not taking into account the variety of backgrounds that brings a variety of life experiences (Phoenix & Woollett, 1991). As a result the psychological constructions of motherhood do not reflect the reality of mothering for many women (Glen, 1994), resulting in contradictions, which can lead to maternal ambivalence as well as depression (Parker, 1995).

2.9.3 Power and Medicine

Women have been largely ignored in traditional approaches to knowledge, and have been measured in masculine terms. Traditionally women are defined in terms of their relationship to men, which becomes a source from which female stereotypes emerge and are sustained. The health care system is based on the values, assumptions and worldview of the larger society (Brems *et al.*, 1993). Matamala (1998) argues that the patriarchal nature of the medical model, which most public health services are based on, promotes hierarchal relations between health care recipients and health care providers. The model encourages dependency and submission, and thus impacts on the relationship between health recipients and health care providers. The overemphasis on prescriptive medicine also creates power issues, whereby women are regarded as ignorant, lacking any form of knowledge of their own childbirth and pregnancy (Davis Floyd, 1994).

In South Africa women in medicine have been disadvantaged, yet research has indicated that women doctors spend more time talking with their patients and are more likely to employ more patient-centred strategies than men (Sanders, 1996). Gender divisions within the South African medical profession persist, and although the majority of health care professionals (such as nurses and midwives) are female, male physicians still hold higher paid and higher prestige jobs (Helman, 1990). This reflects the patriarchal bias in society as a whole.

2.10 CONCLUSION

The medical model has a long history of attempting to define mental health 'disorders' associated with childbirth, often with contradictory results. This model is dominant in South Africa, and it is argued that it has a distorted emphasis on biological and medical causes in defining health problems. It overlooks the promotive and preventative aspects, making it difficult to analyse health problems in countries such as South Africa, where there are high levels of poverty and an under resourced public health system. A feminist standpoint theoretical framework attempts to emphasise the relational, interactional and contextual components of women's perinatal experiences, promoting the subjectivity and personal meaning associated with PND and motherhood.

CHAPTER THREE

METHODOLOGY

3.1 INTRODUCTION

This chapter explores the methodological framework that informs the current study. The reasons for using a qualitative feminist standpoint epistemology are explained, followed by a description of Fourth Generation Evaluation, a model from which this study draws. A description of the participants and the procedure as well as an overview of the analysis of the data is provided. The chapter concludes with a validity and reflexive account of the research process as well as ethical considerations.

3.2 FEMINIST QUALITATIVE RESEARCH

This study was placed within a qualitative feminist standpoint epistemology. It was undertaken in direct response to the needs of women during the perinatal period and addresses and explores the services provided by the PMHP from a user and provider perspective. A basic premise of feminist standpoint research is to improve the understanding of a problem in order to contribute to possible solutions (Hendrick, Bickman & Rog, 1993). For the most part feminists have modified, rather than invented, research methods, but have produced a unique epistemology, in which this study is located.

This research is exploratory and is concerned with the importance of meaning in social interaction (Ussher, 1991), and therefore focuses on the personal meanings and interpretations of the participants' perceptions of the PMHP. The critical nature of the study allows for alternative courses of action. One of the objectives of this study is to

emancipate, by uncovering aspects of society that maintain the status quo by restricting access to knowledge (Nielson, 1990). Feminist epistemology legitimates women's lived experience as sources of knowledge, and examines those experiences with an ethic of respect, collaboration and caring.

Traditional postivist research, however, relies on rationalism and empiricism, with a goal to explain, predict and ultimately control reality (Campbell & Wasco, 2000). Positivist research seeks to explain rather than understand specific phenomenon, and asserts that there is one objective reality, which can be understood through empirical enquiry (Terre Blanche & Durrheim, 2002). The core function of such research is to expand or contribute to a body of knowledge (Hedrick *et al.*, 1993).

With qualitative research more complex aspects of the participants' experience can be studied, and the responses obtained is not contained by a pre-existing hypothesis. A qualitative approach rests on a number of beliefs, including the notion that there are multiple realities and that the observer and the observed are inseparable (DeVault, 1999). Qualitative data is often explained as 'rich' or 'deep' (Terre Blanche & Durrheim 2002).

A feminist standpoint position rejects many of the epistemological assumptions underlying individual studies and the status given to many existing accounts. It suggests that we are dealing with 'open' not 'closed' systems, and therefore need to explain shifting cultural and historical contexts. Feminists abandon single factors that precipitate the onset of PND, or the effectiveness of one treatment over all others. We should instead aim to explain and understand the symptomology women experience,

the meaning, timing and degree of symptoms and the ways in which women cope with the perceived difficulty (Ussher, 1997). Feminist standpoint theory works from the ontological assumption that there is no single objective truth, claiming that class, race, gender and sexual orientation structure a person's understanding of reality (Campbell & Wasco, 2000).

Consistent with feminism, this study assumes that women's experiences have been made invisible within mainstream psychology, by not considering women's knowledge as a source for development of theory or research. A feminist standpoint position assumes that knowledge is grounded in social reality, and emphasises lay knowledge as having equal status to expert knowledge (Campbell & Wasco, 2000, Harding, 1991). To survive, less powerful groups must be attuned to the culture of the dominant group, which allows for a more complete and less distorted view of social reality because of their disadvantaged position (Nielson, 1990).

In addition to focusing on experiences and perceptions, this study is interested in understanding how these experiences and perceptions were derived from larger systems of meaning within social structures and social practises (Terre Blance & Durrheim, 1999). The role of the research is to provide empowerment for women by including accounts of women's experience, both professional and lay, which can be used to challenge the status quo. Thus the emphasis is on research *for* rather than *on* women (Ussher, 1997). Feminist research is used to challenge the status quo and provide material to bring about change (Harding, 1991). From this perspective this study is not purely an academic exercise. It attempts to impact on women's experience of health and illness, and hopefully will elicit practical consequences for its

participants, aiming to ensure that the services offered by the PMHP effectively cater to their needs.

3.3 FOURTH GENERATION EVALUATION

This study drew from the Fourth Generation Evaluation model (Guba & Lincoln 1989), which is consistent with a qualitative feminist standpoint position. Evaluation, according to this model, is seen as a socio-political process. Fourth Generation views cultural and political elements as enhancing the evaluative process, as the values themselves become part of what is investigated and inquired into. Fourth Generation is therefore responsive in orientation, and challenges the 'value-free' notion of science. It recognizes that there are multiple realities, which are socially constructed and influenced by context, evolving out of the shortcomings of previous generations of evaluation, which emphasise measurement, description and judgment. (Guba & Lincoln, 1989).

Evaluation is seen as a joint, collaborative process, which aims at consensual constructions about the evaluand. The researcher drew from this model for the selection of participants, whereby various stakeholders of the project participated. The data was collected and analysed thematically, and presented within a Fourth Generation framework. This involved looking at the claims (the assertion of what is favourable for the evaluand), the concerns (what is unfavourable) and the issues (that which is debatable) with each individual stakeholder. The responsive nature of this study is another element that was drawn from Fourth Generation. The data was presented in a feedback session, which was attended to by relevant staff stakeholders

in order to make a joint effort to resolve certain concerns and issues (Guba & Lincoln, 1989).

3.4 PARTICIPANTS

3.4.1 Selection of Participants

According to Guba and Lincoln (1989) an evaluative study is a collaborative process. It is therefore important that a cross section of stakeholders are involved in the process. Stakeholders are defined as persons who hold a stake in the project. This includes those who produce, use or implement the project (Guba & Lincoln, 1989). The most relevant stakeholders selected for this study comprised of the staff and clients that used and implemented the PNMP at the Liesbeeck MOU.

Six mothers have been included, the criteria for inclusion being those who have been counselled, during the antenatal period, by one of the voluntary counsellors. These clients live in the catchment area around the MOU. The sample also consists of six midwives, as well as two counsellors, the psychiatrist, and the project manager. All participants needed to be able to speak English, but it was ensured that a diverse group of staff and clients was selected in terms of race and language.

Both management and the volunteer counsellors at the Liesbeeck MOU assisted the securing of the participants. The Medical Superintendent of the Mowbray Maternity Hospital granted me access to the files and permission to contact the client participants. The sample was not randomly drawn which is of no concern, as the study did not aim to generalize the findings to a larger population. Rather it aimed to gain an in-depth understanding of the experiences of the participants.

3.4.2 Description of the Participants

The study involved sixteen, ten staff members and six clients. For confidentiality reasons the demographics of the staff participants have not been revealed, because their identities at the LMOU would be too easily distinguishable. I have, therefore not included staff demographic details. However, it is important to note that they are represent diversity in terms of race. This representation has been defined, for the purpose of this paper, by the labels constructed by the previous South African dispensation. The majority of staff are 'white', but 'black' and 'coloured' staff members did participate. I have included the client demographic variables, as their perceptions cannot be separated from their particular context.

	Client 1	Client 2	Client 3	Client 4	Client 4	Client 6
Age	19	20	19	19	25	23
Resides	Salt River	Observatory	UWC residence	Observatory	Rondebosch	Woodstock
Status	Single	married	Single	married	single	married
Lives with	parents, brother	partner	self	partner, children, parents-in-law	parents	partner
Children	1	1	1	2	1	1
Age of child	7 months	2 months	4 months	2 years 4 months	5 months	6 months
Language	Eng/Afrikaans	Sotho	Xhosa	Afrikaans	English	English
Education	Matric	Std. 8	Tertiary	Matric	Tertiary	Tertiary
Occupation	Waitress	Trader	Student	Unemployed	Restaurant Manager	Designer

3.5 DATA COLLECTION TOOL

Two semi-structured, open–ended interviews were prepared in advance, one for the staff of the MOU and one for the clients (see Appendix A). The interviews were a method to provide access to the meanings people attribute to their experiences and their social worlds. They were used to gain rich insights into the women's experiences, aimed at engaging in conversations with a purpose (Nielson, 1990). The

interview process was not linear in nature, since it became necessary to change certain aspects of the interview as it developed. For example, it was necessary to emphasise different themes for different staff members, depending what their role is. Patton (1990) asserts that the researcher needs to have an idea of the topics that need to be covered, however, the exact nature and order of the questions needs to be guided by the exchange between the researcher and the respondent.

I followed up interesting themes as they emerged, to attain a fuller picture. This method, as opposed to a more conventional, structured interview, provided the interviewer and interviewees with more flexibility (Smith, Harre & Langenhove, 1995). From a feminist position, all meanings created in the interview are viewed as being 'co-constructed' as the participants and myself are products of a larger social system. The open-ended questions related to the aims and objectives of the study. They related to the experiences, perceptions and needs of the staff and clients.

The interviews were tape recorded with the client's permission. In addition to this, notes were taken in order to capture the non-verbal behaviour and mannerisms of the participants. Tape recording guards against the researcher substituting her own words for those of the participants' ensuring an accurate reflection of the participants' views (Smith *et al.*, 1995).

3.6 PROCEDURE

I contacted the PNDSA (Postnatal Depression Support Association of South Africa) for current information and literature on PND and general perinatal mental health. A staff member of the association subsequently informed Dr. Simone Honikman, the

project manager of the PMHP, that I was interested in doing research that was PND related. This resulted in Dr Honikman and myself meeting, and eventually agreeing on this proposal. I applied for ethical approval from the University of Cape Town before beginning the interview process.(See Appendix B).

Dr Honikman informed the staff members at the Liesbeeck MOU of the research. The first step of the process was the identification of stakeholders. The stakeholders for this study included staff members who are directly involved on a day-to-day basis with the project, and women who have used the service (clients).

During work hours at the unit I asked permission for participation and interviewed the staff members. The staff participants were representative of a cross section of roles. I received written permission from the Medical Superintendent of Mowbray Maternity Hospital, Dr. Nils Bergman, to access the files of clients who had received counselling at the LMOU. I then telephonically contacted potential client participants. The aims and nature of the research was explained to the participants who then agreed to participate. At this point we agreed on an appropriate date, time and venue of convenience. The meetings took place at the most convenient setting for the client, which included their individual homes, at the Liesbeeck MOU and at a coffee shop. The staff participants were approached and interviewed at the Liesbeeck MOU.

All participants (staff and clients) were asked to sign a consent form detailing their agreement to participate in the study, and assuring them of confidentiality and anonymity (except the psychiatrist and project manager, whose identities are revealed by the nature of their roles). They were also informed that they had the right to

withdraw at any point during the project and that their withdrawal from the project would not prejudice any future treatment at the hospital (see Appendix C). The interviews were conducted in English for the convenience of the research process, as it was the common language spoken by all the participants. Each interview lasted between thirty to forty five minutes and the claims, concerns and issues of each participant were explored.

3.7 DATA ANALYSIS

Thematic analysis was used to analyse the data, guided by Smith, *et al.,* (1995). Thematic analysis focuses on identifiable themes, which relate to the aims and objectives of the study. These are extracted grouping together sentences, phrases and paragraphs, which relate to the same theme.

After the interviews had been transcribed patterns of experiences were listed and all the data that relates to the already classified patterns was identified. The next step was to build up a valid argument for choosing the themes, which is done by reading the related literature. By referring back to the literature inferences were made from the interview. Such an analysis has a mechanical and interpretative component. The mechanical component refers to the organising of data into themes and categories, and the interpretative component involves determining which themes and categories are relevant to the questions being asked (Smith, *et. al.*,1995).

The process of analysis was recursive in that the researcher constantly revisited and honed identified themes. The researcher needed to occasionally stand back from the material in an attempt to impose a sense of order in the data (Patton, 1990). The

quotations from the interview transcripts illustrated the themes that emerged during the process of analysis. This actual descriptive data was analysed by the researcher through a reflexive process.

3.8 REFLEXIVITY

The reflexive, nature of qualitative, feminist research required of me to continuously reflect upon my role and impact on the research as well as my experiences and perceptions during the research process. A discussion of my role and values pertinent to this study, as well as general comments on my experiences follows.

Shortly after I began exploring the feasibility of researching the PMHP, the Medical Officer, Dr. Simone Honikman asked me if I would be prepared to assist her with the project management. I accepted this offer and was, therefore, part of the system that I was exploring. I was not, however, involved in any way in the initial implementation of the project, and was employed by them for a limited period of time. Currently I have no professional association with the PMHP.

The clients and staff, in this study, are an intrinsic part of the research process resulting in research, which is participative and collaborative, aiming at overcoming the traditional power imbalance between researcher and participants. As researcher I provided my own subjective interpretation of the phenomenon while trying to understand the experiences of the participants (DeVault, 1999).

Overall, I felt that my position added value to the research as I was more immersed in the process. I was not setting out to prove a particular perspective, but attempted to be

open to understanding issues as they emerged, allowing my direct experience to enhance insight. From a feminist position, my role could be seen as co-participant, rather than an objective outsider (DeVault, 1999; Terre Blanche & Durrrheim, 2002). The staff participants knew me and were aware of my intentions, which I believe, contributed to rapport building and trust. My familiarity with the complexities of the project made it easier to engage on a deeper level, in order to gain insight into the meanings and experiences. However, a disadvantage may have been an assumption that I knew things without them needing to make it explicit. I had to be very conscious at the time of interviewing to maintain my identity as researcher, and not colleague.

With the clients, I informed them about my affiliation with the project, and explained my intentions. I was very aware of potential power dynamics, particularly with regard to race and age. Participants were not asked to define themselves in racial terms. I have therefore taken the liberty of using broad political terminology and have described participants in terms of being 'black' or 'white' in order to describe specific racial differences. In this study four of the client participants were 'black' (Sotho, Xhosa, and 'coloured') and two were 'white'. I am a 'white', middle class woman. These differences are relevant in the context and legacy of our apartheid past, where issues of power were often, and still are, related to race. Age is an additional consideration, which could have contributed to power and agency, as all the clients were much younger than myself. However, my identity as an older woman and mother, may have been beneficial with regard to the establishment of trust.

From a feminist perspective, it is postulated that an interviewer can never be purely a facilitator standing outside of the phenomenon being researched. Meaning that is

created in the interview is seen as participative, and that meaning is a product of a larger system of meaning created by the social system that both the participants and the interviewer inhabit (Terre Blanche & Durrheim, 2002). It is also noted by Cook (1991) that feminist scholars inhabit the world with a double vision of reality. At a methodological level, an awareness of the double consciousness that arises from being a member of an oppressed class (women) and a privileged class (educated) enables women to explore other women's perceptions from an experiential base (cited in Nielson, 1991).

In terms of my values, I recognise the phenomenon of women's oppression in a patriarchal society, and as a women it is important for me to integrate my 'repressed female subjectivity' (Nielson (1991): p74), making me better equipped to interpret and comprehend women's experiences. Being a mother increases by investment in the research topic. I am committed to challenging the status quo, to facilitate environments that are empowering and caring for women during pregnancy, birth and mothering. However, it is important to reflect on how my own social group status influences the interpretation of my data (Campbell & Wasco, 2000). It is essential for me to be conscious of my white middle class status and my susceptibility to racial and social class biases.

3.9 CREDIBILITY AND TRUSTWORTHINESS OF DATA

In quantitative methodology the relationship between an object and its representation is dealt with by means of concepts such as validity, reliability and generalisability. However, with qualitative research an alternative paradigm is used. This study was

guided by the Fourth Generation Evaluation concepts of credibility, dependability and transferability to evaluate the 'trustworthiness' of the study (Guba & Lincoln, 1989).

Transferability refers to external validity or the extent to which findings can be generalized. It is maintained that the transferability of a study to wider settings can only be judged if the specifics of situations and settings are made known. Dependability, linked to reliability in quantitative studies, is not the same thing as being able to replicate studies, as it is argued that different researchers produce different, but equally valid work. Qualitative studies can achieve dependability through systematic and clearly documented data collection and analysis (Guba & Lincoln, 1989).

The final concept, credibility, is achieved by the researcher receiving feedback from the research supervisor as well as from the participants of the study (Guba & Lincoln's 1989). With regard to this study a feedback meeting was held at the LMOU with the staff participants. The findings were presented and discussed allowing for clarification and the emergence of further data.

3.10 ETHICAL CONSIDERATIONS

This study described people's perceptions of their reality, which requires both ethical and methodological introspection (Terre Blanche & Durrheim, 2002). As an evaluator, I have an ethical and contractual obligation to both the clients and the staff of the 'Liesbeeck MOU. Signed consent was received from the participants. The reason for the study was explained clearly and non-technically (Terre Blanche & Durrheim, 2002). The participants were informed that they have the right to refuse to be

interviewed or to answer a particular question (Mouton, 2001). They were also be informed that they can withdraw from the research at any time (Terre Blanche & Durrheim, 2002).

It will be explained that feedback will remain anonymous and complete confidentiality will be maintained at all times. The process of identifying key stakeholders and listening to their perceptions will require extreme ethical dexterity to maintain honesty and a non-judgemental attitude (Campbell & Wasco, 2000). A presentation of the findings has been made to the staff of the PMHP and the unit will be provided with a copy of the final report.

3.11 CONCLUSION

This study is located a qualitative, feminist standpoint methodological framework and has drawn from Fourth Generation Evaluation methods. A description of the study's aims and objectives were provided, participants were described and the method of data collection and analysis was delineated. Self-reflexive and validity issues were discussed and ethical issues considered. The next chapter presents and discusses the results that emerged out of the analysis.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 INTRODUCTION

This chapter will provide an analysis and discussion of the data collected for this evaluation. The staff and the clients' perceptions of the Perinatal Mental Health Project have been explored and the main themes have been identified. Consistent with Fourth Generation Evaluation (Guba & Lincoln, 1989) the data has been divided into the claims, concerns and issues, which have been revealed by the relevant stakeholders.

The *claims* refer to the positive aspects of the project - an assertion that is favourable to the participant. The *concerns* are assertions that are perceived as being problematic or unfavourable. The *issues* refer to areas of contention; aspects of the project that require further negotiation (Guba & Lincoln,1989). In many instances it is difficult to make firm distinctions between these categories. A concern for example, could be perceived as, or become an issue. The framework of the data is not absolute – the following descriptions set the stage for the evaluation to unfold and for the various stakeholders to reach consensus.

Participants have been numbered in order to preserve confidentiality and anonymity, and their positions as stakeholders have been identified. (For example, Midwife, Counsellor or Client). The project manager and the psychiatrist, however, are identifiable as there is only one of each of these stakeholders. Their consent has been

granted. The quotes have been presented verbatim, and the author has used italics to highlight certain key points.

Six clients' perceptions of the Perinatal Mental Health Project were explored. The midwives screened each participant during the antenatal period. The outcome of their scores suggested that they were experiencing some form of emotional distress. Five of the participants attended one antenatal counselling session and one participant saw two different counsellors once, as well as the psychiatrist.

The coding transcriptions are as follows: MW – Midwife; PM – Project Manager; CN – Counsellor; Psych – Psychiatrist; P – Client Participant.

4.2 STAFF CLAIMS

This section describes what the staff at the LMOU perceive to be the positive aspects of the project. Themes that emerged were the efficiency and usefulness of the screening tools, and the development of the midwife's self-awareness and empathy. Two further claims were providing an emotionally supportive environment and counsellor availability as midwife support. The final theme that emerged in this section was the fact that the Perinatal Mental Health Project provided a free psychological service.

The staff at the Liesbeeck Maternity Obstetric Unit unanimously agreed that the Perinatal Mental Health Project was useful and should be continued at the unit. They all feel that the awareness that they have gained has added considerable value and enrichment to both themselves and their clients.

4.2.1 The Efficiency of the Screening Tools

The interviews for this study revealed that the midwives responded to the way that the program was structured. Many of them referred to the efficiency and usefulness of the screening tools. Even though the LMOU is a well-resourced unit, the midwives have very busy schedules with pressure to adhere to biomedical standards.

The Perinatal Mental Health Project has been designed to fit in with the clinic's antenatal medical routine. The midwives screen the women during their routine visit and then calculate the scores and document them on the obstetric card. This study revealed that the midwives appreciated the tools which are simple to administer.

MW 5: What has been good for me about this project is that I have all these great lofty ideas, in terms of what I want to do – and what I do with women on an individual basis – but it hasn't been structured. This project is structured.
My style is to approach people in a way that gets them talking. The screening tool makes it more simple and streamline.

MW 2: I think it has made me confront the whole PND and anti-natal or social pathology - purely because I have that tool at my fingertips.

And… if they (clients) feel safe they may start crying and you say 'come, lets go and make an appointment'. Not just 'you had better sort yourselves out y'know'. You've got something. Its fantastic.

MW 1: Oh it's the best! What is so amazing for me is that I have got a tool, a resource at the tip of my fingers.

MW 3: The structure of this project helps me – it gives me the tools to work with.

In contemporary obstetric practice birth is seen as a potentially pathological event (Davis-Floyd, 1997). The clinic is busy and the midwives take their clients through a series of routine tests and examinations. Taking care of women's emotional needs in this context inevitably becomes part of the same medicalized paradigm. Brems & Griffiths (1993) argue that in the context of maternal health, most doctors are trained to see labouring mothers as risk patients. Efficiency is paramount and the effectiveness of the project depends on the process being simple and streamline. The midwives appreciated the screening tools, which present an opportunity to begin discussing emotional topics with women whose normality can only be proved after the event. In view of the medical model women are not looked at holistically and maternity care is centred on the pregnancy itself (Ussher, 1997).

4.2.2 Development of Self-Awareness and Empathy

PM: The idea behind the project is to make midwives more conscious of mental health issues or emotional issues, in themselves and in others, and to be aware of the stresses that a woman may be suffering, or may suffer in the future.

The midwives at the LMOU were given a training workshop at the onset of the project whereby they were informed about a wide range of perinatal mental health problems and the associated risk factors, and included an experiential component.

MW1: I have learnt the importance of the whole emotional side. I mean in our (original midwifery) training we did psychiatry and general training so you have some understanding but you get so used to dealing with the physical side – its easy just to get by. This project has broadened our training.

In the workshop the staff were also encouraged to explore their own emotional responses and feelings with regard to their clients, their roles as midwives and when applicable, their own birthing and mothering experiences. The intention of this experiential aspect of the workshop was to expose the midwives to the important role that empathy plays when dealing with mental health issues.

The root meaning of the word empathy is 'feeling into' (Shamasundar, 1999: p18). It involves the ability to be affected by the client's affective state, as well as being able to 'read' in oneself what the effect has been. It involves the cognitive and emotional capacity to interpret physical and psychological states of others and is associated with an attempt to alleviate discomfort in others. (Shamasundar, 1999).

It was evident that the midwives have become aware of the important role empathy plays in understanding their clients, and how their own issues are fundamentally intertwined with their approach to their practice.

MW 3: At the workshop she (the facilitator) wanted us to talk about our experiences, our own births, the impact our pregnancies had on our families and how did the family

react. And..um, well that really opened up a window. This is not just about the patient – it also helps me in my personal life.

MW 5: Pregnancy is a good time to deal with issues – issues that a woman has with her mother will come up and it's a good time to face this. I have my own personal reasons for being interested in this as my relationship with my own mother was very difficult. Every child wants her mother's love. Every mother needs a mother in order to mother her own children.

MW 6: In my own pregnancy I could have benefited from a project like this. I was miserable and teary and when I screen patients it makes me realize what was going on with me then. Because I can identify with them I feel I can help them.

The LMOU midwives' have had varying exposure to psychology - from a midwife who is doing her honours degree in psychology to those who have had no exposure, apart from the psychiatric module of their original training. The above self-reflective discourses highlight that as a result of the implementation of this project there has been personal, experiential learning.

In a recent study a midwife described the qualities of a good midwife as the 'inner based qualities of analysis and discernment' (Davis-Floyd, 1997, p.233). It is important for a midwife to stay in touch with her own emotions so that she is not separated from the process of learning. Thereby feelings of self-respect, self-love, and

self-trust blend to make a midwife humane and keep her connected. (Davis- Floyd, 1997).

PM: I found it interesting to observe midwives in process. I think they are getting an extra component in the training and more experience and exposure that has possibly enabled them to engage with the clients at a deeper more meaningful level. I think that they give clients more time and have gained a level of self confidence with regard to interacting with women who might have issues that are not medical.

4.2.3 Providing an Emotionally Supportive Environment

PM: The strength and aim of the project is to create an environment which, I think, is allowing the patients to open up more and to have access to emotional support. To be able to explore their vulnerabilities and find ways of dealing with problems.

MW 5: The prenatal period is the best time to make contact and to reach out to women who are emotionally over burdened, in trouble or depressed as she is more open hormonally and physiologically when she is pregnant.

MW 1: If you don't actually go there a lot of patients never open up about it and it's difficult. We are now allowing them to be more open .

MW 6: I think the project makes more people comfortable with the idea of seeing a psychologist. Some people think that to see a psychologist you have to be really mad or losing it.

A counsellor with the project confirmed the impact that the midwives were having on the clients.

CN 1: Oh, the midwives are fantastic. They are so interested and caring and protective of their patients. I get such positive feedback from every single client. The midwives are very special people.

There has been a long history of complaints about the dehumanising and depersonalising, non-supportive nature of medical care (Nicholson, 1990). However, the above discourse reflects how the Perinatal Mental Health Project is working towards providing a supportive space for women. There is an emphasis on exploring how women really feel, not just how they are expected to feel. Oakley, (1992) refers to the importance of continuous personal care whereby the patient feels that they are being listened to, and cared for, and responded to as a person, not just as a body, which is the focus of the medical gaze (Oakley, 1992).

4.2.4 Counsellor Availability as Midwife Support

The midwives engage with their clients during the routine antenatal check-up. Since the implementation of the project, some of the midwives reported that they are more open to their clients' emotional needs because they have the option of referring them to a counsellor. In the past, at times they felt helpless when dealing with distressed clients, and may have avoided confronting emotional issues because of the lack of

available support. Increased awareness and the availability of counsellors has given midwives the confidence to approach women on a less superficial level.

MW 2: It has given me a lot more freedom to allow people to be vulnerable and.. well.. because I am not so scared. People are naturally scared of letting people tell us about their problems because you don't know what to say to them. I can now allow people to tell me their problems. I never used to get the details.

The program's structure helps midwives when they are particularly busy and have little time for anything apart from their routine medical care.

MW 1: If I am feeling pressurized I tend to skim over stuff and feel I don't have time to deal with problems. It's nice for me to have a resource to refer women to. It makes me feel better about myself. Before I would have felt helpless.

MW 4: What I have learnt about myself is that I don't draw stuff out of people. It's a relief to have counsellors to refer to.

The midwives have developed the skills to respond to psychological needs, to develop appropriate referral skills and to provide a containing environment for the clients. It has been a relief for the midwives to be able to respond to psychological needs, without having to take on the responsibility of working with these needs. The availability of the counsellors have provided the midwives with support.

4.2.5 Free Psychological Service

The Peninsula Maternal and Neonatal Service (PMNS) is the state-run obstetric and neonatal health system. It consists of eight Midwife Obstetric Units (MOUs), most of these MOU's are situated in lower income group areas or townships (Honikman, 2003). The Liesbeeck MOU provides a unique service as half the clients are non-paying, and the other half pay for the obstetric services. The clients of this unit comprise of a wide range of women from different socio-economic groups. The counselling service is free to all clients and the counsellors volunteer their services. The public health sector contributes a small fund towards the project, which at this point, at the most, allows for a part-time project management salary. An identified major benefit of this project is that it provides a free service to a range of communities.

MW 3: Most of the clients that attend the Liesbeeck MOU can't afford the services of a psychologist. Poorer people of our community are benefiting.

MW 1: The counsellors are able to give time and the patience to all the patients, helping people who can't normally afford counselling.

Impoverished communities are most at risk for perinatal mental health problems but can least afford the consequences of these conditions (Honikman, 2003). It is often the women who have the least resources who, paradoxically, are also those to whom the least is offered (Maynes & Best, 1997).

4.3 STAFF CONCERNS

This section of the evaluation refers to the areas of the Perinatal Mental Health Project that the staff revealed as being problematic. The themes that emerged were the lack of available funds, and the unsuitability of the consulting room. The problem of counsellor availability and appointment defaulting also emerged as a significant theme.

4.3.1 Lack of Funds

The potential growth of the project at the LMOU is limited by the lack of funds. The paying of staff salaries was highlighted as a problem.

PM: I think there needs to be more practical support from people in various positions of power. A co-ordinating position needs to be taken more seriously and my position needs to be better funded. I need to be able to work more hours and be paid for that.

MW 5: The counsellors should get paid. Voluntary work is not always sustainable.

CN 2: It would be wonderful to have a person who was always available that we could contact and who would follow up and give feedback.

There is an aim to rollout the project (or a version of the project) to the whole PMNS and this would require substantial financial resourses. Some of the staff members referred to this rollout and the potential difficulties.

MW 6: Without a doubt in my mind this project should be continued here. We have helped so many women deal with stuff and issues in their pregnancy. I just wish it could be offered everywhere else – but I know money is always an issue.

PM: There is an awareness of the need to improve and expand this service locally as well as further within the PMNS.

MW 5: One of the biggest reasons that this project should be continued here is because it is a semi-private facility so we have the resources so we can finance it. And once it becomes something we can possibly implement it somewhere else.

It appears that a significant hurdle to effective implementation of this project results from a lack of provision and adequate funding and resources by the state. This hindrance is related to current economic practises. The standard response of free market nations, when faced with financial pressures and economic problems, is restraint in welfare budgets and cutbacks in social spending (Dennill, 1999).

The limited state funding that is delegated to the Perinatal Mental Health Project reflects the marginalization of psychology. Psychology has not been allocated sufficient status in order to benefit from adequate funds. This marginalization stems from the premise that medicine, like Western science generally, is based on scientific rationality: that is, all assumptions and hypotheses must be capable of being tested, and verified, under objective, empirical and controlled conditions. Phenomena

relating to health can only become 'real' when they can be objectively observed and measured under these conditions (Davis-Floyd, 1999).

With regard to this project, its worth in the public health sector is dependent on being observed and quantified. Consistent with the medical model the benefits of this service are expected to become a 'clinical fact' before further funds will be allocated.

4.3.2 The Consulting Room

Some of the interviews revealed that a more homely, comfortable setting would be conducive to more effective consulting. At present the counsellors and the psychiatrist consult in a room that is used at other times for antenatal physical examinations.

Psych: I think you need a more comfortable environment. One that isn't strictly medical.

CN. 2: I think something more comfortable would be better – it's a bit strange having a bed and all the medical equipment.

Counselling in a medical setting can perpetuate the contemporary notion of women's emotional problems being defined as medical entities (Oakley, 1992).

CN 1: The room is not ideal but the most important issue is that it is a place where women feel safe – and that is the feeling that I get from women. That they feel safe.

The interviews with the client participants (see Client Counselling experiences, 4.5.3) revealed that they did feel safe as most of them reported that they were able to freely express their feelings and reveal aspects of themselves that they had concealed from others. Taking this into consideration, it appears that even though the room is not ideal, it is adequate.

4.3.3. Counsellor Availability and Appointment Defaulting

A Social Worker and a Counselling Psychologist have been voluntary counsellors since the onset of the project and both work at the clinic on Fridays. Recently, a third counsellor joined the team (a Social Worker) and she is available on Thursday mornings. She was not part of the project when the study interviews took place. The voluntary psychiatrist works, on site, for two hours on Monday afternoons. A concern amongst these practitioners and the midwives is that patients, who have appointments booked for them, regularly default.

The majority of midwives commented that if the counsellors were available on more days, they could refer the women directly, as opposed to setting up an appointment in advance, and this would decrease the defaulting of appointments.

MW 6: I think we need to tackle the days and times the counsellors are available. When the patient comes only for the counselling its sort of intimidating….. also, she may not come at all. You know -wake up and say 'Ag, its only counselling – I feel better today'. We should combine visits.

MW 5: Best if we could have someone here everyday, because often if you make an appointment in advance they won't come back. If you say to them you can see someone now – they may agree.

MW 1: The women are more likely to default if an appointment is made in advance, rather than a direct referral. It may because the clients feel intimidated by talking to a stranger about personal issues. Maybe it has to do with travel costs and childcare difficulties.

Research on health care use has revealed that that those with low support tend to be late prenatal care seekers. The results indicated that this was due to a direct effect of social isolation and a lack of available resources (childcare, transport and money) or a lack an understanding of prenatal care (D'Ascoli, Peterson & Kogan, 1997). Another study revealed that abuse in pregnancy resulted in delayed or decreased compliance with prenatal care. The late attendance was the result of control by an abusive partner (Webster, *et al.,* 2000).

The reason for the clients defaulting of appointments in this project is unknown. Other studies revealed that depressed women with poor support are high consumers of health care. These women report poorer health in pregnancy and postnatally, and seek formal help for such problems more often. It was suggested that it filled a social need not met elsewhere (Forde, 1992; Webster, *et al.,* 2000).

Psych: Patients not arriving is one of the biggest problem areas of the project. Either the patients don't know what the appointment is about – or they feel they don't

need it. Possibly the health givers are more concerned about the patients situation than the patients are themselves which is, I think, one of the reasons why they don't turn up for follow up.

Despite the patient defaulting rate the amount of women needing psychological help is high. The counsellors and psychiatrist carry a substantial patient load.

CN 2: We need more counsellors, whether it be professional psychologists or lay counsellors who work under a psychologist's supervision.

Reliance on voluntary services is unpredictable and unsustainable. The project manager has found it difficult recruiting volunteer psychologists resulting in the program being dependent on a small core group of counsellors who are expected to maintain the demands of a large amount of referrals. Again, this concern indicates how the counselling service has been marginalized in the public health sector (Dennill *et. al*,1999) and highlights the necessity of more adequate funding.

4.4 STAFF ISSUES

This section reflects areas of the project that are contentious. The themes that emerged in this category was the lack of postnatal follow up and counsellor characteristics – with the sub-themes of language, race, culture and gender. This section ends with a discussion of the low screenage coverage rate – out of which the sub-theme intuition emerged.

4.4.1 Lack of Postnatal Follow-Up

'The midwives, counsellors, psychiatrist and project manager all commented on the lack of postnatal follow-up.

Psych: We can't actually run a program like this without focusing on the postpartum. It's too superficial to focus only on the antenatal trauma. Without seeing postpartum clients one is missing the whole point.

PM: One of the biggest weaknesses of this project appears to be the difficulty with postnatal follow-up. Once the mothers have given birth and no longer have contact with the unit, they seldom return for postnatal support and counselling, even though the service is available. The routine 6-week postnatal check visit has been discontinued for many years.

Previously, in the public health sector, perinatal care incorporated a routine postnatal six-week check-up. As a result of budget cutbacks this routine appointment has been abolished. This has resulted in women not returning to the clinic postnatally, and thereby professionals are unable to assess or offer women care during the postnatal period.

This project is at a very early stage of its development and that may account for the low rate of postnatal follow-up. Increased awareness of perinatal mental health problems and the consequences thereof could lead to more women *seeking help* for their problems. Whitton, *et al.,*(1996) research suggest that antenatal education may improve women's understanding and acceptance of available treatments. The authors

noted that if postnatal depression is to be more readily treated, the women themselves need to be more able to recognize its presence and be prepared to seek treatment.

CN 1: One of the biggest weaknesses of the project is lack of patience. The project is in its initial stages so there will obviously be difficulties and challenges. I think that everything is being addressed as it emerges. There will be resistance – not intentional resistance - but resistance to a new project. So the do-not-arrives, or not screening or follow-up problems are inevitable. The project will grow and develop with time.

Another consideration is that may be unrealistic to expect mothers with newborns to *seek help*, particularly if they are depressed, socioeconomically disadvantaged and do not have the practical or economic means to get to the clinic. Interviews with the client participants of this study confirmed that it was practically and emotionally difficult to make an appointment even though they felt depressed. (see Client Postnatal Follow-Up, 4.7.1).

In an Australian study it was confirmed that postnatally depressed mothers benefited considerably from a home delivered program focussing on maximising the health and well being of the infant and the mother. The intervention had major positive effects on maternal mood, parenting satisfaction, and the quality of the maternal-infant dyad (Armstrong, *et al.,* 1999). A British study confirmed these findings, highlighting that home visits enhanced professional responsiveness in that it resulted in an improved understanding of the client's needs (Fuggle & Haydon, 2000). The benefit of both

these home visit services was that the children were not viewed in isolation from the adults who cared for them (Armstrong *et al.*, 1999; Fuggle & Haydon, 2000).

MW 3: They also need to be counselled after delivery- especially people in the location – they don't have anywhere to go. I think we need *a support system* – maybe in 'Gugs'(Guguletu) – that would help a lot I think.

A relatively recent development in psychology in South Africa is community participation in the form of community health workers. This refers to people who have a brief training in the health field and generally work in their own communities. It could be possible that such workers could be in touch with the needs of the women in their communities and design culturally appropriate interventions (Duncan & Lazarus, 2001) Dennill *et al.,* (1999) suggest that primary help care should be entrusted to the people, to promote 'self reliance and self –determination' (Dennill, 1999:p56).

4.4.2 Counsellor Characteristics

The Liesbeeck MOU is unique in that it serves a wide range of women from diverse communities – both middle and lower class women from various racial backgrounds. The midwives at the Liesbeeck MOU are representative of all these communities. The psychiatrist, the counsellors and the project manager are white, middle class and English speaking women. It can be problematic when it is assumed that 'women' are a homogenous group with the same needs, desires and experiences (Chadwick, 2003).

4.4.2.1 Language

Some of the midwives have noticed that certain clients are apprehensive when offered a counselling session. It was suggested that certain clients feel intimidated by the counselling process if they are not English speaking.

MW 1: Some people are intimidated about speaking to someone about their issues. Especially the poorer women who don't speak English. For a lot of communities it is not a common thing to speak to a stranger about problems. It is something that is very strange.

MW 6: There are some clients who don't want to go to counselling. Some are scared – especially if they don't speak much English

Social constructions of 'race' and 'culture' have an effect on an individual's identity and every aspect of their psychological development (Terre Blanche & Durrheim, 2002). Some clients may be misunderstood and marginalized because the majority of psychologists in South Africa speak no indigenous languages, apart from Afrikaans (Swartz, 1996). The above quotes suggest that the language spoken by the counsellors in this project is significant. In order to satisfy the needs of all clients in the South African multicultural setting, multicultural counselling should be provided. Some clients may feel more comfortable if a counsellor is, for example, Xhosa speaking.

Maynes & Best, (1997), believe that women-centred counsellors, ideally should also mirror, to some extent the clients' backgrounds so that the therapeutic space is relevant and responsive to different identities and experiences of women. Historically

most South African psychologists have been white and trained to work with middle class patients (Swartz & Gibson, 2001). Research by black psychologists have suggested that white psychologists have difficulties communicating with and are out of their depth when working with oppressed black communities (Manganyi, 1991 cited in Seedat, Duncan & Lazarus, 2001).

With regards to this project, it appears that, apart from language, the counsellors can still be effective if they are able to share, understand and accept the worldview of all clients. Effective counsellors should understand the socio-political context in which they exist and have an understanding of their own cultural conditioning (Sharf, 2000).

The following quote by a midwife from Guguletu highlights that by offering the counselling service, the project is 'breaking the silence'. The routine screening in itself creates awareness and brings to attention issues, which in many instances, may be hidden.

MW 3: This program is very good for the black community. It's having a good effect because there are people out there who would rather die in silence because they are too scared to ask. They are too scared to open up about personal issues.

PM : Mental health issues can be masked or hidden as a result of the physical changes of pregnancy, predominant concerns of shame and the stigma associated with mental illness. Disempowered women – those who are victims of violence, those who cannot speak English or Afrikaans, women

from low socio-economic class - are less likely to reveal symptoms of emotional distress within the biomedical context of an ordinary antenatal consultation.

4.4.2.2 Gender

MW 6: Women should support other women, especially when they have babies. That is what is good about this place (the Liesbeeck MOU) – the women are supported.

Studies have suggested that supportive care for women in the perinatal period is best provided woman to woman (Nicholson, 1999;Oakley, 1992). Oakley (1992) suggests that this is 'not about the biology of sex but the culture of gender' (Oakley, 1992, p45). Women are generally more sympathetic and skilled listeners and often work harder at close relationships (Nicholson, 1999).

4.4.3 Screening Coverage Rate

An issue, which emerged from this study, concerned the screening coverage rate which refers to the *amount* of women that are screened on a daily basis. It presented itself as a contentious issue because the project manager and the midwives expressed differences with regard to satisfaction with the coverage rate.

PM: Adequate coverage and an appropriate target population are the hallmarks of success of a screening program. Mental health issues could be notoriously well masked or hidden and only through adequate coverage can one be sure that *all* the women are benefiting.

She went on to say;

PM: One of the key problems with the program is the issue of competing priorities. Even though the LMOU is well resourced the staff still struggle with addressing the basic bio-medical needs of the clients – following a standard medical protocol. The introduction of a whole new dimension to the teamwork has caused conflict for them in terms of getting things done. This has contributed to the low coverage rate with regard to screening. 45.5% of mothers were screened from September 2002 – September 2003. This statistic is a bit depressing. I have been frustrated that they (the midwives) haven't screened as much as they could have.

However, most of the midwives reported that the screening process does *not* impact hugely on their workload *unless the clinic is particularly busy*. The general response was that the time used up on screening was 'worth it' as the majority of clients responded positively to being screened. They expressed the fact that they were doing their best.

The answers to the question "How much has the screening process impacted on your duties?" were as follows:

MW 5: It hasn't really impacted on my duties as my style anyway is to approach people in a way that gets them talking.

MW 1: It's relatively easy to fit in.

MW6: I think a little bit. We do have to spend more time with the clients – other clients have to wait longer.

MW 4: The procedure extends the consultation by at least 15 minutes.

MW 2: During the very busy times we are not actually able to do it.

This evaluation has revealed that the midwives are wholly committed to the project for the sake of their clients. The screening *is* being done, but not as consistently as the project manager would like. This issue required further dialogue and was brought up in the follow-up meeting. It transpired that there was a slight change in procedure, which has contributed to an increase in coverage. On a Tuesday antenatal checkups include a series of tests – such as taking blood – and the screening has been incorporated into this routine. This has resulted in a more systematic approach to screening.

4.4.4 Intuition to Assess Clients

A dominant theme that emerged from the interviews was an intuitive discourse. Some midwives reported that the screening material gives them confirmation of what they feel about certain clients, and the availability of the counsellors gives them the confidence to follow through with these feelings or intuitions.

In many ways, the biomedical model has resulted in the under valuation of intuition, emotion, feeling and direct individual experience as ways of knowing (Oakley, 1992). Intuition is described by the *The Oxford Reference Dictionary (1986)* as "immediate apprehension by the mind without reasoning". Other characteristics of intuition

include awareness or a feeling that enables a person to act in a particular way without being able to articulate how and why (Williams & Irving, 1996).

When the clinic is very busy certain midwives reported that they used intuitive 'skills' rather than routine screening.

MW 5: On a normal average day it takes time, but if the workload is hectic then the EPDS takes a kind of backseat. If I am frantic I don't screen unless I feel that someone is not okay.

MW 2: If I see someone that is sad or not looking well I have this score sheet, which nine times out of ten confirms my feeling. It is very seldom that someone looks sad and it doesn't correspond with the score.

MW 4: Sometimes you just get the feeling that things are not okay with a mother. Before I might not of followed through with this feeling. Now I can screen them and refer them.

In practice the midwives appear to be using a mix of intuition, developed interactive skills as well as a knowledge and an understanding of the 'risk factors' that may predispose women to developing perinatal mental health problems. Williams *et al.*, (1986) see intuition as 'the hallmark of expertise to be expected from a healthcare worker in an empathic relationship with a client' (Williams *et al.*, 1986, p221).

PM: Intuition should not be a replacement for consistent and routine screening. These "para-techniques" are uncontrolled and untested and are highly likely to be *less sensitive and specific* than the standardized, pre-validated tool, the EPDS.

Medicine, like Western science generally, is based on scientific rationality in that all hypotheses must be capable of being tested, and verified in controlled conditions (Williams *et al.* 1986). The midwives, however, appear to balance the demands of technologically obtained information such as the 'tested, standardized tools' with a body of intuitive knowledge.

4.4.5 Power Dynamics

The following narratives reflect *an aspect* of the relationship between the midwives and the project manager, who is a medically trained doctor. It appears that a power dynamic has arisen out of the issue of adhering to consistent screening of clients.

MW 4: Like any other project it is difficult getting people to work together – there are often conflicts of interests, power issues, bringing people together and getting them to work for the same purpose, for a common goal. It is always a difficult thing.

MW 6: Midwives are reluctant to get involved when they are busy, and midwives are reluctant to be bossed or told what to do by other people. Midwives can be very difficult. They like to be bossy. They don't like to be bossed.

MW 2: I sometimes feel nothing for this project in terms of stats – you know what I'm saying...they want us to score everybody so that we can have stats. But I do as much as I can – if I see a sad mom I will score for her benefit, for her and not for the project. But then... um.,I suppose this work has to be proven so it can go elsewhere, I guess my attitude is a little bad in terms of that.

MW 5: Doctors are trained in a hierarchical structure – which results in strongly entrenched behaviour patterns. As far as they are concerned 'midwives are just midwives'. And they don't know anything and they are there to be instructed. But midwives are independent, we deliver babies and we can do it without doctors.

PM: I think part of my problem is that I have been a bit of a control freak. That is something that I have learnt about myself through this project. There may well be other right ways of doing things that do not conform to project protocol.

Historically, there have been hierarchical disputes and divides with regard to status in the professional sector of modern medicine (Lewin & Olesen, 1985). The above discourse reflects remnants of traditional hierarchical structures, as well as personal difficulties that inevitably arise as a program of this nature grows and begins to take form. In the hospital structure, it has been argued that in terms of power relationships in the provision of health care, the nurse's sphere is separate, but still subordinate to that of the doctor (Koblinsky, Timyan & Gay 1993).

It has also been suggested that although nursing education still takes place within a biomedical framework, nurses and midwives are much better placed than physicians to understand and deal with the emotional problems of 'illness'. In pregnancy and childbirth, the 'quick fix' of the medical model is often inappropriate or of little benefit. Nurses and midwives are often presented with the *meanings* patients give to their life and suffering and therefore are best placed to negotiate between the goals of the doctor and the goals of the patient (Paltiel, 1993).

On the whole relations have been workable. The workable aspect reflects the 'women centred' focus of the LMOU – all the staff are women, working for women.

PM: We have been so fortunate to have such a group of women who have been so willing to take this on and to contribute to the process in terms of offering suggestions, identifying problems and willing to change as the project has changed.

It appears that, in general, the staff perceive the project as contributing positively to the services provided by the LMOU. The efficiency of the screening tools and the benefits of providing an emotionally supportive environment were emphasised by all the staff members. The main concerns and issues centre around the lack of available funds and the implications thereof, as well as practical problems such as client defaulting and lack of postnatal follow-up. Greater insight into these issues is provided in the following section, which reflects on the client's perceptions.

4.5 CLIENT CLAIMS

This section discusses the aspects of the project that the clients' perceive as being positive. The themes that emerged was the quality care received from the midwives, the positive experiences of being counselled which is divided into the sub-themes – opening up, recognition and validation and neutrality, and positive birth experiences.

4.5.1 Quality Care from Midwives and Nurses

The most consistent theme of this evaluation concerned the caring treatment received from the midwives and nurses at the Liesbeeck MOU. *All* of the women I interviewed reported that they received exceptional quality care, antenatally and during childbirth. The *trust* that the nurses and midwives build up with their clients is integral to the success of the project. So even though the client's birthing experiences are not part of the project per se, the client's experiences and perceptions of the staff in general are intrinsically linked to their responsiveness to being not only physically but also emotionally 'held' during the perinatal period.

P1: The midwife was kind and so gentle with me when I was in labour.

P2: Oh yes, oh yes! The midwives and nurses were helpful and friendly and kind. They were... like... offering us muffins and tea all the time and a beautiful lunch it was very nice, and they were so nice to me. They gave me strength.

P5: The staff at the Liesbeeck MOU were very nice. So very, very helpful. I am still planning to write a letter to them (laugh) . I must sit down and do that – it was six months ago!

Two of the mothers expressed surprise at being treated with concern and dignity. They are both young single mothers and expected to be judged. Certain categories of women are seen by society to be unfit to be mothers – such as unmarried women, teens, lesbians, ambitious professionals and poor women (Lerner, 1998).

P6: It was wonderful, it was the best, I was so surprised! My mother said she was going to take this lady some flowers and chocolates because she was the best. My mother always used to tell me if you go to hospital and you are a single mother and giving birth they will tell you 'come on and get done with this baby' and stuff like that. They were so sweet! They were so nice – wonderful.

P4: Oh the staff were so very, very nice. They weren't rude or anything – they were very nice people.

According to Shula Marks, a South African nursing historian, cruelty to patients by nurses has been legendry for decades. Recent South African studies have also revealed staff aggression and hostility towards teenagers who are either requesting family planning or giving birth. (Jewkes, Mvo, & Abrahams, 1987).

A study done at a MOU in Cape Town explored women's perceptions of the care they received. All but one of the women reported experiencing shouting, scolding, rudeness or sarcasm. Two of the women reported being beaten by staff. The interviews with midwives indicated that they felt justified in scolding patients who they perceived as "morally deviant" for example, pregnant teenagers (Jewkes *et al.*

1987). Contrary to this research, it is evident the staff at the LMOU are setting an excellent example of providing a client centred and caring service.

4.5.2 Perceptions of Being Screened

Recent qualitative research explored women's experiences of routine screening by health visitors using the EPDS concluding that the participants found routine screening with the EPDS to be unacceptable (Shakespeare, Blake & Garcia, 2004). However, this study revealed that *all* the women found the screening acceptable and helpful.

P1: Ja. I felt okay when they gave me that thing to fill in. It was like they cared about how I was.

P5: It was only after I filled in the questionnaire that I realised that I was not actually feeling great. They offered me a counselling session and I realised how much strain I was under.

P2: I felt a bit strange at first when I read the questions, but I didn't mind. They did it in a kind way.

It appears that these women did not perceive the screening to be a personal intrusion. They reported the screening to be supportive and not pathologizing or stigmatising as was experienced by Shakespeare *et al's* (2004) participants.

4.5.3 Counselling Experiences

The majority of the women that I interviewed (six out of eight) reported that the counselling that they received was helpful. Each of these participants had a single antenatal counselling session and the main themes that I identified were narratives around 'opening up', 'recognition and validation' and 'neutrality'.

4.5.3.1 Opening Up

In the context of this study, 'opening up' refers to the cathartic experience of expressing and verbalizing feelings and problems. The participants appeared to appreciate the uninterrupted safe space to express themselves. Many women experience a lack of entitlement to personal space (Maynes & Best, 1997)

P 4: The session was nice just to speak to someone, and y'know just talk about it and just feel free to talk. I like…really opened to her…..at that time I was really emotional and things were going through my head. "

P 2: It went okay. I did start to cry a bit so I could actually let go while I was speaking.

P 1: It did help me, actually…um. I think. I could realize something that I didn't realize because I was keeping it in – I was blocking it up inside but once I let go so my mind was more broader then I could think better".

P 3: It is something very good because you can open up.

P 5: I spoke about things that I would not normally talk about. Like, I told her that I sometimes have a problem expressing myself. That I sometimes don't have the words to say how I actually feel. I felt stronger after expressing that!"

Oakley (1992) conducted a study that demonstrated the effectiveness of a social support intervention in 'high risk' pregnancy. The results showed that sympathetic listening support is a more effective way to promote the mother's health and that of their babies than most of the medical interventions carried out in the name of antenatal care.

4.5.3.2 Recognition and Validation

A key factor that contributed to the participants having a supportive experience is that of being recognised and validated. In this context *recognition* refers to the counsellors acknowledgment of the participants emotional state and *validation* refers to the reassurance of worth. This involves the acceptance of the responses and feelings of the clients. Many women may have never felt recognised or validated, and according to Parker (1995), these processes are central to therapeutic intervention.

P 4: The counselling session did help so much. She (the counsellor) talked so much pride in me – it helped me a lot. I was so confused because this is my second baby and I had a two year old already and I didn't know what to do with my mother in law because she was stressing me out. I couldn't take it any more so I spoke to the lady at the clinic (the counsellor).

P 1: It was helpful and the lady really listened to me and she asked me so much stuff.

P 2: She (counsellor) went really deep in stuff, and she listened to all my problems.

P 5: I had a couple of risk factors but I knew they were to do with my partner's lack of involvement. He is in the States. The counselling session helped because I came out of there thinking "I am okay!" (laughter) I felt relieved.

P 2: I told her (the counsellor) that I am so frightened because it is sore when I have sex - it hurts. I was frightened about the birth – the fact of the pain. She helped me – we spoke about my fears. And then the birth was so perfect. I could do everything!

The participants appeared to have appreciated having an uninterrupted space to focus on themselves and reflect on aspects of their lives. Cutrona (1984) highlighted validation as being integral to well being. Women are less likely to feel that their problems and frustrations are unique if they are able to share their experiences. She suggests that reassurance of worth benefited women postnatally in that it helped them take action towards eliminating stressful circumstances and to adjust psychologically to circumstances that cannot be changed.

4.5.3.3 Neutrality

The mothers that I interviewed appreciated having someone other than family members or friends to confide in.

P 1: Ja, it was good because I couldn't speak to my mother or my father – like you know its too close. With somebody that I didn't know I could actually talk and set free what was actually hurting me.

P 4: I was so stressful and I didn't want to talk to nobody about it. That day I just made up my mind I am going to talk to her (the counsellor). I couldn't say anything to my family – they just think I am being lazy or stupid.

P 5: If you don't want to open up with someone from your family, relative or something like that. You can really open up to the counsellor."

Recent studies have reflected that close friends and family are not as helpful for support as more distant contacts. The studies were referring to conditions such as cancer or miscarriage whereby commonplace supportive behaviours were frequently perceived as unhelpful (Oakley, 1997). In a sense this is the crux of the program – it depends on the willingness of women to unburden themselves to counsellors.

The participants, it appears, felt supported and comforted by the counselling session. It is beyond the scope of this study, however, to assess to what degree the counselling sessions helped the clients.

4.5.3.4 Positive Experiences of Motherhood

Numerous studies have explored the relationship between adaptation to motherhood in relation to social support. Three out of the eight mothers that I interviewed were content and coping with motherhood.

P 4: I was very worried about having another baby... and then the lady (the counsellor) spoke pride in me".

She went on to say;

P 4: I felt fine after the birth because I have a lot of support. I was worried in my pregnancy, and at first I didn't want the baby - but it all turned out well. The counselling gave me strength.

4.5.3.5 Positive Birth Experiences

Six of the mothers that I interviewed had very positive birth experiences. Birth in western society is polarised into two dominant models – the medical model and the natural or holistic model. It is widely accepted that the medical model is dominant (Chadwick, 2003). The LMOU is unique in the Western Cape in that it is an 'Active Birth Centre' aspiring towards natural birth methods, and as much as possible avoids medical technology and intervention.

P 2: The birth was so perfect. I could do everything!" My partner supported me a lot.

P 6: My birth was incredible – it was an amazing experience.

P 1: My birth was fine. Everything went well. Just painful!

These discourses reflect a sense of empowerment. The staff at the LMOU clearly gave these women the space to experience their births. The descriptions reflect how it was

for them rather than what was done to them. Studies have revealed that the degree to which women are empowered to make their own active decisions and feel in control of the birth processes has a direct relationship to women's satisfaction with childbirth. Allowing women to do things their way is a critical ingredient of what women describe as 'natural' in childbirth (Chadwick, 2003).

4.6 CLIENT CONCERNS

This section deals with the aspects of the project that the client's found problematic. The Perinatal Mental Health Project cannot be separated from the context in which it is implemented. I have, thereby, explored with the clients, their entire experience at the LMOU, including their birth experiences. Even though their births are not directly related to the Perinatal Mental Health Project per se, studies suggest that birth experiences have a significant impact on postnatal depression. Apart from negative birth experiences, the experience of mtoherhood

4.6.1 Negative Birth Experiences

At the Liesbeeck MOU, if a birthing process becomes problematic the patient is referred to Mowbray Maternity Hospital, which is attached to the unit. Two of the participants in this study were transferred to Mowbray Maternity Hospital and induced.

P 6: I was struggling. It was terrible. Terrible. Frightening. I was induced and they used a vacuum. My baby didn't feed on me the first night because he did not sleep by me and then we struggled to put him on the breast. It just didn't work so he went on a bottle. I was very shocked after that. My baby lost weight and

then they said he had yellow jaundice. In the beginning he was a real crying baby. We took him to the clinic to fetch something".

P 5: I had a vacuum and I tore badly. I had 3rd degree tears. I lay in the ward for ages before they decided to stitch me up. I lost a lot of blood. My recovery was hectic. One month after the birth I was still in pain. The stitches became infected. It was hard with a tiny baby and I resented by partner not being there.

These examples illustrate the potentially life threatening aspect to childbirth which must be considered when evaluating the 'technocratic' method (Davis-Floyd, 1997) critically. These women did have the privilege of receiving skilled medical assistance, whereas many women in South Africa have lack of choice and resources. However, the concern is that the mothers who had received such quality antenatal care at the LMOU ended up feeling disillusioned about their birth experiences and staff treatment after beinge transferred to the Mowbray Maternity Hospital. These women appeared to be effected by the low degree of maternal control technology, exacerbated by a perceived lack of support from both staff and partner.

P 5: My experience at Mowbray was terrible. Mowbray has got a lot to learn from the Liesbeeck MOU. In my experience they were very uncaring. Some of the women around me had hectic experiences and they were alone.

However, interestingly, both of these mothers, despite difficult births and resultant prolonged recovery process, were two out of three mothers that were not depressed at the time of the interview. This is not consistent with research that suggests that a

women's birth experience impacts on her emotional well being postnatally. Stress after childbirth, where there has been a high level of obstetric intervention, has been highlighted in many studies as a risk factor for postnatal depression (Beck, 1998; Davis-Floyd, 1997; Epperson, 1999; Gotlieb, 1991). There are various factors that could have contributed to this finding.

Firstly, their babies were six and seven months old respectively, which may have allowed for a recovery period. Both mothers reported a prolonged physical recovery period, Secondly, and significantly both participants had very adequate support systems and neither of them had temperamentally difficult or challenging infants at the time of the interview.

P 6: I felt such relief that my baby was fine. And then afterwards I had a sweet baby. A real sweet baby. I am so happy now. I feel fine. My mother helps me a lot too and my partner visits us everyday.

P 5: He is such a contented, happy baby and my parents (she lives with her parents) are also 'head over heals.' My mother looks after him in the evenings and she loves being a grandmother.

Thirdly, both of these mothers responded very positively to their antenatal counselling session. It is possible that this support impacted on their recovery.

P 5: If I ever felt depressed I would definitely go back to the Liesbeeck MOU for counselling. The counsellor really helped me during pregnancy.

P 2: I felt strong after my counselling session. I was no longer so scared.

4.6.2 Unsuccessful Referrals

Two of the participants felt that they did not benefit from the counselling program.

P 3: I didn't spend much time with the counsellor. She referred me to someone else. So no, it didn't help. I need to see someone but I haven't had time.

This participant was very depressed when I interviewed her. The counsellor referred her to a psychologist at the institution where she is studying. She gave birth before she made contact with the psychologist, and postnatally it appeared that she clearly needed psychological support. In this instance she appeared to be too overwhelmed with her circumstances to take action and seek treatment

Another mother who I interviewed saw both counsellors and the psychiatrist. She felt let down by the discontinuity she experienced.

P 1: I was shunted from one referral to the next. I went to a counsellor and she said that I needed medication. I found the psychiatrist unhelpful. I was concerned about the medication. I must say I am cynical. I went to one counsellor and when I made another appointment I was sent to the other counsellor.

It is unknown whether this participant's experience of the service was hindered because she was unable to build up a therapeutic bond because of the discontinuity, or if she began the process from a defensive standpoint.

4.6.3 Difficult Experiences of Motherhood

In general, the women that I interviewed were struggling with motherhood. There appeared to be an unwillingness of fathers to take emotional and physical responsibility, a lack of money and social isolation and stress. Recognition that poor social support may have an effect on postnatal outcomes is increasing (Webster *et al.* 2000). The participants' perceptions of new motherhood were explored to assist the project in two ways. Firstly, to assess whether a follow-up postnatal counselling session could have been appropriate. And, secondly, to illuminate the core themes of women's postnatal experiences to give insight into the social and psychological context of the project.

4.6.3.1 Sacrifices

The transition to motherhood comes with enormous sacrifice and the majority of the participants were experiencing this impact. Sacrifices are particularly difficult if the child was unplanned.

P 2: Its been hard because I am so young. I could have gone on with my schooling because I wanted to finish. Ja, I wanted to finish my studies.

The lack of choice is evident – this woman's partner left her when she fell pregnant.

P1: I got this job and then three months later, I think, I fell pregnant and then everything like just went down the drain. I mean I could have a better career now. I could have gone out when I wanted to go out. I could have moved when I wanted to move and I can't do that now.

P 3: I am a third year student and it is so difficult to achieve. Everyday I cry when I try to work and take care of this baby. There is no time for enjoyment – I have to be so responsible because the baby is living with me.

This woman was able to continue with her studies but was experiencing the loss of enjoyment. Her experience of motherhood appeared to be dominated by 'responsibility' - she is combining studying and single parenting.

CN 2: It is sad to see women who, for example, have sacrificed so much to go to university, and their parents may have been in domestic service or something and when they get pregnant they want to be good mothers but have worked so hard to get where they are. So they are so devastated.

Contemporary messages that are given by the media celebrates the notion that 'mothers can have it all.' Societal messages imply that it is straightforward for mothers to have careers as well as an exciting social life (Coward,1997). Motherhood comes with unavoidable sacrifices, which are linked to the degree of social support that the mother receives. Social support consists of both instrumental support (such as childcare and help with household chores) and well as emotional support (the quality of family and social networks) (Beck, 1998).

The majority of women take on the responsibility of childcare and children. It is assumed that the role is primarily a feminine one – a notion that is perpetuated by psychobiological thought. Motherhood in Western industrialized societies is

characterized by economic dependence yet the notion of maternal instinct is perpetuated (Nicholson, 1999). Motherhood for many is experienced as drudgery and self-sacrifice (Bolla, 1984) in contrast to the common discourse of mothering being the ultimate fulfilment.

4.6.2.2 Single Parenthood

Four out of the six of the participants were single parents.

P 3: I am coping okay but its hard being a single mother and he (the baby) has been sick quite a lot and then I get very upset and I'll get angry. In the back of my mind I am thinking 'your father is not here – if he was he could help me out. He could hold him'. And that stresses me out a lot.

P 1: Sometimes I am so stressed and then I get angry at the father for not being there and I take my stress out on the child.

P 3: Even though I went to that session and for a while it felt okay – but you know when you are at home with the child it feels lonely. Like you know your family is there but the father figure isn't there and I am thinking if he was here by now I could have gotten a bath and he could have watched the child or I could have eaten. Sometimes when I get up in the morning and no one is around in the house and I am hungry and then I am doing everything with the child and it is 3 o'clock in the afternoon and it is supposed to be breakfast – you understand.

P 1: I want to get my own flat or something but I am first waiting for him to walk. Then I can get a better job and I can get myself a car. I want to learn how to live on my own. I don't want to stay at home anymore under my parent's roof and bring them all this stress and grief because they are getting old and now they must sit with the child. I don't want to put that stress on them.

Lone parents and one-parent households have increased significantly in the Western world (Gillespie, 2000). Research indicates that single parents show higher rates of depression than married men and single women. One explanation for these differences involves lifestyles that lead to depression and anxiety through a combination of low power and role overload. A 'housewife' is an example of low power, and full time employment plus caring for children constitutes role overload (Paltiel, 1993).

In South Africa teenage pregnancy is extremely common (Jewkes, *et al.,* 2001). The impact pregnancy has on teenagers, such as interruption of schooling, unemployment, poverty and obstetric complications is concerning (Cunningham & Boult, 1996). The burden of emotional and physical care for these children falls almost exclusively upon the women.

4.6.3.3 Sadness

P 3: I am depressed, I have a lot of issues but she is not a crying baby. She lies still. I can do the nappies and I can leave the baby and she doesn't cry. But I cry inside myself."

The nurturing of children has universally been seen as 'natural' to women and the concept of 'maternal instinct' is taken for granted in Western culture (Nicholson, 1999). This uncontested notion is disadvantageous for women as it implies that

motherhood is universal and unchanging (Gillespie, 2000). It defines what is seen as normal behaviour for women, not taking into consideration the divergence of women with regard to expectations, desires and experiences (Nicholson, 1999).

Motherhood has been defined by normative discourses whereby it is seen as central to the 'essence' of female identity (Gillespie, 2000). Essentially the discourses of Western culture define motherhood as fixed, unchanging, natural, fulfilling and central to feminine identity (Gillespie, 2000). It is evident from these interviews, that that motherhood might be better understood as a social and historical construction with diverse ways of experiencing it.

4.6.3.4 Child Care and Life Stress

A key risk factor for postnatal depression is stress (Beck, 2002). Stressful events relating to child care can involve factors such as an infant experiencing health problems or difficulties with regard to feeding or sleeping. Other lives stresses such as marital issues or occupational problems during pregnancy or postnatally, are likely to impact on the mother's emotional health (Kahn, 2000).

P 3: I was happy at first and then the sadness started to come when I had stress with my studies. I felt so emotionally stressed. Even now."

This mother struggled with a child that had regular chest problems.

P 2: Every night I pray to God that He must give me strength to look after my child - even if he is sick. Even if I have to get up 20 times in the night. It's just so very hard.

P 1: Its hard to work at night and look after him in the day. I just tell myself, I'm going to do it...I'm going to do it...for my child. I'm not going to do it for nobody else but my child.

The arrival of a new baby is a stressful event, requiring a high degree of adaptation (Cutrona, 1982). It has been hypothesised that women who experience additional stressful events around the time of pregnancy and childbirth are those who become depressed (Beck, 1998; Paykel *et al.*, 1980).

4.6.3.5 Maternal Ambivalence

This participant revealed her intense ambivalence she felt, at times, towards her baby.

P 1: Sometimes, I look at my child and I think 'you know if I could kill you I would do it' but then I just fall back and I think to myself, 'Oh God – please just help me, help me because its not his fault.

Maltreatment of a child, by its own mother, is perceived by the public as the most ultimate incomprehensible act. Discourses of evil surround mothers who violate the innocence that she is meant to protect (Coward, 1997). It is understandable that society reacts with despair at the frequent cases of child abuse or child murders by their mothers.

However, public discourses, which only echo the polarities of good and evil, give no acknowledgment to maternal ambivalence. In reality, all mothers share both loving and hating feelings for their children. The denial of the feelings of fury, boredom or

even dislike towards children, all of which are part of motherhood, makes the burden harder to bear and can result in these feelings being expressed in perverse ways (Maynes & Best, 1997).

Parker, (1995), distinguishes between manageable and unmanageable ambivalence. She suggests that manageable ambivalence can play a creative role in a mother's capacity to think and act. Parker argues that it is the coexistence of loving feelings and hating/resentful feelings that guide a mother into thinking about what goes on between herself and her child (Parker, 1995). However, we live in a culture which is 'ambivalent about maternal ambivalence' (Featherstone, 1997: p185) and this can become overwhelming and immobilizing for women. It provides a context that can induce feelings of intense guilt and at times render ambivalence unmanageable (Parker, 1995). Social workers come across unmanageable ambivalence on a regular basis and sometimes a failure to recognise what is happening can have tragic consequences (Featherstone, 1997).

Public discourses about motherhood often makes it look so easy. Despite an extremely high incidence of postnatal depression, becoming a mother is still expected to be a happy life event, emotionally fulfilling and easy. The myth that predominates is that the mother should be perfectly in tune with her infant, and seemingly needs nothing for herself. That is the cause of so much guilt amongst mothers (Maynes & Best, 1997).

4.6.3.6 Isolation and Social Support

P 1: I'll be in my room and then I get very stressed out and I will burst out crying and the baby's sleeping then I will feel – you know – I need someone to hug me or

hold me and I can't go to my mother and tell her I feel uncomfortable – telling her you know, I just need to be hugged.

P 2: I feel lonely. It is hard when my friends go out and enjoy themselves and I am left alone with the baby.

Previous studies have found a strong association between low support and depression with women. Women with low support were twice as likely to score above 12 of the Edinburgh Postnatal Depression Scale (Webster *et al.*, 2000). Long term follow up studies have also shown that women with low support require more psychiatric counselling, display delayed psychomotor development and are more frequently hospitalised than other infants (Webster *et al.*, 2000) This underpins the importance of identifying at risk women during the prenatal period and ensuring that they are adequately monitored in the postnatal period.

Psych: Something I have learnt from this project is that pregnant mothers and the women that we see here are not aware of the attachment process with their infants. They are therefore not aware of the potential difficulties due to their current mental state. They are not informed about the need for adequate bonding in the early months.

Women who are in need of therapeutic help are often perceived only in relation to their perceived success or failure of mothering. In patriarchal medicine there tends to be an ownership about reproduction and motherhood. It is the health professionals who claim to 'know', not the mothers themselves, who 'in line with their constructed

positions construe women as ignorant and culpably resistant to the (supposed) benefits of professionalized medical knowledge.' (Oakley, 1992: p88).

Mothers do have a separate non-maternal self and all generalizations about maternal feelings are problematic, especially when they tell you what is 'normal, 'right' or 'true'. Maynes & Best, 1997, describe a women centred counselling facility should be based on the central belief 'that seeing the mother as a subject, a person with her own needs, feelings, and interests, is critical to fighting against the dread and the devaluation of women' (Maynes & Best, 1997: p125).

4.7 CLIENT ISSUES

4.7.1 Postnatal Follow-up

A mother articulated the ambivalence she felt before she went for her counselling appointment. She also found it difficult to phone for another appointment postnatally even though she had been depressed and felt she needed one.

P 4: At first I didn't want to go to my appointment. I was like 'oh no! Don't go' but then the woman came in and said 'You can come inside' and then I went inside and I was there. So that is why I think I should rather just take myself again and just go again. It will be fine. But I am always hesitant, you know – 'how am I going to feel' and 'what am I going to say' and things like that – so it's a bit uncomfortable.

P 4: I thought of phoning for another session, but then I don't know. Something just keeps me back.

And the mothers said:

P 3: I felt better. I felt much better after my first session but then I didn't want to go for the other session because it involved the tablets. (She was referred to a psychiatrist)

P 1: I'll be talking, and it may even be a stranger, and then she hugs me and I burst out crying and it then all comes out. So sometimes I do feel that I need to talk to somebody. It is difficult to phone to make an appointment.

P 4: I do need a follow-up appointment but I don't have the time. I have problems with childcare and stuff. But I have always been thinking of making another appointment.

P 6: I didn't think of making another appointment because there was so much going on after the birth. How can I say...it took over a month to heal. I couldn't walk. I just lay on the bed. My baby had colic and we had to go back to the clinic and I was sore and I just had to cope. There was no time to think. No time for me to go to talk to a counsellor.

In general, there appears to be a secrecy and mystique surrounding counselling. And for some the concept revealing emotional problems to a stranger is completely foreign. This requires potential clients to make enormous efforts to order 'to gain access to the active and motivated part of themselves that can seek out this kind of help' (Maynes & Best, 1997). It is easier for the women when a midwife refers them

directly – she can embody the motivation to get help. Postnatally, it requires logistical, motivational and emotional energy to seek help.

4.7.3 Medication

Nicolson, (1990), argued that there are social pressures for women to be feminine, but femininity itself represents a pathological condition. Medicine has also, in many ways, been stripped from it social and cultural context.

Since the 1950's the individualist discourse of health education has dominated health policy. Oakley (1992), points out how this provides a powerful ideological smokescreen behind which environmental constraints on achieving health are veiled as being individuals irresponsible choices. The discourses around health imply that it is determined around lifestyle, not living conditions. Individuals are therefore morally culpable if they do not make responsible choices (Oakley, 1992).

Women have been placed in a paradoxical position within the household. They have been assigned the role of health carers in the family as well as promoters of moral order. At the same time they are blamed and viewed as the main perpetrators of unhealthy behaviour, choosing unhealthy diets or failing to have their children immunized (Mayall, 1986 – cited in Oakley, 1992).

P 1: They told me I should go to another counselling women at Red Cross or Groote Schuur to get tablets but then I thought I don't want to go on tablets because they said that stuff is addictive and everything."

Medicalization refers to the way in which modern medicine has expanded to encompass problems that were previously not defined as medical entities (Lewin & Oleson, 1985). Feminists argue that normal phases of the female life cycle (menstruation, pregnancy, childbirth and menopause) have been pathologized.

The biomedical model portrays human beings as 'physical bodies subject to malfunctioning' (Oakley, 1992: p17). Historically, the health practitioner's role has been to fix 'the machine' by physical means. Body and psyche are seen as separate entities. Identities and social beings are not seen as being intimately connected to the social and material world (Oakley, 1992). However, it is generally accepted, amongst professional and the lay population that social relationships contribute to physical well being.

4.8 CONCLUSION

It evident that both the staff and the clients have benefited from the implementation of PMHP. The screening tools and the available counsellors have provided a containing structure for the midwives to attend to the client's emotional issues. The clients appreciated the intervention. A key concern is, however, the lack of postnatal follow up despite the mothers' experiences of postnatal difficulties. The practical and theoretical implications of the claims, concerns and issues, which emerged from this study, will be discussed in the following chapter.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter summarises the key findings of the study and makes recommendations based on these findings. These recommendations aim to assist the PMHP in ensuring that the services it provides are best suited to the needs of the clients. Limitations are also considered and the chapter concludes with suggestions for further research.

5.2 SUMMARY OF FINDINGS AND RECOMMENDATIONS

The themes that emerged from this study were divided into staff perceptions and client perceptions. The overall responses from both the staff and the clients, with regard to the perceived efficacy of the PMHP were extremely positive. All the staff unanimously agreed that the PMHP should be continued at the LMOU, and all the clients claimed to have benefited, in some way, from the project.

A positive factor that emerged from the staff related to the efficacy of the screening tools and the structured nature of the project. The EPDS and RFA enabled the midwives, despite the busy schedules, to engage with their clients' emotional issues. It is beyond the scope of this research to assess the reliability of the screening tools, but what did emerge was the midwives' appreciation of being able to use a simple and streamline tool that focuses on mental health problems in the busy medical practice. It also emerged that the client participants were experiencing emotional problems antenatally, and claimed to appreciate the intervention and did not find the process

intrusive or exposing. This, it seems, also reflects the sensitive manner in which the midwives handled the screening.

A contentious issue, which emerged with regard to screening, relates to the coverage rate. The screening is not being done as consistently as the project manager would like. This issue was brought up in the research follow-up meeting and it transpired that a necessary change in procedure would contribute to an increase in coverage. A specific day was delegated to implementing a series of physical tests, such as blood taking, and the screening procedure was incorporated into this routine. Newport, Hostetter, Arnold, & Stowe, (2002), argue that accurate diagnosis of postnatal mental conditions are often hampered by poor screening practices for potential medical causes such as diabetes, anaemia, or hypothyroidism, which that may contribute to depressive symptoms. It was decided that the PND screening will be done in conjunction with medical tests allowing for a more systematic approach to screening.

With regard to intuition, this study recommends encouragement and acknowledgment of the midwives' balancing of the tested, standardized tools with a body of intuitive knowledge. It is argued that the biomedical model has resulted in an under valuation of intuition (Oakley, 1992, Williams & Irving, 1996), but it is also understood that within this context consistent and routine screening is essential. The midwives personal attributes of sensitivity and respect are integral to the screening process, in order to avoid women feeling stigmatised or intruded upon, as has been reported in previous studies (Shakespeare *et al.*, 2004; Thurtle, 2003).

From a feminist standpoint perspective this paradigm shift is important. The term paradigm is used loosely in the social sciences to mean perspective, worldview and assumptions about reality (Nielson, 1990). The midwives' intuitive perspective is in a sense reconstructing and reinterpreting patriarchal models of scientific knowledge. This is not to deny the importance of quantifiable psychological knowledge, but allows for the recognition of the less visible (Eagleton, 2003).

Another recommendation is that an even more simplified screening method could be considered for under resourced MOU's. This is in response Webster *et al's.*, (2000) research which advocates the use of the Maternity Social Support Scale. It was described as objective and simple, and useful in areas where resources are minimal. This could be considered for the less advantaged MOU's in the Western Cape. Alternatively the RFA could be used in isolation, when screening becomes difficult.

It emerged from this study that the midwives' perceived an increase in self-awareness as well as empathy towards their clients, as a result of this project. This theme was mirrored by the clients' responses, reporting exceptional quality care from the midwives and nurses at the LMOU and significantly some were surprised at being treated with such caring respect. It was revealed that the training workshop, which the midwives attended at the onset of the project, was simultaneously informative and experiential, facilitating the midwives' self-awareness. It is recommended that the midwives, and possibly the counsellors, have regular feedback and support groups to sustain and enrich personal awareness and receive ongoing skills development. This recommendation was raised in the research feedback meeting and it was agreed that a staff support group would be beneficial.

This study also revealed that the availability of counsellors relieved the midwives' feelings of helplessness when dealing with distressed clients. In support of this view, the majority of client participants reported that the counselling they received was beneficial. The client participants appreciated the safe space to express themselves and talk about their concerns, and also felt acknowledged and validated. The clients also reported that it was useful to confide in someone that was 'neutral', as opposed to family members or friends.

However, despite the help received from the counsellors, the majority of the mothers were experiencing difficulties with motherhood, The themes relating to the problems that the client participants were experiencing as mothers, were single parenthood, childcare and life stresses, isolation, coming to terms with making sacrifices and maternal ambivalence. yet none of them had returned for a follow-up counselling session. This is significant because a main concern relating to the PMHP is the lack of postnatal follow up. All the staff participants felt that the fact that mothers were not coming back for a postnatal follow-up session was problematic.

In essence many of the problems that mothers' experience are related to socio-economic restraints, lack of social support, as well as responses to the oppressive discourses which surround mothers in Western societies. It is assumed that the role of childcare is primarily a female one, and motherhood is characterised by economic dependence (Nicholson, 1999). Even though the common discourse of mothering implies the ultimate fulfilment, many women experience many aspects of motherhood as drudgery (Boulton, 1983). This often leads to maternal ambivalence, guilt and high

incidences of PND. The client participants were experiencing many of the risk factors that research has indicated leads to PND. These include single parenthood, infant health problems, lack of social support, unemployment and financial difficulties.

The client participants' responses for not making a follow-up appointment, despite experiencing difficulties, were varied. The main theme that emerged was gaining access to the motivated part of themselves to seek out help. The PMHP effectively reaches out to women who are part of an antenatal system. However, since the six week postnatal visit has been dropped from this system, the services with regard to physical intervention end after the women give birth. The fact that the LMOU is a medical environment may be a factor in women not returning. Literature suggests that women perceive medical settings as being primarily concerned with treating mental illness, rather than protecting and promoting mental health (Dennill, 1999). This also relates to the appropriateness of the counselling venue. The less 'medicalized' the environment, the less likely clients will make 'illness' associations with counselling, as opposed to social support and the promotion of positive mental health. Ideally, a room needs to be delegated to the counsellors, which is more 'homely'.

Women's help seeking behaviours fall into three main groups: perceptions such as fear; the stigma relating to mental illness; knowledge - such as knowing where to go and what counselling involves; and distance, transport and logistical factors (Women's Health Council, 2002). The availability of educational material, which is women centred, and non-stigmatising, could increase awareness and help seeking behaviour. Another recommendation would be to facilitate support groups for women and the introduction of mental health promotion workshops for women during the

antenatal period. This could be a means of reaching out to women in a way that promotes social support for *all* mothers, not only those who are postnatally depressed. It would be beneficial for health workers to address issues such as mental illness stigma, with the clients during the antenatal period.

Health promotion indicates a philosophical basis of self-empowerment, through education and consciousness raising. Ideally individualistic values that influence help seeking, such as apathy, personal ignorance and incompetence, should be rejected, by pointing out the broader structural socio-political barriers (Dennil *et.al.*, 2004). This will enable the women to incorporate a consciousness of their social location and this location's relation to their lived experience. From a feminist standpoint position, the mothers' understanding is potentially more complete, deeper and complicated, leading to more accurate, complex knowledge (Eagleton, 2003).

A feminist standpoint perspective begins with the idea that the less powerful members of society have the potential for a more complete view of social reality than others, because of their disadvantaged position (Nielson, 1990). This study promotes a double consciousness, which allows for sensitivity to the dominant worldview as well as incorporating the perspective of the mothers, who in relation to the patriarchal medical model, are subordinate (Ramazanoglu & Holland, 2002).

The PMHP relies on the voluntary services of a small core group of counsellors, which is an indication of how the service has been marginalized in the public health sector, and highlights the necessity of increased funding. A recommendation is for the PMHP to look into the possibility of becoming accredited with the Health Professions

Board, in order to offer community placement to psychology students. This could result in the counsellor service being more predictable and sustainable. More available counsellors could also reduce the percentage of DNA's ('did-not-arrives'). Ideally, the introduction of a health home visiting service would be an effective means of reaching these women. Literature supports the benefits of maximising health and well being for mothers and infants through home visits (Armstrong, *et al.*, 1999). This is recommended as a long term goal.

Lack of funding is a major concern relating to the sustainability and growth of this project. Many of the staff participants commented on the benefits of the free service, providing support to women from low socio-economic sectors. Impoverished women are those who are most at risk for perinatal problems, but can least afford to obtain help. However, as the project manager noted, more practical and financial support is needed from people in positions of power. The PMHP would benefit from a full time paid co-ordinator, and ideally the counsellors should be paid. This would contribute towards the sustainability of the project, and assist the process of expanding the PMHP to other MOU's.

Financial difficulties are key to the potential expansion of the project to less resourced MOU's. For example, the frustrations of the nursing staff in the less resourced MOU's who are grossly underpaid, impact on client-staff relations, with reports of stressed nursing staff shouting and swearing at their clients (Honikman, 2005; Jewkes *et. al.*, 1998). A project of this nature requires staff expertise, which include trusting and non-judgemental personal attributes. On a positive note, a recent development is the

Western Cape government's indication of a willingness to help with the MOU's in Hanover Park and Heideveld (Honikman, 2005).

This study revealed themes pertaining to the diversity of counsellor characteristics. The LMOU is also unique in that it serves a wide range of women from diverse backgrounds, in terms of class, race and language. Writers have commented that ideally counsellors should mirror, to some extent, the client's background (Maynes & Best, 1997). It is recommended that, ideally, the PMHP should aim at recruiting counsellors from diverse backgrounds. On a positive note, with regard to gender, it was noted that the staff, who are all women, could bridge the gaps relating to diversity. Supportive care for women, during the perinatal period, is best provided women to women (Oakley, 1992, Nicholson, 1999). This allows for a way to tap into women's collective consciousness in order to confirm the experiences of women, which have often been denied within the male-dominated medical model (Ramazanoglu & Holland, 2002).

Finally, in order for the project to be recognised by those in power, and taken seriously, it is recommended that more research is carried out with regard to the PMHP's feasibility. The implementation of ongoing public relations activities are also essential for fundraising, as well as increasing public awareness.

To summarise, the key recommendations that emerge out of this study are:

- Ongoing workshops or support groups for the staff (in particular the midwives) to maintain self-awareness, to provide support and to promote skills development.

- The implementation of support groups for mothers, antenally and postnatally, to create a social support network for clients.
- Ensure that educational material with regard to women's mental health is provided for women antentally. It is important that this is provided in way that minimizes stigma and highlights the social issues that women face.
- Engage in ongoing public relations activities that are aimed at publicising the nature of perinatal mental health problems as well as the services that are offered by the PMHP.
- Encourage ongoing research to explore the efficacy of the project, particularly for funding purposes.
- Consider the possibility of a briefer, more simplified screening tool to increase efficiency during very busy periods, as well as for less resourced MOU's.
- Recruit counsellors from diverse backgrounds, and if possible, increase counsellor availability, for direct referrals.
- Consider the placement of intern psychologists or community service placements.
- Consider the long-term plan of home visits as a means to reach out to women postnatally.

5.3 LIMITATIONS OF THE STUDY

A limitation of this study is that the interviews were all conducted in English and participants needed to be fluent in English. I did, however, interview participants whose first language is not English which may have compromised their descriptions and feedback. Also, it cannot be assumed that issues of power were not present as I

am white, middle class and English speaking. Furthermore, the participants were aware that I was an academic researcher with affiliations with the project. These variables could have impacted on the nature and quality of the interviews and the information obtained.

The theoretical limitations relate to the feminist standpoint position's assumption that a women's understanding is potentially more complete, deeper and more complicated, and it is presumed that this leads to a more accurate complex knowledge (Nielson, 1990). This implies criteria for 'accuracy', which confronts the problematic idea of objective reality. A key dimension of feminist research is its opposition to positivist assumptions, which reflects hard facts, objectivity and individual competition (Terreblance & Durrheim, 1999). Arguably, true subjectivity cannot be measured.

A second problem is the implication that the more disadvantaged a group is, the more potential for knowledge construction. This leads us into a discussion of who is more oppressed and who is therefore potentially more knowledgeable (Ramazanoglu & Holland, 2002). The notions of experience do not have consistent meanings across all versions of standpoint (Nielson, 1990).

Sandra Harding suggests that feminist standpoint is a case of epistemology in transition as it attempts to explore the relations between knowledge and power. This leaves feminists divided on how to make knowledge claims authoritative, how to understand power and how feminist knowledge can be grounded in women's experiences and differences (Harding, 1991).

5.4 RECOMMENDATIONS FOR FURTHER RESEARCH

Although qualitative research was the chosen methodological approach, it does have its limitations. It is proposed that a range of studies using different methodological approaches should be undertaken to ensure that a comprehensive assessment of the effectiveness of the PMHP is obtained. For example, it would be of value to assess the benefits of the project quantitatively, with a broader sample of mothers. Such a study would reveal detailed demographics of who is benefiting from such a project. It would also be useful to do a needs analysis of other MOU's in the Western Cape. The LMOU is unique in that as a unit it bridges the gap between public and private health resources and well as bridging the gap between technological and 'natural' childbirth, making it an ideal context to pilot this project. However, each MOU in the Western Cape differs in social location.

There is also scope for more in depth research on the effectiveness of antenatal counselling by conducting follow up studies. Women's perceptions of being screened as well as assessing the Risk Factor Assessment and other valid alternatives to screening in this setting would be beneficial. Theoretically, women would benefit from studies that reflect on women's perceptions of PND. We live in a culture that emphasises the ideological importance of motherhood but at the same time declines to confront what makes motherhood so difficult (Oakley, 1992).

5.5 CONCLUSION

The present study will hopefully be used to initiate further research in this area. The findings suggest that the PMHP is a much needed resource. At present the PMNS lacks routine postnatal care with regard to the well being of the infant as well as the

detection of perinatal mental health problems in mothers. This deficiency in the system has been exacerbated by the discontinuation of the 6-week postnatal check visit. The intention of this study is to do more than talk about the benefits, problems and limitations of the PMHP. It is hoped that it will contribute towards a paradigm shift by consciously adopting women's perspectives in order to reinterpret and reconstruct perinatal mental health.

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APPENDIX A

Semi-structured Interview Guide

Midwives

1. In what way, if any, has the Perinatal Mental Health Project (PMHP) impacted on your workload and duties.
2. In general, what are the responses from the clients when you screen them?
3. Do you think there are positive aspects to this project? If yes, what are they?
4. Do you think there are negative aspects to this project? If yes, what are they?
5. As a midwife, have you learnt anything from this project? If yes, what?
6. What changes/contributions could this project benefit from?
7. Do you think this project should be continued at the LMOU? Why?

Clients

1. How did you feel when you were asked to fill in the questionnaire during your pregnancy?
2. How did you feel when you were offered a counselling session?
3. In general, how did you find the treatment you received from the LMOU staff?
4. What was the counselling session like for you?
5. How did you feel after the counselling session?
6. In general, how were you feeling emotionally after your baby was born?
7. Did you make an appointment for a follow-up counselling session?
8. Do you think this service should be continued at the LMOU? Why?

Project Manager

1. How would you define your role?
2. What do you consider to be the key benefits of this project?
3. What do you consider to be the key problems/issues that have arisen with regard to this project?
4. How have you found working in collaboration with the staff at the LMOU?
5. Have you learnt anything from the project? If yes, what?
6. What changes/ contributions do you think this project could benefit from?
7. Do you think this service should be continued at the LMOU? Why?

Counsellors and Psychiatrist

1. What do you consider to be the key benefits of this project?
2. What do you consider to be the key problems/issues that have arisen with regard to the project?
3. How do you think your role as counsellor/psychiatrist is impacting on this project?
4. How do you find working in collaboration with the staff at the LMOU?
5. Do you find the environment conducive to effective consulting?
6. Have you learnt anything from this project? If yes, what?
7. What changes/contributions do you think this project could most benefit from?
8. Do you think this project should be continued at the LMOU?

APPENDIX B

Application for Ethical Approval

To Whom it May Concern

Re: Application for ethical approval

Enclosed are the relevant documents to apply for ethical approval from the University of Cape Town to conduct research at the Liesbeeck Maternity Obstetric Unit. The title of my proposal is "The Perinatal Mental Health Project: An Evaluation".

I have enclosed:

3 copies of this covering letter
3 copies of the application form
3 copies of a detailed protocol
25 copies of protocol summary
25 copies of a consent form

With Thanks

Julia Chesselet

APPENDIX C

Signed Consent

Dear Participant

Thank you for agreeing to take part in this study. The procedure involves a brief interview which will be recorded for convenience purposes. Your identity will remain anonymous and confidentiality will be maintained at all times. You have right to refuse to answer a particular question or to withdraw from the interview at any time.

If, for whatever reason, you feel you need emotional or psychological support following this interview, I am committed to refer you to the relevant agency.

Your signed consent will be much appreciated.

Participant: _____

Researcher: _____

Witness: _____

ABBREVIATIONS

EPDS – Edinburgh Postnatal Depression Scale

LMOU – Liesbeeck Maternity Obstetric Unit

MCWH – Maternal, Child and Women's Health Plan

PMHP – Perinatal Mental Health Project

PND – Postnatal Depression

PMNS – Peninsula Maternal and Neonatal Services

P – Client participant

MW – Midwife participant

PM – Project Manager participant

CN – Counsellor participant

Psych- Psychiatrist